

Wakefield District Health and Care Partnership Committee

Tuesday 9 September 2025

1.30pm – 5.00pm

Carleton Grange, Carleton Road, Pontefract, WF8 3RJ

PUBLIC AGENDA

Administration:				
Time:		Item:	Purpose	Lead
1.30pm 2mins	1	Welcome and Apologies	Verbal Information	A Carroll
1.32pm 2mins	2	Quorum and Declarations of Interest	Verbal Information	A Carroll
1.34pm 3mins	3	<u>Minutes of the previous meeting held on 3 June 2025</u>	Paper Approval	A Carroll
1.37pm 3mins	4	<u>Action log</u> and matters arising	Paper Review	A Carroll
1.40pm 10mins	5	Questions from Members of the Public	Verbal To Note	R Unwin
1.50pm 5mins	6	Chair Opening Remarks	Verbal To Note	A Carroll
1.55pm 10mins	7	<u>Wakefield Place Lead Quarterly Report</u>	Paper To Note	M Brown
System Delivery and Strategy:				
2.05pm 45mins	8	<u>Birth Choices in the Wakefield District</u>	Paper Oversight	P McSorley/ R Unwin
2.50pm 15mins	9	<u>Wakefield District Plan</u>	Paper Approval	R Unwin
Break at 3.05pm for 10mins				
3.15pm 15mins	10	<u>Provider Collaborative Workstream and Progress</u>	Presentation Oversight	R Unwin
3.30pm 15mins	11	<u>Financial Plan</u>	Paper Approval	A Whittaker/ I Currell
System Assurance and Committee Reporting:				
3.45pm	12	<u>Quality, Safety and Experience Highlight Report</u>	Paper	P McSorley

15mins			Assurance	
4.00pm 10mins	13	<u>Performance Exception Report</u>	Paper Assurance	N Tolson/ Leads
4.10pm 10mins	14	<u>Quarterly Finance Highlight Report</u>	Paper Assurance	A Whittaker/ I Currell
4.20pm 5mins	15	<u>Report from the Chair of the Wakefield Integrated Assurance Sub-Committee</u>	Paper Assurance	R Hindley
4.25pm 5mins	16	<u>Report from the Chair of the Wakefield Transformation and Delivery Collaborative Meeting</u>	Paper Assurance	M Brown
		Governance and Assurance:		
4.30pm 10mins	17	<u>Beter Care Fund Section 75 Partnership Agreement</u>	Paper Approval	M Brown
4.40pm 10mins	18	<u>High Level Risk Register and Board Assurance Framework</u>	Paper Assurance	A Sacha
		Final Items and Closing:		
4.50pm 5mins	19	Escalations to the West Yorkshire ICB Board	Verbal Discussion	A Carroll
4.55pm 5mins	20	Any Other Business	Verbal Discussion	A Carroll
5.00pm Close	-	Date and Time of the Next Meeting: The next meeting of the Wakefield District Health and Care Partnership Committee is scheduled to take place on Tuesday 11 November 2025 from 1.00pm at St Georges Community Centre, Lupset Broadway, Wakefield	Verbal To Note	A Carroll

	Information:	
21	Minutes of the Wakefield Transformation and Delivery Collaborative Meeting a) <u>Tuesday 22 April 2025</u> b) <u>Tuesday 13 May 2025</u> c) <u>Tuesday 17 June 2025</u> d) <u>Thursday 17 July 2025</u>	Information
22	<u>Minutes of the Wakefield Integrated Assurance Sub-Committee held on Thursday 1 May 2025</u>	Information
23	Minutes from the People Panel a) <u>Thursday 6 February 2025</u> b) <u>Thursday 10 April 2025</u> c) <u>Thursday 22 May 2025</u> d) <u>Thursday 24 July 2025</u>	Information

24	<u>Alert, Advice and Assure Report from the previous meeting held on 3 June 2025</u>	Information

Proud to be part of West Yorkshire Health and Care Partnership

ITEM 3**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 3 June 2025 from 2.15pm at Agbrigg Community Centre, 5 Montague Street, Wakefield, WF1 5BB

Present:

Paula Bee (PB)	Chief Executive, Age UK Wakefield and Voluntary, Community and Social Enterprise Representative
Mark Brooks (MBr)	Chief Executive, South West Yorkshire Partnership NHS Foundation Trust
Melanie Brown (MB)	Interim Wakefield Place Lead and Accountable Officer
Dr Ann Carroll (AC)	Independent Chair of the Wakefield District Health and Care Partnership
Chris Evans (CE)	Chief Operating Officer and Deputy Chief Executive, Mid Yorkshire Teaching NHS Trust (on behalf of Brent Kilmurray, Chief Executive)
Stephen Hardy (SH)	Non-Executive Member and Independent Chair of the People Panel
Richard Hindley (RH)	Non-Executive Member and Independent Chair of the Wakefield Integrated Assurance Sub-Committee
Penny McSorley (PM)	Director of Nursing and Quality, Wakefield Place
Lewis Smith-Connell (LSC)	Chief Officer, Healthwatch Wakefield
Dr Colin Speers (CS)	Medical Director for Wakefield Integrated Community Services
Stephen Turnbull (ST)	Director of Public Health, Wakefield Council (also representing Suzy Joyner, Director of Adult Social Care)
In Attendance:	
Sue Baxter (SB)	Head of Partnership Governance, West Yorkshire ICB
Ian Currell (IC)	Chief Finance Officer and Senior Responsible Officer, Wakefield Place
Roger Grasby (RG)	Chair, Healthwatch Wakefield
Dr Lyn Hall (LH)	General Practitioner and Local Medical Committee Representative
Dr Linda Harris (LH)	Chief Executive, Spectrum CiC

Jemma Harris (JH)
Stephen Knight (SK)
Jenny Lingrell (JL)

Sara Miles (SM)
Sean Rayner (SR)

Cllr Duncan Smith (DS)
Ruth Unwin (RU)

Claire Vodden (CV)
Amy Whittaker (AW)

Natalie Tolson (NT)

Governance Manager, Wakefield Place facing
Chief Executive, Conexus Wakefield
Service Director for Children's Health and Wellbeing,
Wakefield Council (also representing Vicky Schofield,
Director of Children's Services)
Business Support Manager, Wakefield Place
Executive Director of Provider Development, South
West Yorkshire Partnership NHS Foundation Trust
Chair of the Wakefield Health and Wellbeing Board
Director of Strategy, Wakefield Place (also
representing Becky Barwick, Associate Director of
Partnerships and System Development)
Head of Communications, Wakefield Place
Chief Finance Officer and Senior Responsible Officer,
Mid Yorkshire Teaching NHS Trust
Head of Business Intelligence, Wakefield Place/Mid
Yorkshire Teaching NHS Trust (agenda item 10 only)

W001/25 WELCOME AND APOLOGIES

AC welcomed all to the meeting held in public and noted apologies for absence from and on behalf of Brent Kilmurray, Phillip Earnshaw, Suzy Joyner, Vicky Schofield, Phillip Marshall, Becky Barwick and Sharlene Featherstone.

W002/25 QUORUM AND DECLARATIONS OF INTEREST

The meeting was quorate in line with the terms of reference and there were no noted conflicts of interest made arising from matters on the agenda.

W003/25 MINUTES OF THE PREVIOUS MEETING HELD ON 11 FEBRUARY 2025

The minutes of the previous meeting held on 11 February 2025 were approved as a true and accurate record following the below amendment.

Removal of Stephen Turnbull from the attendee list and move to apologies.

W004/25 ACTION LOG AND MATTERS ARISING

There were no outstanding actions recorded on the action log as below, and no matters arising from the previous meeting:



- **98/24: Deep Dive into Children's ADHD Services:** Deep Dive undertaken and outcome recorded with the sub-committee Assurance and Escalation Report. Action Closed
- **116/24: Support to Sexual Health Services:** Wakefield Council Public Health Commissioning Manager confirmed progress had been made following support from colleagues. Action closed
- **121/24: Shared Referral Pathway position:** Presented to the Planned Care Alliance and included within the Performance Exception Report. Action closed

W005/25 CHAIR OPENING REMARKS

AC reported that Cllr Faith Heptinstall had recently stepped down as Chair of the Wakefield Health and Wellbeing Board and expressed her thanks for Cllr Heptinstall's contribution and extended a welcome to Cllr Duncan Smith who had assumed the role.

AC reiterated that the committee was a sub-committee to the West Yorkshire ICB Board and held a delegated budget for the population of Wakefield and the partnership was committed to delivering high quality services aligned to plans.

She acknowledged the significant organisational change and the requirement to make a 45% reduction in staff. Despite this, staff had responded with professionalism and resilience whilst supporting priorities aimed at maintaining healthcare standards. In addition to this AC highlighted the development of provider partnerships across the Places with Wakefield expected to move into shadow arrangements from September 2025. Progress on that would be reported through regular development sessions led by SR.

W006/25 WAKEFIELD PLACE LEAD QUARTERLY REPORT

MB confirmed that she had, along with other lead colleagues, written to Rob Webster (RW), West Yorkshire ICB Chief Executive, setting out the place plans for provider partnership and a copy of that letter would be shared for oversight. In terms of progress towards those partnerships, she reported that a decision had been made not to seek external facilitation support for work to progress the establishment of a local provider alliance and that shadow arrangements were scheduled from September 2025 and full implementation by the end of 2025/26.



MB noted the successful opening of the new Surgical Hub at Dewsbury Hospital at the end of April 2025. The additional theatre capacity would enhance elective activity and be a valuable facility for the local population. She also highlighted the Wakefield Diagnostic Centre had been open for one year delivering more than 70,000 scans and tests to date. The centre's enhanced technology continued to benefit the local community.

The progress made on the operational plan was noted with assurance given that the plan had been triangulated across Places. It was also acknowledged that there was a delay to the release of the 10 Year Health Plan from NHS England, however assurance were given that when it was released briefing sessions would be held with partners which would also be used as an opportunity to share learning.

MB confirmed that several colleagues had been involved in the recent interview process for the Director of Adult Social Services at Wakefield Council. The successful candidate Rachel Bowes will commence in the role on 1 July 2025.

She also recorded that the birth choices consultation at Pontefract Hospital had concluded on 18 May 2025 with the team now analysing the responses from members of the public. She thanked everyone involved particularly those colleagues who led a series of community drop-in sessions.

The Public Wakefield District Health and Care Partnership Committee:

- **NOTED** the Wakefield District Health and Care Partnership Place Leads Quarterly Update, provided for oversight and assurance.

SYSTEM DELIVERY AND STRATEGY

W007/25 DEVELOPMENT OF THE WAKEFIELD DISTRICT PLAN

RU said that Wakefield Council had initiated a piece of work to develop a plan to position the district as a place where people want to build their future. Six key lines of inquiry had been identified following an initial summit hosted by the Wakefield Together Partnership in autumn 2024. Following a period of engagement with stakeholders from the public, private and voluntary, community and social enterprise (VCSE) sector, a further Summit had been held with over 200 attendees. She confirmed that there had been agreement that the Living Healthy Lives framework would replace the current health and wellbeing strategy, recognising that the areas of focus for the



district plan addressed social determinants that affect population health and wellbeing.

In addition, she noted that the Living Healthy Lives element was progressing and would focus on not only living well but also aging well recognising that aging is a lifelong process that began from birth. The Living Healthy Lives section would focus on three priorities: reducing health inequalities; empowering people to live well and maximise independence; and improving health through joined up neighbourhood approaches.

It was noted that discussions and further development would continue with the understanding that the timing of plans did not necessarily align, particularly while awaiting the delayed publication of the 10 year plan. Nevertheless, it was confirmed that the district plan would be presented to the Council's Cabinet for endorsement in July 2025.

MB asked when the draft plan would be ready and asked if it would be shared for approval at the next meeting. RU confirmed that, following consideration by Cabinet, the plan would be taken through the governance processes of partner organisations for them to confirm their commitment and agree how it impacted on local organisational plans. MB also asked if there was a gap in the leadership of the healthy lives workstream following Len Richards' retirement at Mid Yorkshire Teaching NHS Trust (MYTT). RU confirmed that Brent Kilmurray, the incoming Chief Executive, had stepped in and covered the leadership role.

MB questioned what engagement there had been with members of the public and RU advised that the plan had been built from evidence from previous public engagement, including the Big Conversation, and there had been a process of stakeholder engagement involving stakeholders from the health and care sector, including VCSE. The team had analysed the evidence to inform development of the priorities.

As chair of the Ageing Well Board, PB reported there had been a strong appetite for adopting a plan for a life course approach to healthy ageing. Whilst the Ageing Well Board functioned well as an entity, it was not sufficiently aligned to other parts of the system. AC agreed this was an important issue and queried where oversight of the work and deliverables in the District Plan would sit. RU confirmed that the overall governance of the Living Healthy Lives element would sit with the Wakefield Health and



Wellbeing Board but agreed that the ageing well programme delivery would need to be aligned along with appropriate scrutiny arrangements.

RH asked about the relationship between the healthy lives chapter of the plan and the chapter focusing on children. RU confirmed that whilst the Children and Young People's programme would take the lead on driving forward the children's priorities, the Health and Wellbeing Board would continue to have an all-age focus. This was agreed by DS.

MB said she had recognised the most recent event had a high level of engagement from stakeholders. PB recognised this and added that the Aging Well Board linked across multiple forums which was challenging.

SK questioned whether approval of the plan should have been delayed until after the publication of the NHS 10 Year Plan. RU confirmed that publication of the NHS 10 Year Plan had been delayed but it would have informed this work had it been available. Engagement undertaken to support the development of the 10 Year Plan had been considered in developing the District Plan. She acknowledged that, given that the District Plan reflected many of the social determinants of health, it was likely the Health and Wellbeing Board would focus more on ill health prevention and maintaining positive health and wellbeing through well-coordinated support.

SK recognised that neighbourhood health priorities would be addressed through the plan although felt they may differ from those within primary care. MB expressed confidence that the plan would be complementary.

AC recorded the significant amount of work undertaken and commented on the high level of engagement across the district and MB concluded by confirming that ongoing development and engagement would take place through the committee's development session.

The Wakefield District Health and Care Partnership Committee:

- **CONSIDERED** the proposed priorities and **NOTED** progress made towards the development of the Wakefield District Plan

SYSTEM ASSURANCE AND COMMITTEE REPORTING

W008/25 HIGH LEVEL RISK REGISTER



SB confirmed that there were 19 risks on the Wakefield Place risk register. This included five new risks, two that had decreased in score following review and no risks closed. She said that the Board Assurance Framework had undergone its ICB focussed review during the first cycle and would move to a Place based review during cycle two.

SB confirmed that new risk, 2513, was scored at 16 in relation to issues arising from statutory compliance at the King Street Walk in Centre, Wakefield which will require further urgent work to put in place business continuity plans. PM then confirmed that four additional risks related to quality had been identified since the last cycle as below:

- Risk 2507 (score 12): confirmed as a national risk that ICBs will not meet its statutory duties in the delivery of Deprivation of Liberty Safeguards for those eligible for NHS Continuing Healthcare (CHC) due to a lack of assessor capacity, preparation of application and availability of court of protection time. The risk had been added to all Place registers
- Risk 2495 (score 12): confirmed risk of reduced availability of nursing and dementia care home beds in the district due to poor care quality, staffing challenges, and management shortages. This may lead to the Care Quality Committee (CQC) enforcement actions, potential care home closures or registration changes, increased pressure on remaining services, and reduced choice for service used and their families
- Risk 2506 (score 9): inability to deliver all of the statutory functions of the ICB in regard to All Age Continuing Care 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.
- Risk 2501 (16): risk to poor patient outcomes, safety and experience in the district due to overcrowding at MYTT linked to bed shortages and reduced patient flow. This may result in long waits and care being provided in temporary escalation spaces, potentially affecting the ICB's ability to meet its statutory duty to deliver quality services in Wakefield.

Regarding risk 2513, RH enquired about the challenges in securing a new location for the walk in centre noting that if the situation were to worsen rapidly the service might face closure. RU said that the long term solution and accompanying business case were nearly ready for review and alternative business continuity arrangements were being developed with the provider to ensure continuity of service. .



SK asked whether the speed of organisational change should be added as a risk. MB said it had been raised at the West Yorkshire ICB Board with confirmation that a risk would be added to the ICB risk register. SB noted that a risk aimed at supporting staff morale and wellbeing during the organisational change would also be taken into consideration.

PB highlighted the risk to dementia patients as captured within risk 2495. She expressed her support for the inclusion of the risk and agreed it was appropriate to call out given its potential impact on a vulnerable patient group. As a representative of the voluntary sector, she emphasised that the issue was recognised within the sector and warranted acknowledgement. AC asked whether it was possible from a voluntary perspective to quantify the risk and PB believed it was. She agreed to liaise with the ICB Risk Manager to discuss in more detail.

Action: PB to discuss risk 2495 in more detail with the ICB Risk Manager, Asma Sacha.

In terms of the overcrowding in A&E and use of temporary escalation spaces, AC asked if the issues faced were seasonal or year round. CE responded that capacity challenges would continue. He confirmed that the matter was being progressed through the unplanned care alliance. He also reported a positive development in the reduced length of stay at MYTT which continued to reflect an improving trend.

The Public Wakefield District Health and Care Partnership Committee:

- **RECEIVED** and **NOTED** the High Level Risk Report including Board Assurance Framework Summary as an accurate representation of the current risk position.

W009/25 QUALITY, SAFETY AND EXPERIENCE QUARTERLY REPORT

PM took the report as read but highlighted several key points, including concerns regarding the availability of nursing and dementia care beds in Wakefield. She noted that the CQC had recently visited Manor Park Care Home and issued a warning notice addressing the following five breaches:

- Regulation 9: person centred care
- Regulation 12: safe care and treatment
- Regulation 13: safeguarding service users from abuse or improper treatment
- Regulation 17: good governance



- Regulation 18: staffing

In addition, the home were put under significant scrutiny through formal enhanced quality oversight in line with the ICB Quality Assurance Framework for Adult Social Care. The provider had also instigated a voluntary suspension on new admissions.

PM confirmed that a rapid quality review had been undertaken at MYTT during quarter 4 to fully understand the impact as a result of its urgent care performance. As assurance was provided and the improvements were beginning to show an impact, it had been agreed that a Quality Improvement Group would not be required, and instead the Trust would be given time to embed the changes.

PM noted that the Office for Standards in Education, Children's Services and Skills (OFSTED) had carried out an inspection of Wakefield Local Authority Children's Services (ILACs) in March 2025, and that the CQC had conducted an assessment of Adult Social Care. The assessment included an onsite inspection visit and meetings with both staff and service users. It was reported that the findings from both inspections were expected to be published shortly. In addition, JL confirmed that there was a briefing available with more detail on the inspection carried out at ILACs and would share with committee members.

SR asked how many people were in the care home following the CQC inspection. PM confirmed there were 22 beds at the care home all situated on the same floor for dementia patients. The loss of these would be detrimental therefore ongoing efforts to support improvements would continue.

AC asked what was being done to support all care homes more broadly. PM explained that a matrix team was in place with nurses from the ICB able to bring in additional support when required. One of the key areas of focus had been medicines management and wound care, which the community education team were supporting and delivering training.

MB thanked PM for her contribution, noting the positive impact and ongoing improvements that had been delivered since she came into post in December 2024.



The Public Wakefield District Health and Care Partnership Committee:

- **NOTED** the contents of the Quality, Safety and Experience Summary Report for Quarter 4 2024/25

W010/25 ANNUAL REPORT FOR WAKEFIELD HEALTH AND CARE PARTNERSHIP

RU reported that this year the annual review had been based on the strategic priorities and included a focus on Equal Health for All, Building Community Support and Managing Service Demand.

She said that last year in Wakefield the annual review had been shared internally and externally in animation form, and this year initially it had been prepared in written form but would be converted to animation for public facing communications.

The report also outlined the ongoing work required to support individuals with a mental health condition and those placed out of area placements. It described developments in community support and service offerings including contribution from the voluntary community and social enterprise (VCSE) sector. Additionally, it addressed the goal of achieving equal health for all, enhancing community based support and managing service demand.

AC recommended the report for approval with MB adding the importance of the public facing animation to support the Wakefield populations understanding of the work undertaken.

The Public Wakefield District Health and Care Partnership Committee:

- **NOTED** the 2024/25 Annual Report for Wakefield **APPROVED** its approach for public facing communications, plain-English animation drawing out many of the main milestones and achievements over the last 12 months

W011/25 REPORT FROM THE CHAIR OF THE WAKEFIELD INTEGRATED ASSURANCE SUB-COMMITTEE

RH highlighted that the sub-committee had initiated deep dive sessions to explore key service areas in more detail. The first deep dive meeting had two areas of focus which were Children's ASD and ADHD Services and System Waiting Times and Patient Flow. The session was valuable and provided assurance that services were progressing and that levels of scrutiny and oversight were appropriate. RH expressed his appreciation to



colleagues who attended the additional session and to those who led on discussion.

He highlighted that due to the timing of the reporting cycle the last meeting did not receive a financial update but was assured that a full report would be presented at the next meeting.

Under the advice section of the triple A report, RH reiterated that issues raised regarding the care home sector and increased operational costs had been noted and would be closely monitored by the sub-committee.

The Public Wakefield District Health and Care Partnership Committee:

- **RECEIVED** the Wakefield Integrated Assurance Sub-Committee Triple A report

W012/25 REPORT FROM THE CHAIR OF THE WAKEFIELD TRANSFORMATION AND DELIVERY COLLABORATIVE MEETING

MB reminded colleagues that the Wakefield Transformation and Delivery Collaborative Meeting was a monthly forum and consistently saw high levels of attendance. Alliances had been providing updates via highlight reports on a bi-monthly basis but as part of the end of year review, the function and purpose of the meeting had been reviewed, resulting in a shift of focus towards neighbourhood health as the primary area of work. The meeting had also developed a strong financial focus which had contributed to collective efforts in achieving greater efficiency savings. CS added that each of the neighbourhood health core components would report monthly providing full oversight and updates on both soft and hard launches scheduled over the coming months. MB also confirmed that the business intelligence unit had been working to understand the benefits and impact modelling of key projects and schedules. This work was intended to support the wider system and would also inform future planning rounds with some of the assumptions already tested at the last meeting with significant work on virtual ward and integrated neighbourhood teams noted.

AC asked when the full description of the neighbourhood health model would be available and CS confirmed by the next meeting in September 2025.

The Public Wakefield District Health and Care Partnership Committee:

- **RECEIVED** the Wakefield Transformation and Delivery Collaborative Meeting report and update provided

W013/25 PERFORMANCE EXCEPTION REPORT

NT joined the meeting and took members through the performance exception report executive summary. AC commented that the revised layout and format represented a significant improvement and effectively highlighted the substantial work undertaken to support the achievements of performance targets.

MB commented that the work within the mental health and learning disability alliance was clear to see within the report. She noted that the improvements were substantial compared to the previous year and although the serious mental illness (SMI) health checks target was narrowly missed mental health and wellbeing remaining central to the ongoing work. SR agreed and noted that the improvement in the SMI health check rate had been an impressive achievement especially given low uptake in previous years. Although the target had not been fully met, more people were now receiving annual checks.

CS asked if the team had been able to add data on the Children's Autism Spectrum Disorder (ASD) and Children's Attention Deficit Hyperactivity Disorder (ADHD) services into the dashboard. NT confirmed that integrating the children's dataset into the new data platform was a priority though significant work was still needed to achieve this. JL explained that the dataset was currently collected manually which limited access to granular detail. The work would progress through the Children's Alliance. She noted that full oversight and assurance would feed through both the Wakefield Integrated Assurance Sub-Committee and the Wakefield Transformation and Delivery Collaborative Meeting.

CE highlighted patient long waits at hospital sites noting a small number of 52 week breaches which continued to be tracked at MYTT. The opening of the surgical hub was expected to support and potentially accelerate improvements in that area. AC observed that the increase in planned care demand aligned with national trends. CE recognised this and said that some organisations had been able to reduce the waiting lists, but there was no significant change overall.

RG suggested the committee review benchmarking against similar organisations, citing that 71.2% of GP appointments in March 2025 were face to face despite public perception that access had reduced. MB confirmed



benchmarking data was included in all received information and noted that public perception around GP and dental appointment access was a reoccurring topic raised at the Overview and Scrutiny Committee. She acknowledged the difficulty in shifting the perception and the need for continued efforts.

CS added that while new clinical roles under the Additional Roles Reimbursement Scheme have increased appointment options, the public expectation remained focussed on seeing a GP. This was due to inadequate communication nationally in relation to the benefits of seeing others practitioners. A similar issue occurred with the Pharmacy First launch which lacked the needed national communication. LH agreed and felt it important to communicate to improve understanding and help to manage expectations.

SF said that patients value continuity of care and CS agreed. He noted a further misconception and stated that often continuity was based on consistency of professional role rather than continuity from the same clinician.

NT concluded by confirming the 2025/26 report would continue to focus on local priorities and standard metrics that formed part of the operational and financial planning guidance

The Public Wakefield District Health and Care Partnership Committee:

- **NOTED** the latest performance and those indicators where performance was below target and the associated exception information where provided.

GOVERNANCE AND ASSURANCE

W014/25 WAKEFIELD PLACE PARTNERSHIP AGREEMENT REFRESH

MB confirmed that the agreement had first been developed and agreed in July 2022 and had now been reviewed and refreshed with minor changes in line with its current review process and in recognition that significant work that would be required to further develop the agreement as we move into a provider alliance.

SB added that a review had been undertaken across all five Places, as well as a review of the West Yorkshire Partnership Board agreement. She said that non-material changes had been made to update the agreement to reflect



current legislation and that a change to the review period would be introduced, extending it to three years, following the planned review associated with the establishment of the provider alliance. There would also be a period where a temporary memorandum of understating would be required and that would be managed through the governance function.

MB asked whether governance leads for each organisation had contributed to the review. SB confirmed that they had not on this occasion as the current iteration had non-material changes, however, she provided assurance that a governance task and finish group would be established as the provider alliance framework further developed.

AW noted that all but the mental health alliance had been removed from the signatories and asked if there was a reason it differentiated between other alliances. MB confirmed she would review and amend appropriately the signatories as this had been an oversight.

Action: MB to review the signatory element of the agreement to ensure its accuracy

The Public Wakefield District Health and Care Partnership Committee:

- **NOTED** and **APPROVED** the changes made to the Wakefield Place Partnership Agreement
- **NOTED** the move to subsequent review cycles to every three years, following material change expected during 2025/26
- **NOTED** the change to signatory from the ICB Chief Executive to the Place Accountable Officer, upon NHS England approval of the ICB constitution (agreed 17 December 2024)

W015/25 THE WAKEFIELD DISTRICT HEALTH AND CARE PARTNERSHIP COMMITTEE 2024/25 ANNUAL REPORT

Attendees were advised by RU that, subject to Committee approval, the annual report would feed into the West Yorkshire ICB's overall annual report.

In terms of how the meeting functions, feedback from the effectiveness survey she said this had been largely positive with a strong grip on performance highlighted.



RU said that as the meeting had progressed, she had noted a couple of additional topics that would need to be included within the committee's Work Plan for 2025/26, as below:

- Neighbourhood Health – September 2025
- Maternity Birthing Model – September 2025

The Public Wakefield District Health and Care Partnership Committee:

- **NOTED** the results of the effectiveness survey and highlights from 2024/25
- **APPROVED** the 2024/25 Annual Report for onward inclusion within the West Yorkshire ICB Annual Report
- **ENDORED** the development for 2025/26 and progression into a Provider Alliance is undertaken
- **NOTED** and recommended to the ICB Board meeting on the 24 June, to approve the revised Terms of Reference
- **NOTED the** 2025/26 Work Plan following the amends as above

W016/25 END OF YEAR COMMITTEE EFFECTIVENESS FOR THE WAKEFIELD INTEGRATED ASSURANCE SUB-COMMITTEE

RH noted the achievements and highlights as recognised within the report and thanked all members of the sub-committee for their ongoing contribution.

The Public Wakefield District Health and Care Partnership Committee:

- **NOTED** the results of the effectiveness survey and highlights from 2024/25
- **APPROVED** the recommendations for development across 2025/26
- **APPROVED** the revised Terms of Reference and 2025/26 Work Plan

W017/25 END OF YEAR COMMITTEE EFFECTIVENESS FOR THE WAKEFIELD TRANSFORMATION AND DELIVERY COLLABORATIVE MEETING

MB noted that results from the end of year effectiveness survey were positive and would support and shape the progression to a Provider Alliance.

The Public Wakefield District Health and Care Partnership Committee:

- **NOTED** the results of the effectiveness survey and the highlights from 2024/25
- **ENDORSED** the recommendations for development across 2025/26 and progression into a Provider Alliance is undertaken
- **APPROVED** the 2025/26 Work Plan

FINAL ITEMS AND CLOSING

W018/25 ESCALATIONS TO THE WEST YORKSHIRE ICB BOARD

The Committee agreed that there were no areas requiring escalation to the West Yorkshire ICB Board.

W019/25 ANY OTHER BUSINESS

There were no items of other business therefore AC called the meeting closed at 4.00pm.

DATE AND TIME OF THE NEXT MEETING

The meeting of the Wakefield District Health and Care Partnership Committee is scheduled to take place on Thursday 4 September 2025 from 9.00am at St Mary's Community Centre, The Circle, Pontefract, WF8 2AY

THE FOLLOWING ITEMS WERE RECORDED FOR INFORMATION:

- a) Minutes of the Wakefield Transformation and Delivery Collaborative Meeting (19 November 2024 and 19 December 2024)
- b) Minutes of the People Panel (19 September 2024 and 7 November 2024)
- c) Minutes of the Professional Leadership Group (2 October 2024)

Proud to be part of West Yorkshire Health and 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
3 June 2025	W008/25	High Level Risk Register	PB to discuss risk 2495 with the ICB Risk Manager, Asma Sacha in more detail	Paula Bee	July 2025	Meeting arranged and undertaken	Complete
3 June 2025	W014/25	Wakefield Place Partnership Agreement Refresh	MB to review the signatory element of the agreement to ensure its accuracy	Melanie Brown	June 2025	Review complete and signatories collated	Complete
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
11 February 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 7

Report of the Wakefield District Health & Care Partnership

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

Tuesday 9 September 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 24 June 2025. You can view all the papers and a recording from the meeting [here](#). During 2023/24, Healthwatch across West Yorkshire produced a series of 'focus on' reports for each ICB Board meeting, looking at people's experiences of health and care at different life stages, with a focus on health inequalities. At their meeting in June 2025 the ICB Board received a report reflecting on the themes emerging from the health inequalities 'focus on' sessions in 2024/25. The consistent themes included:

- The 3 Cs: 'Communication, Coordination and Compassion'
- Access
- Equity in access and experience – listening to people to make sure we get this right
- Information, education and delivery of services with and within communities
- Person-centred holistic care that meets the needs of all communities
- Prevention and wellbeing

The meeting also included discussions on the Integrated Neighbourhood Teams Blueprint; the Urgent and Emergency Care Blueprint; and Joint Capital Resource Use Plan 2025/26.

The West Yorkshire Health and Care Partnership Board

The West Yorkshire Health and Care Partnership Board met in public on 15 July 2025. A recording and the meeting papers are [on the partnership website](#).

10 Year Health Plan

The Government's [10 Year Health Plan for England](#) was published on 3 July 2025. The plan is the summation of substantial work over several months and extensive engagement with the public. It sets out ambitions for the coming period, with both nearer term commitments and a vision for the health system at the end of the 10-year period.

The Plan reinforces the government's three shifts as the core components of the proposed new care model:

ITEM 7

- hospital to community – with a significant focus on a neighbourhood health service.
- analogue to digital – with substantial shifts based on five fundamental changes (see below); and
- sickness to prevention – including collective working on shared problems across agencies.

To support the scale of change required and the new vision for health and care service, the government has committed to changes in the NHS to prepare for the delivery of these 3 shifts:

- Through a new operating model, which includes the work to reduce and refocus the number of people and capacity within ICBs as they transition to become strategic commissioners; and changes to Department of Health and Social Care/NHS England and regional offices.
- By emphasising transparency, through a commitment to publish quarterly league tables, “give greater priority to patient voice and choice”, and strengthen the focus on quality and financial oversight through contracts and regional teams.
- By creating a new workforce model, which will include the publication of 10-year workforce plan later this year.
- Through a reshaped innovation strategy, with emphasis on what they call “five big bets”: improved data to drive earlier diagnosis and treatment, AI to drive productivity and liberate staff, genomics and predictive analysis, wearables to deliver real-time care, and robotics to enhance precision.
- By taking a different approach to NHS finances, including the establishment of two new contract forms for neighbourhood health, a commitment to establish Integrated Health Organisations to improve integration and retain financial flexibility to reinvest within the same organisation, eradicating block contracts, new tariff models, and “patient power payments” where patient feedback will correlate with provider payment.

NHS West Yorkshire ICB will be working with all partners, to develop a shared set of ambitions for how we want to work together to deliver meaningful change in the medium term. The issues that affected local people prior to the 10 Year Plan, often driven by poverty, multi-morbidity, structural inequity and differing access to healthcare and support, have not changed. The need for us to work in partnership in ways that meet national expectations and local circumstances remains.

NHS Operating Model Changes

In March 2025 the Government and NHS England announced a requirement for ICBs to reduce their running costs by an average of 50%, as part of a set of wider reforms to the health and care system. These reforms include:

- Nationally – NHSE will be abolished and its functions merged with the Department of Health and Social Care (DHSC) over a two-year programme, reducing their combined running costs by 50%.
- Regionally – NHSE’s regional teams will be replaced with new regional bodies which will take over responsibility for some ICB functions, including the formal oversight of providers;

ITEM 7

- At System level - ICBs will reduce staff costs by an average of 50% by December 2025 and will re-focus their role as strategic commissioners; and
- At Place level - providers will reduce growth in corporate running costs by 50% and place provider partnerships will be established as a vehicle for integration and supporting neighbourhood health.

Following these announcements, a [Model Integrated Care Board – Blueprint v1.0](#) was published by NHSE and DHSC on 2 May 2025, setting out the future functions of ICBs and how current functions would transition to other organisations as part of the wider reforms. To deliver this 50% reduction in running costs will require a fundamental shift in how the ICB operates. We have established a Transition Committee of the West Yorkshire ICB Board to provide assurance on the organisational change process.

Wakefield Place

Wakefield District Annual review 2024-25 animation

The great strides made by Wakefield District Health and Care Partnership during 2024-25 have been captured in a [brand new animation](#).

This animation gives a quick tour of some of our partnership highlights, from the opening of the Community Diagnostic Centre, which has already delivered more than 70,000 tests and scans, to the work of our Mental Health Alliance helping more than 250 people into employment through the Individual Placement and Support Scheme.

The animation also highlights the impact our Voluntary, Community and Social Enterprise (VCSE) sector continues to have through initiatives such as our Blood Pressure Wellbeing Champions who helped deliver hundreds of vital blood pressure checks this year.

Wakefield District's support for children in care

Ofsted's latest inspection report into its children's services confirms the Wakefield District continues to provide a Good overall service, with 'Outstanding' support for children in care. The report highlights the strength of Wakefield's leadership, the dedication and stability of its workforce, and a clear commitment to achieving the best outcomes for children and young people.

Highlights from the Ofsted report include:

- outstanding support for children in care, including placement stability and emotional wellbeing services
- a highly skilled, well-supported workforce and strong management oversight
- child-centred care planning and creative life-story work
- an extensive early help offer through nine family hubs and three youth hubs
- strong political leadership and a clear culture of improvement
- above national average support for care leavers in education, training and employment

ITEM 7

More information about the inspection, including the full report, is available online: [Wakefield's support for children in care rated 'Outstanding' in Ofsted report - Wakefield Council](#)

Better Care Fund Approval Letter

On the 30 May 2025 Wakefield Place received our BCF approval letter 2025-26 from Ben Jupp, Interim SRO for the Better Care Fund in NHS England (this can be found at appendix 1).

Our plan was submitted for regional assurance and approval as part of a new one-year planning process. The letter acts as permission to spend the NHS minimum contribution and that our partnership agreements must be signed prior to the deadline of the 30 September 2025. Wakefield will meet this requirement following approval at the Wakefield Health and Wellbeing Board meeting on 25 September 2025.

Fast-track musculoskeletal service helping Wakefield's workforce stay healthy and active

A new fast-track musculoskeletal (MSK) service, launched in April 2025, is already improving health outcomes for staff in organisations across Wakefield District that don't have access to occupational health support – particularly smaller businesses without in-house or outsourced provision.

The 12-month pilot, part of the Healthy Working Life programme led by the West Yorkshire Combined Authority and NHS West Yorkshire Integrated Care Board, is designed to reach workplaces not covered by NHS occupational health services.

The service offers rapid access to physiotherapy through a combination of remote triage, personalised online exercise programmes and in-person treatment where needed. Staff are referred through a simple online portal and are contacted within 24 hours, with most receiving a full remote assessment within just four.

In its first three months, the service received 181 referrals from 36 organisations, reaching over 16,000 staff. So far, 142 patients have completed treatment, with many returning to work sooner than expected. Notably, 60% of patients recovered without needing face-to-face care, with outcomes showing a 63% reduction in pain and a 33% improvement in physical function, all delivered with an average of just 100 minutes of support per person. As the pilot continues, work is underway to further embed the service into local systems and explore options for long-term funding beyond April 2026. See the [case study on the Healthy Working Life pages](#) on the West Yorkshire Health and Care Partnership website for more information.

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

30 May 2025

To: Cllr Faith Heptinstall, Cllr Michelle
Collins, Chair(s), Wakefield Health
and Wellbeing Board
Rob Webster, Melanie Brown,
Integrated Care Board Chief Executive
or Representative(s)
Tony Reeves, Chief Executive,
Wakefield Council

cc. Jane Sproat, Jenny Sleight

Dear Colleagues,

**Better Care Fund 2025-26 – approval for 25-26 plans and permission to spend NHS
minimum contribution**

Thank you for submitting your Better Care Fund (“**BCF**”) plan and for the collaborative work among local partners to develop the plan.

As you will be aware, the BCF is a joint programme operated by the Department of Health and Social Care (“**DHSC**”), Ministry of Housing, Communities and Local Government (“**MHCLG**”) and NHS England. As outlined in the [BCF Planning Requirements](#), NHS England is responsible for final approval of the use of the NHS minimum contribution, following a collaborative regional review process which includes input from social care representatives. This letter details the outcome of that process.

I am pleased to let you know that following the review process, your plan has been classified as ‘**approved**’.

BCF conditions for financial year 2025-26

The BCF funding from NHS England for the financial year 2025-26 can now be formally released, subject to continuing to meet the national conditions set out in the [BCF Policy Framework for 2025-26](#) and further detailed in the [BCF Planning Requirements for 2025-26](#) including:

- Delivery of your approved plan, including progress against BCF goals and wider objectives of the BCF,
- BCF funding is used in compliance with grant and funding conditions, including maintaining the NHS minimum contribution to adult social care,
- Compliance with monitoring, oversight and support processes, working with regional and national BCF teams, including submission of jointly agreed quarterly reports to the national BCF team and regional Better Care Manager(s) (“**BCM**”) in line with the BCF reporting cycle and compliance with escalation processes,
- The transfer of BCF funding from NHS England into one or more section 75 pooled funds.

Separately, the conditions relating to the use of the Local Authority Better Care Grant and Disabled Facilities Grant (“**DFG**”), that form that local government contribution to the Better Care Fund, are set out in Section 31 Grant Determinations ([Local Authority Better Care Grant Determination 2025 to 2026 - GOV.UK](#), the Grant Determination Letter for the DFG 2025/26 will be published in due course). This makes clear the purpose and use of this local authority funding and directly relates to the [BCF Policy Framework](#) and [BCF Planning Requirements](#) (see section on the legal framework below).

Legal framework

As set out in the [BCF Planning Requirements for 2025-26](#), the BCF is operated by the Department of Health and Social Care, the Ministry for Housing, Communities and Local Government and NHS England.

NHS England makes BCF funding available to ICBs under section 223GA of the 2006 Act. Grants to local government (Local Authority Better Care Grant and Disabled Facilities Grant) will be paid to local government under section 31 of the Local Government Act 2003, with a condition that they are pooled into local BCF plans.

The escalation process set out in the Planning Requirements explains how action may be taken if the ICB or local authority do not comply with conditions. This includes the escalation process if, following enhanced support and oversight, a HWB area does not meet a national condition or there is a material risk that they will not do so.

Next steps

Now that your plan has been approved the NHS minimum contribution may now be spent, subject to compliance with the conditions set out above. Section 75 agreements must be in place across all HWB areas by 30 September 2025.

Ongoing support and oversight regarding the spending of BCF funding will continue to be led by your local BCM(s).

There will be an opportunity for HWB areas to review local goals set out in their approved HWB plan where improvements in data accuracy mean that they might benefit from revision. This will be communicated to local areas as part of the information on the BCF Quarter 1 reporting process. Any changes in local goals will need to be approved by your BCM(s).

It is expected that HWB areas will continue to work in partnership with ICB colleagues to ensure alignment to 2025-26 delivery plans, particularly urgent and emergency care winter planning.

Thank you for your work and best wishes with your implementation and ongoing delivery of the BCF.

Yours sincerely,

A handwritten signature in black ink, appearing to read 'Ben Jupp', with a stylized, flowing script.

Ben Jupp

Director of Intermediate Care and Rehabilitation
Interim Senior Responsible Officer, Better Care Fund
NHS England

ITEM 8

Meeting name:	Wakefield District Health and Care Partnership Committee
Agenda item no:	8
Meeting date:	Tuesday 9 September 2025
Report title:	Birth Choices in the Wakefield District
Report presented by:	Penny McSorley, Director of Nursing and Quality, and Ruth Unwin, Director of Strategy
Report approved by:	Ruth Unwin, Director of Strategy
Report prepared by:	Penny McSorley, Director of Nursing and Quality, and Ruth Unwin, Director of Strategy, Nick Mant, Senior Commissioning Manager for Maternity and Children's Services.

Purpose and Action			
Assurance ☐	Decision ☒ (approve/recommend/ support/ratify)	Action ☐ (review/consider/comment/ discuss/escalate)	Information ☐
Previous considerations:			
The Case for Change for birth choices in the Wakefield District has previously been considered in January 2024 by the Wakefield District Health and Care Partnership Committee (WDHCP) which is a sub-committee of the West Yorkshire Integrated Care Board (WY ICB) and Mid Yorkshire Teaching NHS Trust (MYTT) Board. The proposal has been reviewed by NHS England as part of the national Service Change Assurance Process and confirmation has been received that it meets the NHS Service Change Assurance Process requirements. The letter from NHS England has confirmed that the Region is satisfied that the WY ICB has followed the correct process and that the submission can proceed to decision at the WDHCP. The proposal and consultation feedback have also been subject to engagement and scrutiny by the Wakefield Council Adult Services, Health and Communities Overview and Scrutiny Committee. The Birth Choices across Wakefield District Decision-Making Business Case has also been discussed at the WY ICB Executive Management Team. WY ICB had previously determined that the configuration of birthing services for the Wakefield District was a local decision which should be taken by the WDHCP.			
Executive summary and points for discussion:			
The proposal set out in the business case is for WDHCP to consider the recommendation to make permanent the temporary suspension of the birthing facility at Pontefract and to focus the			

service at the Pontefract unit on delivering comprehensive, high-quality ante-natal and post-natal care and family support. The key drivers for making this change are:

- Quality and safety
- Patient choice and experience
- Workforce
- Activity, demand and complexity

This service was temporarily suspended in Autumn 2019. Before this, work had been underway to assess the future viability of the service due to low numbers of people birthing in the Freestanding Midwifery Led Unit (FMLU). This had included independent advice from the Yorkshire and Humber Clinical Senate and a period of public engagement, culminating in a deliberative event attended by clinicians and members of the public to review the feedback and consider options.

At the time, the temporary suspension of the birthing facility was an urgent decision taken by Mid Yorkshire Teaching NHS Trust (MYTT) on the grounds of safety due to the inability to safely staff all three birthing sites operated by MYTT (Pinderfields, Pontefract and Dewsbury) because of national and local midwifery recruitment challenges and staff absence.

Concerted efforts to recruit to the midwifery service mean that the MYTT maternity service is now staffed to establishment. Recruitment and retention are significantly improved with turnover rates at 7.48% in 2024/25 reduced from 15.5% in 2022.

Subsequent consideration of the sustainability of the service has focused on making optimum use of the midwifery resources, taking into consideration changes in complexity and demand, patient choice and the changing pattern of use of services since the alongside midwife led unit (AMLU) was established at Pinderfields in 2016/17.

The context to this proposal is:

- National guidance on birth choices, midwifery staffing and safer births (Business Case: Section 1, P8)
- A decline in the number of women choosing to birth in FMLUs and a specific decline in the number of people choosing to birth at Pontefract following the opening of the AMLU at Pinderfields in 2016/17. (Business Case: Figure 14 and 15. P23/24)
- An increase in complexity nationally and locally resulting in more people requiring intervention to support a safe delivery (Business Case: Figure 6 – 12, P18 - 21)
- MYTT was one of a very small number of Trusts nationally (and was unique in West Yorkshire) in providing 2 FMLUs, an AMLU and a consultant labour ward (Business Case: P11 and Figure 5, P15).
- People in the Wakefield District would still have access to all four birth choices: home birth, AMLU, FMLU in a neighbouring district, and consultant led obstetric unit.
- The Yorkshire and Humber Clinical Senate previously reviewed the service model and concluded that the FMLU was not viable, that the case for an on-demand service was not sufficiently made and that the proximity of the AMLU at Pinderfields Hospital site offered a realistic choice for midwifery led birth for women living in the east of the district
- In terms of its strategic significance as a Yorkshire-wide resource, data analysis from the period when the unit was fully operational show that small numbers of people from outside the district chose to birth at Pontefract (17 of the total 214 births in 2017 – noting that this includes people registered with a GP practice within the district but living outside the district boundary)

The rationale for recommending the proposal at this time is:

- The sustainability of the service was already under review at the time of the temporary suspension in 2019. The temporary suspension has remained in place since 2019.
- The proposed model is based on five years' experience of delivering this pattern of care, during which staffing in the midwifery service and retention have significantly improved and the Trust has been able to make better use of the midwifery resource to support safety and experience across the service. The Care Quality Committee (CQC) inspection rating for the MYTT maternity service has improved during this period and there have been no safety incidents associated with the withdrawal of the birthing facility.
- The Trust has also introduced an enhanced ante-natal and post-natal offer at Pontefract for people living in the east of the district.
- Increased complexity requires a higher level of intervention and support during pregnancy. The proposal enables midwifery resource to be directed into providing more ante-natal and post-natal services at Pontefract, targeting the specific needs of the population
- Establishing a permanent model of service will enable the birthing rooms at Pontefract to be re-purposed to increase the space available for ante-natal and post-natal care, family support and group work, providing a more comfortable and confidential environment.
- Establishing a permanent model of service removes on-going uncertainty for the population and staff.
- There are no cost savings associated with permanent withdrawal of the midwifery service as resources are being utilised differently to ensure safe staffing across the service and provide enhanced ante-natal and post-natal care. However, reinstating the service without having a negative impact on the existing service would require additional staff at a cost of £1.33m per year.

Evidence from engagement and formal consultation (Consultation report and Section 4 of the Business Case. P29 – 32):

- Formal consultation with the public was carried out over a 14-week period from February to May 2025. The process was developed in conjunction with the Overview and Scrutiny Committee for health and was independently assured and analysed
- Activities were targeted towards people most likely to be using maternity services currently or in the future and included members of the project team going out to community venues to events attended by the target groups, supplemented by promotion of the consultation via website and social media, print and online media outlets, posters and leaflets distributed in 198 venues
- Additional targeted activity was undertaken to capture migrant communities and asylum seekers and people living in areas bordering onto the district
- 732 people engaged in the consultation and 437 individual completed surveys were returned
- 75% were women aged 20 to 39
- 76% of respondents would choose to give birth at Pinderfields
- 44% would choose to give birth at an AMLU and 29% at a consultant led labour ward
- 14% would choose to give birth at a FMLU
- People who had previously given birth at Pontefract were most likely to perceive that the proposal would have a big impact (59%). 36% of all respondents said the permanent withdrawal of the birthing facility at Pontefract would have no impact for them and 27% of all respondents felt it would have a big impact. Of current and future users of maternity services,

53% felt not reinstating the service would have no impact. 30% of people living in Pontefract felt it would have no impact. (Full details are given in section 6.5 of the consultation report) - Objections to the proposal centred on: travel distance, increased demand on Pinderfields Hospital, positive experiences at Pontefract, loss of local choice, concerns about more medicalised births. - Comments in support of the proposal focused on: effective use of staff resource, unsuitability of the unit for higher risk births, low demand, safety concerns re: transfer during labour - Mitigations for these concerns have been discussed with MYTT Board and centre around support during pregnancy to enable people to plan for the birth and continued monitoring of demand, capacity and safety across maternity services (Business case: P31 and 32) Equality Impact Assessment, Quality Impact Assessment and Travel Impact Assessments are included as appendices to the business case and confirm there are positive impacts to the proposal and any detrimental impacts identified can be mitigated. Birth rates nationally and locally show a declining trend, which mean capacity in the maternity service exceeds current and projected demand. However, future capacity requirements will need to be kept under review to reflect any growth in population or increase in birth rate in the district or changes to national guidelines on staffing. Additionally, the WY ICB has been asked to undertake a review of the overall utilisation of Pontefract Hospital, to provide reassurance to the public that optimum use is being made of the facilities and that it continues to play a vital role in the overall MYTT service offer.
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 recommended to: - Support the proposal contained in the business case to make permanent the temporary suspension of the birthing facility at Pontefract and to focus the service at the Pontefract unit on delivering comprehensive, high-quality ante-natal and post-natal care and family support. - Continuously review capacity and demand across maternity services for the district and undertake a stocktake in 2028 of the impact of any demographic changes in the district on the future demand for maternity services. - Commission a review of utilisation of Pontefract Hospital to ensure capacity on the site is being used to optimum effect.
Does the report provide assurance or mitigate any of the strategic threats or significant risks on the Corporate Risk Register or Board Assurance Framework? If yes, please detail which: No
Appendices 1. Decision Making Business Case – Birth Choices in the Wakefield District - Equality Impact Assessment

- [Quality Impact Assessment](#)
 - [Travel Impact Assessment](#)
2. [Report of the outcome of consultation](#)
 3. Presentation (attached)

Acronyms and Abbreviations explained

1. WDHCP – Wakefield District Health and Care Partnership
2. MYTT – Mid Yorkshire Teaching NHS Trust
3. AMLU – alongside midwifery led unit
4. FMLU – freestanding midwifery led unit
5. LMNS – Local Maternity and Neonatal System
6. MNVP – Maternity and Neonatal Voices Partnership
7. NICE – National Institute for Health and Care Excellence
8. CQC – Care Quality Committee

What are the implications for?

Residents and Communities	The proposal impacts residents across the whole district as it ensures staff are more effectively deployed to support people throughout pregnancy, labour and during the early years. There is a greater impact for people living in the east of the district.
Quality and Safety	Positive quality and safety impacts have already been realised during the last five years (2019 to 2024) – evidenced by assurance reports and assessments (including the latest CQC inspections in April 2022, and the LMNS Assurance visit in December 2023). Overall the proposed change ensures improvements to patient safety and quality by being able to adequately staff the maternity units and ensure that resources are deployed as effectively as possible.
Equality, Diversity and Inclusion	Equality impact assessment has been carried out. This confirms that overall the proposal delivers the majority of care closer to home which offsets the negative impact of increased travel for people for intrapartum care.
Finances and Use of Resources	The proposal is designed to make optimum use of resources
Regulation and Legal Requirements	The proposal reflects current regulations and guidance for maternity services
Conflicts of Interest	None identified
Data Protection	Not applicable
Transformation and Innovation	Not applicable
Environmental and Climate Change	Environmental impact is considered in the business case and is confirmed to be neutral

Future Decisions and Policy Making	No impact
Citizen and Stakeholder Engagement	The proposal has been subject to extensive engagement, including formal public consultation. The outcomes of the consultation are included with the business case.

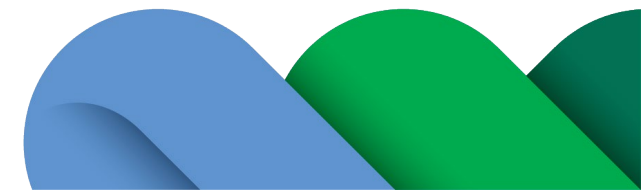


**Wakefield District
Health & Care
Partnership**

Birth Choices in the Wakefield District

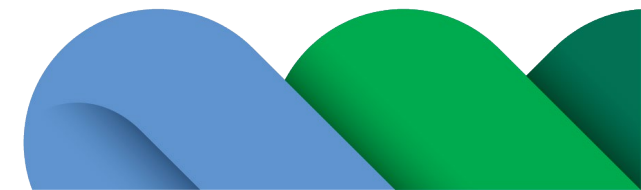
The proposal

- The Decision-Making Business Case sets out the proposal to make permanent the temporary suspension of birthing services at Pontefract Hospital and to continue to offer enhanced ante-natal and postnatal care
- The proposal will provide certainty for people making choices about where to give birth
- The proposal ensures safe staffing across the whole service, which benefits people in terms of access to high quality ante-natal care and post-natal support as well as ensuring appropriate staffing levels for people giving birth in the AMLU or labour ward at Pinderfields (including people from the Pontefract area)
- The proposal will enable birthing rooms at Pontefract to be re-purposed to provide better and more confidential clinical space for people accessing the ante-natal and post-natal care.



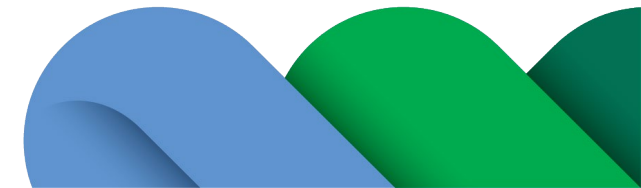
The context

- The proposal is set in the context of national and local maternity strategies and guidance on safer births (Section 1)
- The national and local picture is one of increasing complexity in the health needs of people using maternity services, an increase in need for additional ante-natal interventions and more people choosing or being recommended for Caesarean and consultant led births
- Less people nationally are choosing to birth in FMLUs and there was a specific decline in the number of people choosing to birth at Pontefract following the opening of the AMLU at Pinderfields in 2016/17.



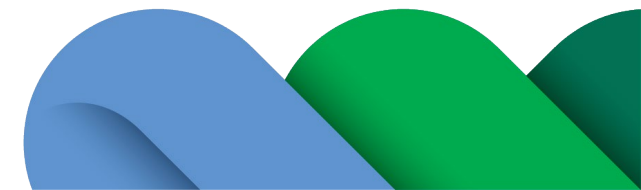
Impact assessment

- Quality, equality, travel and sustainability impact assessments have been carried out (appendices)
- A number of positive impacts have been identified and have already been realised during the last five years (2019 to 2024) – evidenced by assurance reports and assessments (including the latest CQC inspections in April 2022, and the LMNS Assurance visit in December 2023).
- In the main, the proposed change ensures improvements to patient safety and quality by being able to adequately staff the maternity units and ensure that resources are deployed as effectively as possible.
- Negative impacts in relation to choice and travel and political interest have been identified. Mitigations have been added and will be monitored.
- From an equality perspective, the enhanced ante-natal/family support offer available at Pontefract Hospital has brought care closer to home, reducing the cost for travel for antenatal and postnatal appointments, which reduces the negative impact for low income families.
- Whilst the proposal could limit birth choices, it should be noted many individuals would have chosen or been advised to give birth at Pinderfields MLU for clinical reasons
- Worst case travel time would increase by 25 minutes (which for a return trip equates to a cost of approximately £3.16)
- Increased availability of local ante-natal and post-natal support, which accounts for the majority of journeys, means the overall travel impact is positive. Previous engagement feedback showed that 89% of people travel by private car for intrapartum care.



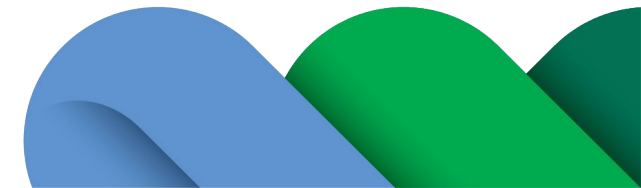
Background

- The facility to give birth at Pontefract Midwife Led Unit was temporarily suspended in autumn 2019
- Whilst this urgent decision was taken on the grounds of safety due to national and local midwife staffing shortages, work had already been underway firstly to attract more people to use the service and latterly to assess its future viability because of low numbers – 350 at peak versus 500 ambition
- The service is now fully staffed and vacancy/turnover rates have reduced
- Subsequent considerations have focused on making best use of the midwifery resource for the whole service in line with population health need
- The ante-natal and family support offer at Pontefract has been significantly enhanced – specifically in response to previous engagement feedback
- No savings have been derived from withdrawing the birthing service as resources have been deployed differently. However, reinstating the facility would require additional staffing at a cost of c£1.3m
- In January 2024, the Wakefield District Health and Care Partnership, supported by Mid Yorkshire Teaching NHS Trust Board, confirmed its intention to formally withdraw the birthing facility
- Formal consultation commenced in February 2025 and concluded in May 2025 (14 weeks) and builds on engagement undertaken in 2018/19.



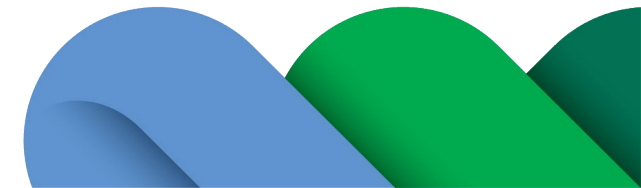
Case for Change

- Prior to the temporary suspension, MYTT was one of very few Trusts nationally (unique in West Yorkshire) to offer 2 FMLUs, an AMLU and a consultant labour ward.
- People in the Wakefield District would still have access to all four birth choices recommended by the National Institute for Clinical and Health Excellence (NICE): home birth, AMLU, FMLU in a neighbouring district, and consultant led obstetric unit.
- The Yorkshire and Humber Clinical Senate previously reviewed the service model and concluded that the FMLU was not viable, that the case for an on-demand service was not sufficiently made and the AMLU at Pinderfields offered a realistic choice for midwifery led birth for women living in the east of the district
- The strategic significance of the Pontefract FMLU and its ability to attract people from outside the area has been considered: data from the period when the unit was fully operational show that small numbers of people from outside the district chose to birth at Pontefract (17 of the total 214 births in 2017 – this figure includes people registered with a GP practice in the district but living outside the boundary)



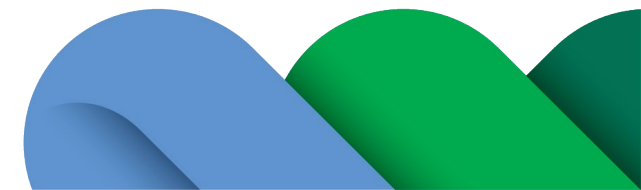
Case for Change

- The proposed model is based on five years' experience of delivering this pattern of care
- During this time, the Trust has been able to make better use of the midwifery resource to support safety and patient experience across the service and an enhanced ante-natal and post-natal offer at Pontefract, targeted to the needs of people living in the east of the district.
- The CQC rating for the service has improved during this period and there have been no safety incidents associated with the withdrawal of the birthing facility.
- Increased complexity requires a higher level of intervention and support during pregnancy. The proposal enables midwifery resource to be directed into providing more ante-natal and post-natal services at Pontefract, targeting the specific needs of the population
- A permanent decision will enable the birthing rooms at Pontefract to be re-purposed to increase the space available for ante-natal and post-natal care, family support and group work, providing a more comfortable and confidential environment.
- Establishing a permanent model of service removes on-going uncertainty for the population and staff.

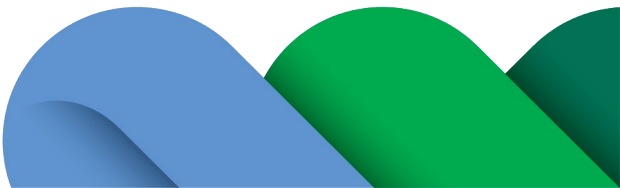
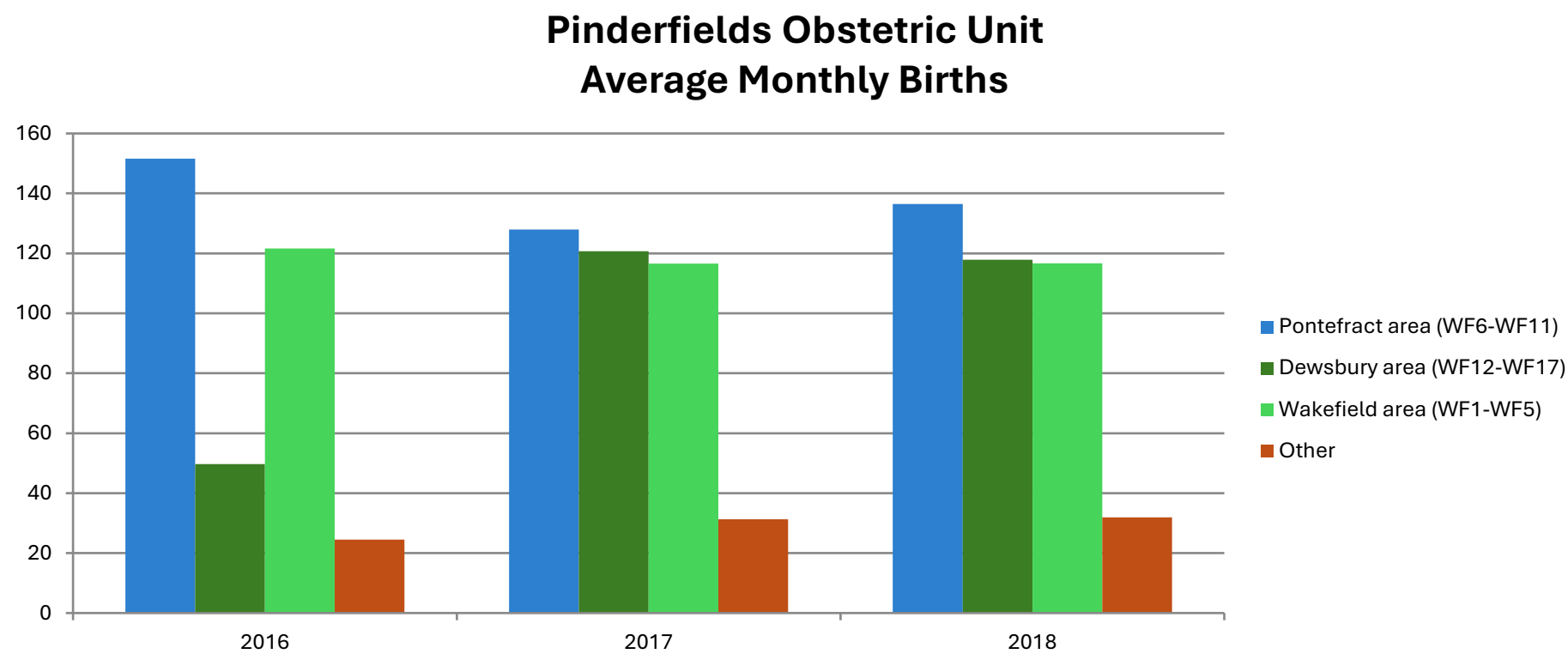


Evidence considered & independent assurance

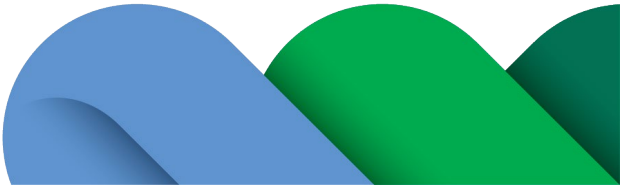
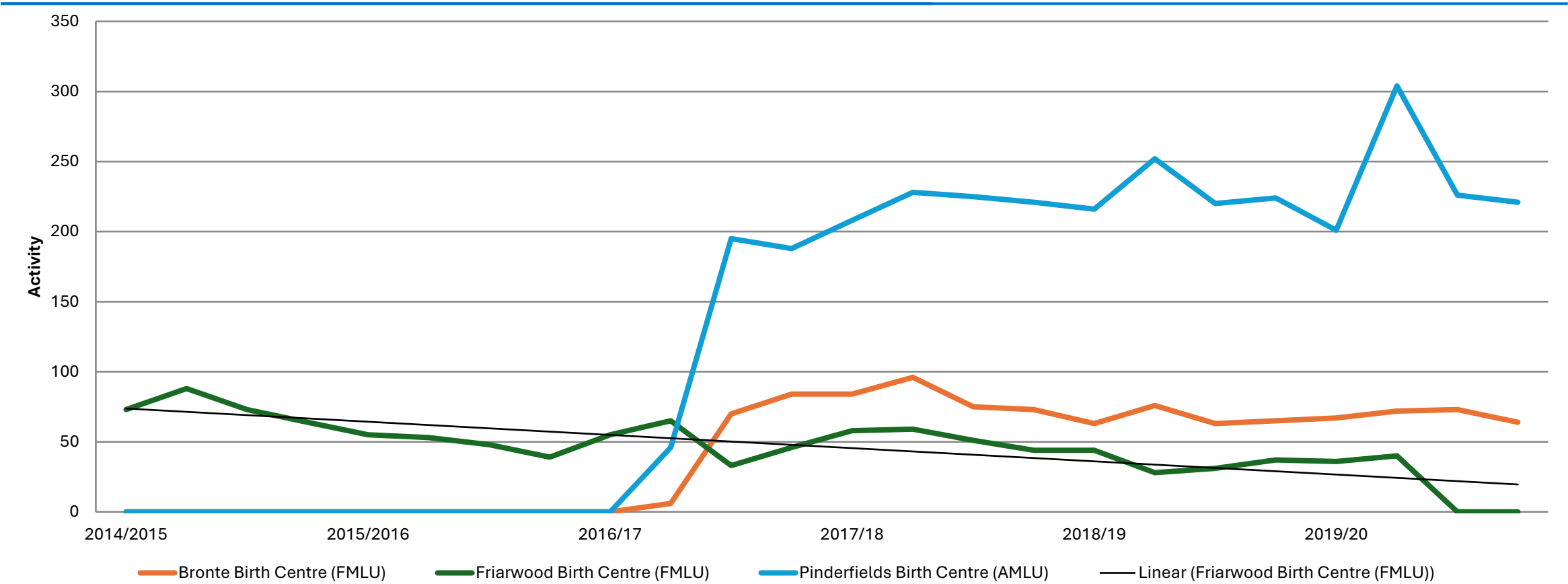
- National guidance on safer births, NHS 10-year plan & national and local maternity strategies
- Analysis of local and national data
- Perspectives provided by the public and staff during engagement in 2018/19 and formal consultation in 2025
- Equality, quality, travel and sustainability impact assessments
- Review of the service when it was operational and feedback on options for future viability from the Yorkshire and Humber Clinical Senate in 2018/19
- Independent advice on the consultation approach and analysis of consultation feedback
- Work with OSC and the WDHCP People Panel to assure the consultation process
- NHSE service change assurance process



Distribution of births by place of residence 2016 - 2018 (prior to the temporary suspension)

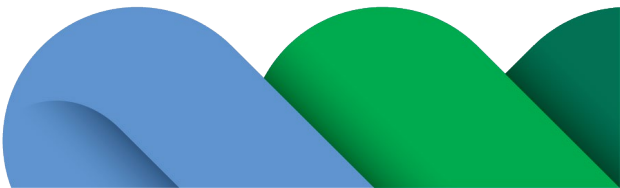
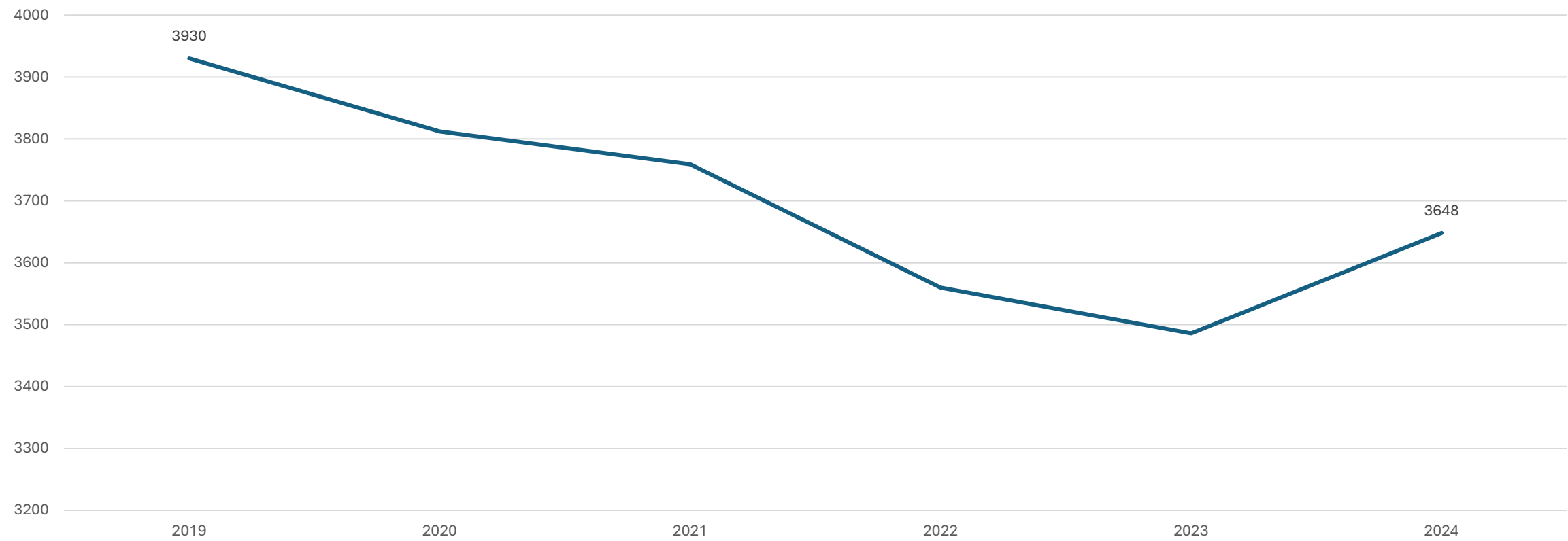


Birth data by site



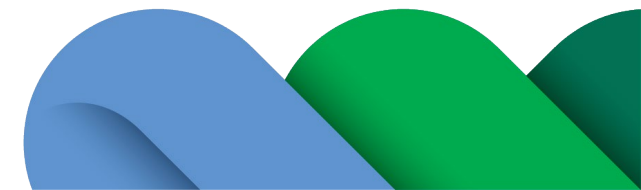
Total births Wakefield residents 2019 - 2024

Wakefield births:



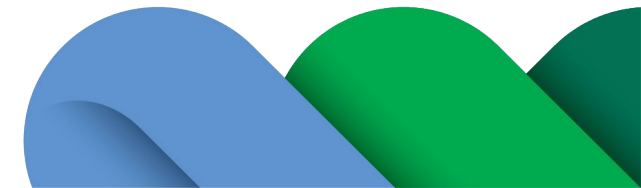
Consultation statistical analysis

- Target group was current and recent users of the services and those likely to use the service in the future. Response rate 26% current & 54% recent
- 53% from Pontefract/Castleford. 23% Wakefield
- 762 people engaged in the consultation and 437 individual completed surveys were returned
- 75% women aged 20 to 39
- 76% of respondents would choose to give birth at Pinderfields
- 44% would choose an alongside MLU and 29% a consultant led labour ward
- 14% would choose a freestanding MLU



Consultation statistical analysis

- Main reason for survey respondents' choice: proximity to home (39%)
- Other key reasons: easy to travel to (22%), the type of birth they wanted (22%), safer (19%), experience of using the service before (18%) and access to doctors if needed (17%)
- People who had previously given birth at Pontefract were most likely to perceive the proposal would have a big impact (59%)
- 36% of all respondents felt the proposal would have no impact. This was lower for people from Pontefract (30%) but higher (53%) in current/future users of the service.
- People aged over 40 were more likely to say it would have a big impact



Themes and proposed mitigations

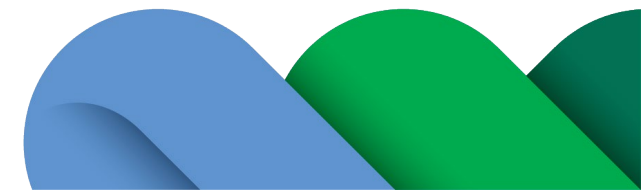
Theme	Response/mitigation
Distance to travel	Ante-natal and post-natal care to continue at Pontefract and in community settings. Birth plan discussion with midwife during ante-natal care to consider any individual issues due to distance. Home birth remains an option for anyone who meets criteria for birth in FMLU
Increased risk of baby being born on route to hospital	Evidence from last five years shows the number of babies born before arrival has reduced year on year since 2020
Positive birth experience at Pontefract/familiarity of Pontefract Hospital	AMLU offers same birth experience. Videos/visits to AMLU available to enable parents to familiarise themselves with the Pinderfields maternity unit before the birth
Capacity at Pinderfields to cope with extra demand	Service model has been operating for more than five years so no change in demand. Capacity challenges at Pinderfields are due to staffing not estate. Reinstating the service at Pontefract would reduce availability of staff to support the larger proportion of people who birth at Pinderfields. Stocktake of capacity and demand to be undertaken in 2 years to assess impact of population growth.

Themes and proposed mitigations

Theme	Response/mitigation
Rationale for proposal based on out-of-date information (pre-2019). Parents were being discouraged from using Pontefract before this by staff and due to short notice closures.	More current data not available for Pontefract as births have not been offered there since 2019
Awareness of birth choices	Campaign to encourage people to book in with maternity service early in pregnancy so that birth choices can be discussed well in advance of onset of labour.
Loss of choice/local provision	Comprehensive ante-natal and post-natal offer remains at Pontefract and in community. Wakefield residents will still have all four birth options available.
Retaining the service at Pontefract is a waste of money	The business case is designed to address this and make optimum use of resources.

Additional issues to consider

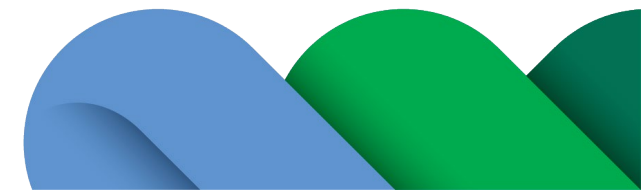
- Birth rates nationally and locally show a declining trend, which mean capacity in the maternity service exceeds current and projected demand. However, future capacity requirements will need to be kept under review to reflect any growth in population or increase in birth rate in the district or changes to national guidelines on staffing.
- Additionally, the ICB has been asked to undertake a review of the overall utilisation of Pontefract Hospital, to provide reassurance to the public that optimum use is being made of the facilities and that it continues to play a vital role in the overall Mid Yorkshire Teaching NHST Trust service offer.



Recommendations

The Committee is recommended to:

- Support the proposal contained in the business case to make permanent the temporary suspension of the birthing facility at Pontefract and to focus the service at the Pontefract unit on delivering comprehensive, high quality ante-natal & post-natal care and family support.
- Continuously review capacity and demand across maternity services for the district and undertake a stocktake in 2028 of the impact of any demographic changes in the district on the future demand for maternity services.
- Commission a review of utilisation of Pontefract Hospital to ensure capacity on the site is being used to optimum effect.



ITEM 9

Meeting name:	Wakefield District Health and Care Partnership Committee
Agenda item no:	9
Meeting date:	Tuesday 9 September 2025
Report title:	Wakefield District Plan
Report presented by:	Ruth Unwin, Director of Strategy
Report approved by:	Ruth Unwin, Director of Strategy
Report prepared by:	Ruth Unwin, Director of Strategy

Purpose and Action			
Assurance ☐	Decision ☒ (approve/recommend/ support/ratify)	Action ☐ (review/consider/comment/ discuss/escalate)	Information ☐
Previous considerations:			
Partners across health and care services have been involved in engagement events to support development of the Healthier Outcomes section of the District Plan. Similar stakeholder engagement has been undertaken to support development of the other aspects of the Plan and there have been a series of Summit events involving partner organisations to bring the plan together. The priorities have previously been discussed at development sessions of the Wakefield Health and Care Partnership Committee (WDHCP).			
Executive summary and points for discussion:			
The Wakefield District Plan is the culmination of a year-long piece of work involving partners from across the statutory sector and voluntary organisations, including representatives of the police, fire and rescue service, housing, education, commerce, voluntary organisations, the Council, NHS providers and Integrated Care Board (ICB) representatives, who form the Wakefield Together Partnership. The plan builds on the outputs of a series of partnership summits as well as reflecting the previous public engagement insight and data analysis. The development of the plan has been led by the Chief Officers of the constituent organisations of the Wakefield Together Partnership, who will be responsible for taking it forward. The District Plan sets out six ambitions for the district: • An economy that works for everyone • A place where children and young people grow and thrive • People live healthy lives • Tackling climate change together • Thriving, welcoming and safe communities • Strong local services that work for people and places			

The holistic nature of the plan will support people to live healthier lives by addressing fundamental causes of ill health such as deprivation, social isolation and pollution.

All partner organisations are being asked to commit to orientate their plans to support delivery of the overarching aims.

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

- Note the inclusive partnership working that has led to the creation of the draft Wakefield District Plan.
- Agree to adopt and endorse the content of the draft Plan.
- Note that the Plan will ultimately be signed off by the Wakefield Together Partnership once all partners have endorsed the Plan, and that the Leader will then sign the Pledges set out in 5.2 on behalf of the Council.

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:

BAF 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.

Appendices

1. District Plan draft document

Acronyms and Abbreviations explained

1. ICB – Integrated Care Board
2. WDHCP – Wakefield District Health and Care Partnership Committee
3. KLOE – Key Lines of Enquiry

What are the implications for?

Residents and Communities	The Plan describes how partners will work with residents and communities to make the district a place where people want to build their future.
Quality and Safety	None directly
Equality, Diversity and Inclusion	Understanding and reflecting the diversity of the Wakefield district and its communities will be a requisite element of all actions undertaken to deliver the District Plan.
Finances and Use of Resources	There are no direct financial implications

Regulation and Legal Requirements	None
Conflicts of Interest	None
Data Protection	None
Transformation and Innovation	The plan describes a way of working between partner organisations to deliver improvements to people lived experience
Environmental and Climate Change	Tackling climate change is one of the priority areas in the district plan.
Future Decisions and Policy Making	In signing up to the plan, partners commit to orientate their plans to support its delivery.
Citizen and Stakeholder Engagement	The plan priorities have been built from existing engagement evidence and there has been extensive stakeholder engagement.

Background

Wakefield has a history of strong partnership working and long-standing relationships across our private, public, and voluntary sectors.

The Wakefield Together Partnership has been and continues to be a focus for this collaboration. Working together towards shared, outcome-focussed goals makes a real difference and helps to address our financial challenges by finding better, bolder ways to work together. In time this will save money by increasing early interventions, empowering people to take control of their own lives, and supporting our voluntary and community organisations to help us deliver improvements and outcomes for our residents.

In September 2024 at a Partnership Summit partners discussed and endorsed the desire for a new outcome-focussed District Plan, developed and owned by the Partnership and covering a 10-year period.

Developing the District Plan

Over the last 9 months, the Wakefield Together Partnership has come together with a clear mandate to develop an outcome-focused plan. The work has been led by Chief Officers through the Wakefield Strategic Partnership.

Based on a review of intelligence and feedback from partners at the Summit, a thematic strategic outcome framework was developed to allow more detailed engagement to take place and focus in on what the vision and ambitions of the Plan should be. These themes were used to establish six key lines of enquiry (KLOE) engagement groups, each led by a sponsor and convenor. These were as follows:

KLOE	Sponsor	Convenor
An economy that works for everyone	Martin Hathaway, Mid Yorkshire Chamber of Commerce; Sam Wright, Heart of Yorkshire Education Group (Wakefield College)	Jamie Appleton, Wakefield Council
Happy and healthy children	Vicky Marks, New College Pontefract	Vicky Schofield, Wakefield Council
Living healthy lives	Brent Kilmurray, Mid Yorkshire Teaching NHS Trust	Ruth Unwin, Health and Care Partnership; Steve Turnbull, Wakefield Council
Tackling climate change together	Cllr Jack Hemingway, Wakefield Council	Helen Grayshan, Wakefield Council
Thriving, welcoming, and safe communities	Stuart Bainbridge, West Yorkshire Police; Maddy Sutcliffe, Nova Wakefield	Jackie Mould, Wakefield Council
Complex lives	Tony Reeves, Wakefield Council	Simon Topham, Citizens Advice Wakefield District

Each KLOE has considered evidence and narrative gathered from qualitative and quantitative sources, such as the State of the District report, the Joint Strategic Needs Assessment, and case studies provided by partners. They have considered what currently

works well, the challenges and opportunities, where there may be gaps in service provision and ways things could be done better. Following this period of activity, recommendations have been made around potential areas of focus for the Plan, as well as outcomes and actions that could be taken forward. These were also sense checked between KLOEs to identify cross-cutting issues, and to provide constructive feedback as the work evolved.

The development of outcomes and associated activities contained within the Plan has been guided by a set of design principles, outlined below. These have been adopted in the Plan as principles for future ways of working across the Partnership. Feedback throughout the engagement process has led to three more principles for ways of working to be added, as reflected in the Plan. These are around empowering residents, focusing on prevention, and taking a trauma informed approach.

- 1. Be proactive, outcome focussed, and evidence based.*
- 2. Take an asset-based approach (utilising volunteers, community, entrepreneurs), harnessing combined expertise and resources*
- 3. Tackle inequality. Equality, diversity and inclusion is promoted and advanced, ensuring no-one is left behind.*
- 4. Build on what works: sharing learning and celebrating success*
- 5. Be aspirational, innovative and collaborative.*
- 6. Activities have a positive environmental impact and contribute to our net zero ambitions*

Engagement work via the KLOEs concluded in April 2025, and recommendations and outputs were tested with a large group of partners and elected members at the Partnership Summit on 19 May. There was broad support from those present at the Summit, and these outputs have informed the content of the emerging Wakefield District Plan.

What does the Wakefield District Plan cover?

The District Plan sets out the Wakefield Together Partnership's shared vision and its aspiration to make the Wakefield District an even better place to live, work, and study over the next decade. It provides a framework for how our area positions itself within West Yorkshire and with national Government. It will be a living document, refined as needed to reflect emerging challenges and opportunities.

The Plan will help us tackle complex issues in a more integrated way, reducing inequality, boosting productivity, improving health outcomes, and becoming more sustainable.

It will be a key strategic document for the Wakefield Together Partnership, bringing together a wealth of ideas, aspirations and evidence from across the district. It will take forward tangible actions and improve service delivery through enhanced partnership working.

Based on the recommendations and outputs of the KLOEs, the Plan sets out a vision and six Ambitions for the district over the next 10 years. These are:

Vision: Building a stronger Wakefield

By 2035 Wakefield will be a place with equal access to opportunities. Where everyone feels valued and has the chance to thrive. Where barriers to inclusion are broken down. Resources are managed responsibly for future generations. And which people are proud to call home.

Ambition One: An economy that works for everyone

By 2035 we will create a growing economy that works for everyone, positioning our district to take advantage of regional and national opportunities. With safe, reliable and sustainable transport, decent jobs and opportunities, and quality homes. And where no one is left behind.

Ambition Two: A place where children and young people grow and thrive

By 2035, we want all children and young people to be happy, healthy, safe, resilient and hopeful for their future. And have a coherent, joined up offer for young people that makes Wakefield an attractive place for them to live, work and build their future.

Ambition Three: People live healthy lives

By 2035, we will create fairer opportunities for everyone to enjoy good health and respond to what matters most to people in terms of improving their health and wellbeing – enabling people to Live Well and Age Well.

Ambition Four: Tackling climate change together

By 2035, we will reduce the district's carbon footprint on the journey to net zero (net zero by 2038), improve public health and help our residents and businesses adapt to a changing climate. And we will ensure that the impacts of climate change are addressed in a fair, just and inclusive manner.

Ambition Five: Thriving, welcoming and safe communities

We will put communities at the heart of everything we do, with residents and partners working collectively together towards shared goals, utilising our assets and Community Anchors.

Ambition Six: Strong local services that work for people and place

By 2035 our local services will be working together in a smarter way, aligned to a set of common causes and goals, and utilising the scarce resources we have more effectively to deliver better outcomes for our District.

Each Ambition is underpinned by a series of outcomes (22 in total), which are outlined within the Plan at Appendix 1. The Plan also outlines agreed ways of working, high-level metrics that will be used to monitor achievement towards the vision and ambitions, as well as next steps over the next 12 months.

Next steps

All constituent organisations of the Wakefield Together Partnership will be considering the draft District Plan and endorsing their involvement in its future delivery. This will be taken through each partner's own internal governance mechanisms over the next couple of months. The content of the Plan will then be finalised by Chief Officers through the Wakefield Strategic Partnership.

Partners – including the Council – will be asked to sign up to the following Pledge at the launch of the Plan:

As a core partner of the Wakefield Together Partnership we pledge to:

- *Endorse the vision and ambitions set out in the District Plan.*
- *Commit to working in partnership and playing our part in achieving the agreed outcomes, making the resources available to achieve success.*
- *Agree to be held accountable – collectively and individually – for delivery of our vision.*
- *Ensure that decisions we make as a Partnership are influenced by the views of our residents and communities.*

The District Plan will be launched formally at a Partnership Summit, scheduled to take place on 29 September 2025. The Plan will then be published on the Wakefield Together webpage, currently hosted by Wakefield Council. It is expected to be published on the websites of all key partners and other stakeholders, and progress updates will be shared as appropriate through this mechanism as the Plan enters delivery phase.

The District Plan will be available in digital format and a pdf version will be made available for download and printing.

An easy read version of the Plan will also be developed, along with alternative accessibility formats on request, e.g. braille, languages apart from English.

There will be an annual Partnerships Summit at which partners will be able to hold the Wakefield Together Partnership accountable for the delivery of the Plan. Development of the Plan has been overseen by the Wakefield Strategic Partnership group of chief officers, who will continue their oversight and regularly review the progress of the Plan.



Wakefield District Plan

2025-2035

Wakefield has a history of strong partnership working. Underpinned by long-standing relationships across our private, public, and voluntary sectors.





Contents

Introduction	x
Our vision	x
Who we are	x
What do we want to achieve? Our ambitions and outcomes	x
Ways of working	x
Measuring success	x
What happens next	x
Glossary of terms and useful information	x

Introduction

Wakefield has a history of strong partnership working. Underpinned by long-standing relationships across our private, public, and voluntary sectors.

The Wakefield Together Partnership is a focus for this collaboration. We know that working together makes a real difference and will help unlock the potential of our places and our people.

Partnership has never been more important. We've a rapidly changing economy. Growing financial and demand-led pressures on our public services. And significant challenges facing our voluntary and community organisations.

We can only take advantage of future opportunities by focusing on a shared set of positive outcomes. By doing that together we can deliver more with our local communities.

This is where our District Plan comes in. It sets out the great things we're already achieving in Wakefield. Outlines how we're going to build on those successes. And provides a bold, shared vision for how local organisations can better align our resources so that we make the biggest difference we can.

This isn't just the best way for us to work. It's the only way we're going to meet the challenges we face as a district and provide the best support and value for our residents.

Our plan is the result of an intensive period of partnership working. Since September 2024 the Wakefield Together Partnership has come together with a clear mandate to develop an outcome focussed plan that we all own.

Our District Plan sets out our shared aspirations over the next decade. Its mission is to make Wakefield an even better place to live, work, and study. It provides a framework for how our area positions itself within West Yorkshire and with national Government, so that we can make the most of our great assets.

The plan will help us tackle complex issues in a more integrated way. Reduce inequality. Boost productivity. Grow our economy. Improve health outcomes. And become more sustainable.

It is supported at the highest-level right across the district. We've engaged with over 270 organisations, residents, community groups and businesses. Shared our plans with every Wakefield Councillor. And talked to people with lived experience to build more in depth understanding on key issues.

This has helped us to take advantage of the broadest possible expertise. Focusing relentlessly on better outcomes. Learning from what already works. And building on our existing evidence base.

The result is this plan. It brings together a wealth of evidence, ideas and aspirations for our area. Sets a clear framework for delivering our partnership work. And enables us to measure the difference we're making.

Work to deliver the promise of our District Plan starts today. Wakefield has an incredibly bright future, and this is a key milestone on recognising that potential.

The promise to increase access to high-quality jobs and skills and enable the growth of our exciting cultural and social scene so that more of our young people choose to stay in our district.

The promise to improve our health, reduce inequality, and to have a flourishing natural environment that our children can enjoy.

And the promise to build on our strong identity and heritage so that everyone, wherever they live, is proud to call our district home.

**We will do
this together.**



Our vision

Building a stronger Wakefield

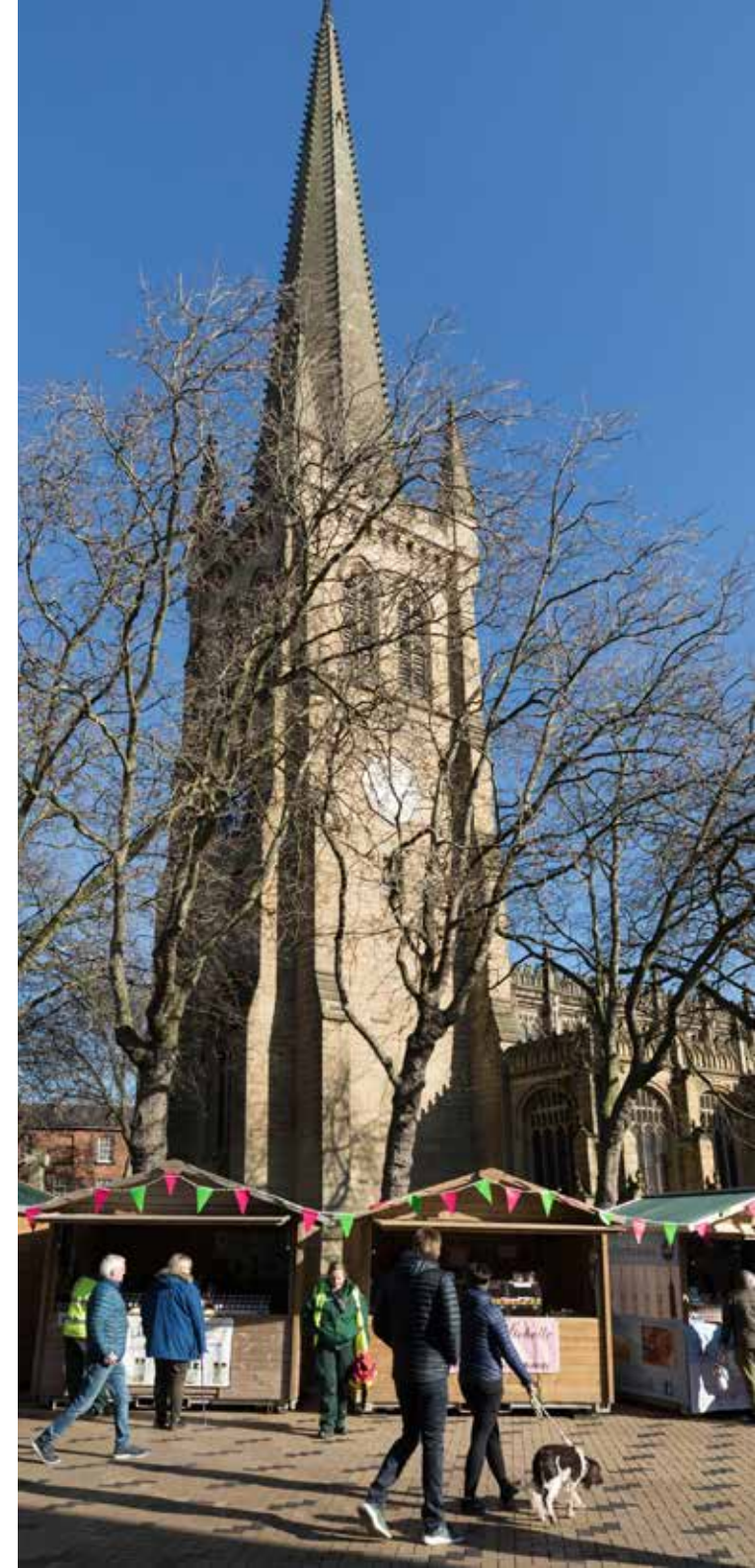
Wakefield is a district of proud towns, vibrant villages, and stunning countryside. Already one of the best-connected parts of West Yorkshire - with direct links to Leeds, London, and the national motorway network - we are building on strong foundations.

We are ambitious for our district.

By 2035, Wakefield will be a fair and sustainable place where everyone can access opportunity, participate fully in society, and enjoy a high quality of life. It will be a district where people feel valued, where communities thrive, and where resources are managed responsibly for future generations. A place people are proud to call home.

Our communities are the beating heart of Wakefield. Their strength, vibrancy, and resilience are our greatest assets. We will work side by side with residents, harnessing their energy, expertise, and skills to improve the things that matter most to them. Together, we will shape a district that reflects the hopes and ambitions of the people who live here.

We have a bold vision for our high streets and urban centres. Across Wakefield, Castleford, Pontefract, Normanton, and Featherstone, regeneration will have transformed our towns into vibrant, mixed-use destinations - combining affordable homes, thriving retail, cultural and leisure attractions, excellent





schools, and strong transport links. Wakefield city centre will be a dynamic hub of culture, commerce, and community life.

Our economy will be stronger, more diverse, and more inclusive. By working together across local, regional, and national partnerships, we will have delivered sustainable growth and increased productivity. Wakefield will be a key player in the West Yorkshire economy and a vital contributor to the Leeds growth corridor - leveraging our unique location, local assets, and historic strengths in advanced manufacturing and the green economy.

We are committed to tackling climate change and achieving net zero. By working together, we will create a greener, more resilient district - reducing energy costs for residents and businesses, improving air quality, and creating new green jobs and industries that support long-term prosperity.

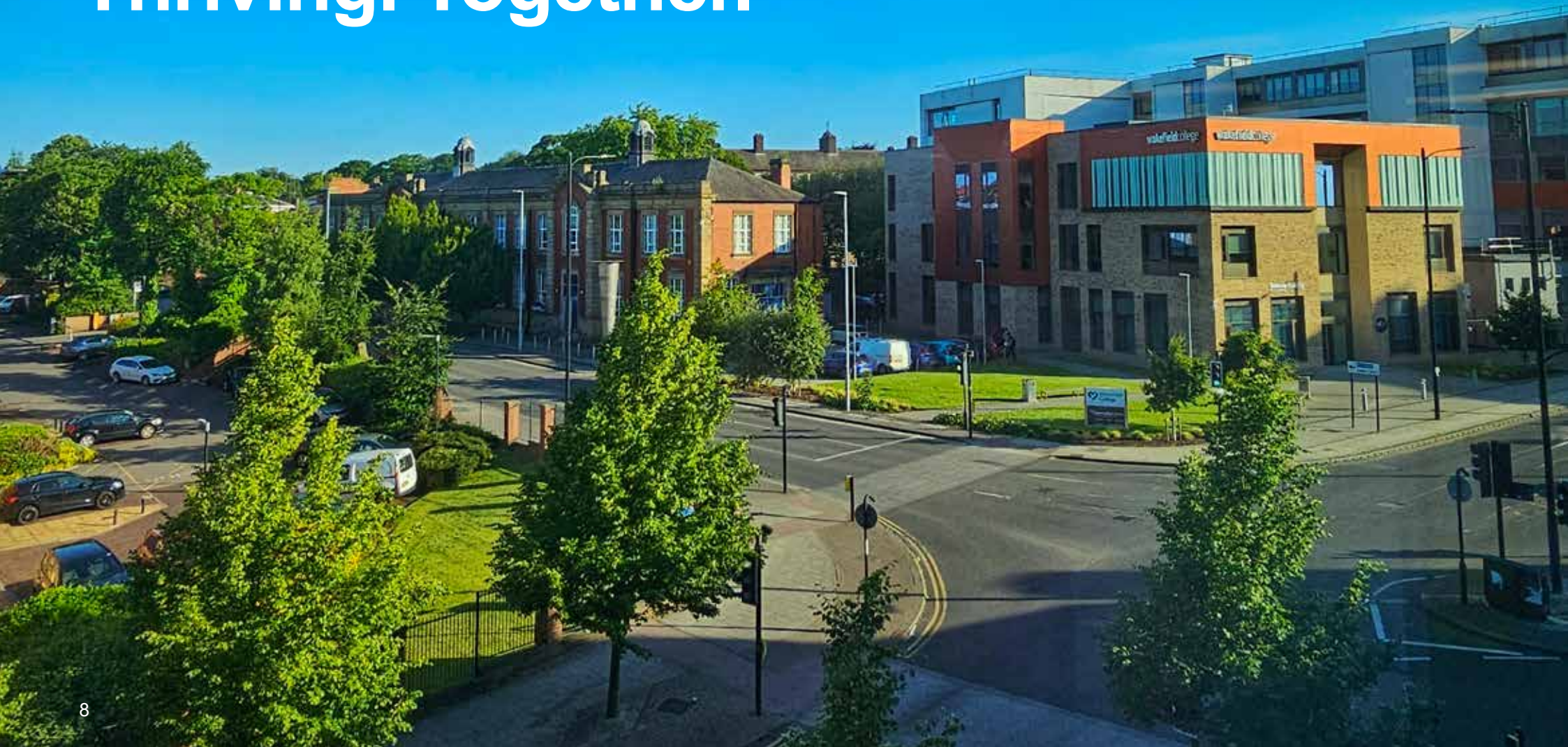
Public transport will connect every part of the district, making it easy and affordable to move across our communities. Our integrated neighbourhood model will be well established, with councillors, residents, community organisations, and service providers working together to shape local decisions and drive improvement. New models of decision-making will put communities at the heart of everything we do.

Wakefield has always been a great place to grow up. By 2035, it will be even better. Our comprehensive pathway for children and young people will ensure that every child - regardless of background - can thrive. From excellent schools and educational opportunities to pathways into good jobs and a rich cultural and leisure offer, Wakefield will be a place where young people choose to stay, study, and succeed. Affordable living and proximity to Leeds will make it a destination for students and graduates alike.

We will raise the standard of living in the least affluent parts of this district, reducing the inequalities in health between the richest and poorest. and delivering support that empowers people, maximises independence and keeps people in control of their own health journey. Our communities will be at the heart of everything we do - active, engaged, and empowered to shape their future.

This vision is shared and driven by the Wakefield Together Partnership - a collective of public, private, voluntary, and community sector organisations committed to working collaboratively to deliver real change. Together, we are united by a common purpose: to improve lives, reduce inequalities, and create a district where everyone can thrive. Our shared outcomes are rooted in the voices of our communities, and we will continue to work in partnership to turn this vision into reality.

**This is our Wakefield.
Bold. Fair. Sustainable.
Thriving. Together.**





Aim: By 2035 Wakefield will be a place with equal access to opportunities. Where everyone feels valued and has the chance to thrive. Where barriers to inclusion are broken down. Resources are managed responsibly for future generations. And which people are proud to call home.

Outcome 1: Everyone has a good standard of living.

- We will build anti-poverty measures into our economic, social and health work, targeting interventions on those people and communities who need support most.
- We will overcome barriers to inclusion, ensure good access to life-long education and skills, high quality housing and build thriving, connected communities.
- We will make sure the actions we take are fair and just. A just transition will provide good jobs, support better health and wellbeing, and help our communities adapt to climate change.

3. Who we are

The Wakefield Together Partnership brings together decision makers across our biggest institutions and sector bodies to work together, delivering better outcomes for all residents and businesses.

The governance and strategic direction of the District Plan and the Wakefield Together Partnership is overseen by a small group of chief executive and senior officers from within it, and which cover the health, education, local government, emergency services, voluntary sector, housing, and business sectors in our District.

But the actual Partnership is much wider. Over 60 local groups, elected councillors and University academics are involved in contributing ideas, experience, knowledge, and different ways of working. And our residents are a key pillar of our Partnership

We know that existing partnerships such as the Health and Wellbeing Board, the Community Safety Partnership, the Net Zero Partnership, the Children and Young People Partnership and the VCSE Collaborative are already doing fantastic work in their own areas.

We will not duplicate or re-visit work that is already being done. We will look for gaps, for areas to add value, and for where we can better coordinate and improve. And we will build upon and support our fantastic partnerships and networks.

That's why the Wakefield Together Partnership is, and will continue to be, a dynamic and responsive network for the District.

We know that to achieve our aims we must also look to partners outside of the District.

The issues we want to address in Wakefield are complex, and the answers are not contained within our own boundaries.

Regional and national institutions with a wider geography contribute to our work on national and entrenched challenges such as poverty, climate change, and economic inclusion and we will continue to foster these relationships to drive our shared agendas whilst learning, influencing, and make sure our voice is heard.

Key partners in this work are:

- **The West Yorkshire Combined Authority**
- **National Government**
- **Academic partners in universities and colleges**
- **Local Government Association**

The work on devolution, through the West Yorkshire Combined Authority and the Mayor of West Yorkshire, is key to delivering many of our ambitions. Devolution will allow partner organisations and communities to have a stronger say in decisions that directly impact our area - whether it's transport, housing, skills or economic development. And ensure that investment and policies are tailored to meet the needs of our people and places.





We will also link in with other organisations with a regional or national footprint such as Migration Yorkshire and the Yorkshire and Humber Climate Commission, to ensure that we complement and don't duplicate influencing work already being undertaken.

You can find out more about the various partnerships that form part of the Wakefield Together family [in the Glossary at the end of this Plan.](#)

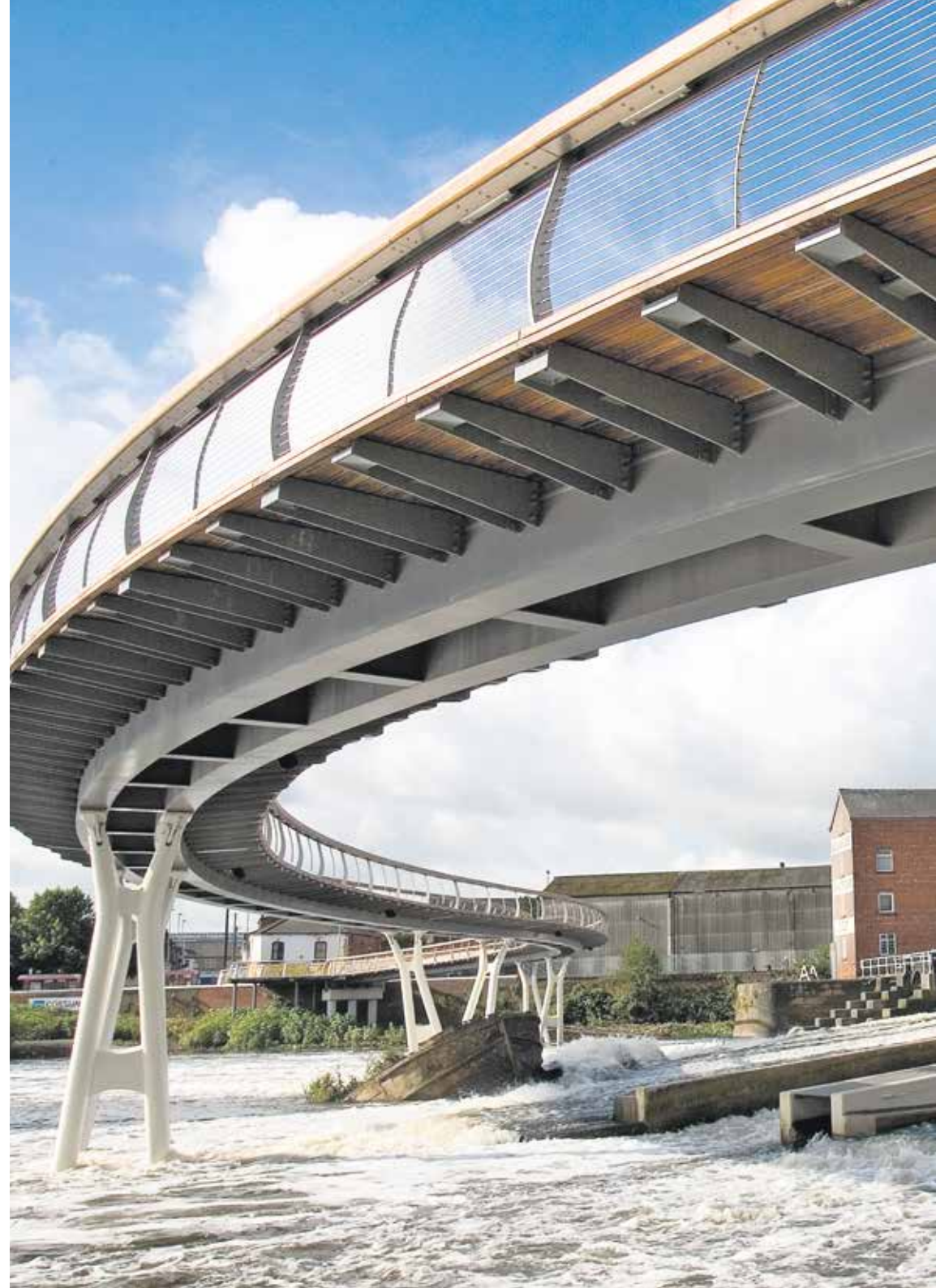
“It is exciting to see our collective commitment as partners to come together to drive forward collective action to tackle the wider social determinants of health as part of Wakefield’s District Plan. It is refreshing that we are focused on achieving Better Lives for our population in Wakefield District”

Wakefield District Health and Care Partnership



**What do we
want to achieve?**

**Our ambitions
and outcomes**





Ambition One - An economy that works for everyone

Aim: By 2035 we will create a growing economy that works for everyone, positioning our district to take advantage of our strong position in West Yorkshire and national opportunities. With safe, reliable and sustainable transport, decent jobs and opportunities, and quality homes. And where no one is left behind.





trinity walk

Outcome 2: A stronger, more inclusive and more sustainable economy.

- Our bold new Growth Plan will build on our economic wellbeing strategy and help us take advantage of opportunities in West Yorkshire and nationally, partnering with the West Yorkshire Mayor to bring investment into our District.
- We will establish an Economic Growth Board to help drive growth, attract investment, and help boost local productivity.
- We will develop community wealth building principles to improve the resilience of Wakefield communities and the economy.
- We will target growth in advanced manufacturing and the green economy, focusing on skills so that residents benefit from the creation of jobs in these key sectors.
- We will create an environment where businesses can establish, thrive and grow, and which encourages entrepreneurs to invest in new start-ups.
- We will maximise our economic links with West Yorkshire, and in particular the Leeds/ Wakefield Growth Corridor.

Outcome 3: High streets and urban centres to be proud of.

- We will take forward comprehensive programmes of sustainable regeneration in all of our city and town centres, exploiting the exceptional connectivity of Wakefield and Castleford to attract thousands more people and families to live and work in high quality urban centres. This will involve right sizing the retail and leisure offer, creating great public spaces, calming traffic and creating thriving, liveable urban spaces.
- We will exploit our easy road and rail connectivity to Leeds and London to attract large numbers of graduates, young professional families and employers to the District as well as ensuring that we have a diverse housing offer that meets a range of needs and leaves nobody behind.
- We will improve connectivity within the District and transform our urban centres to become, distinctive, sustainable, thriving places to work and live, providing high quality jobs, education and leisure opportunities for young people growing up in our District.
- We will use culture, creativity and physical activity to help improve our towns, city and local areas, increasing a sense of place, pride and connection.





Outcome 4: People in the Wakefield District have access to good and varied job opportunities in the Wakefield District.

- We will support aspirations through access to education and skills, and to decent, secure jobs and wages.
- We will work with education providers on climate literacy courses and lobby for apprenticeships and T-Levels aligned to green transition skills and careers.
- We will build on our mining and engineering heritage to develop an offer and a skilled workforce to support the growth of advanced manufacturing in the District.
- As key employers, we will maximise career development opportunities in the health, care and public sector and promote local employment.
- We will support people back into work where health or life circumstances have become a barrier, which will in turn boost productivity.

Outcome 5: Sustainable and decent housing.

- We will ensure the right housing is built in the right places for a changing population and supports the regeneration of our town and city centres.
- We will ensure that housing growth complements our strategic position, taking advantage of excellent rail links to Leeds and London and the good standard of living that we enjoy in the District.
- We will improve the quality of housing across the District, reducing poor conditions and supporting retrofits and other climate adaptations.
- We will ensure housing is accessible and affordable for all, with the right type of housing available for every stage of life.

Outcome 6: Public transport is accessible for all, safe for all, and affordable for all.

- We will work together on the local public transport system to enable easy and cheap access to work and cultural opportunities for all residents.
- We will influence at a West Yorkshire level to ensure that the Wakefield District has a strong voice in the regional bus franchising and mass transit processes, and receives the investment and commitment needed to make travelling around and between our places easier.

What does this mean for Children and Young People?

- Outcomes will support access to education and skills development, create pathways into credible jobs, ensure accessible and affordable housing options for young people at all stages of their lives, and improve public transport, making it easier for young people to access employment, education, and leisure opportunities.



Ambition Two - A place where children and young people grow and thrive

Aim: By 2035, we want all children and young people to be happy, healthy, safe, resilient and hopeful for their future. And have a coherent, joined up offer for young people that makes Wakefield an attractive place for them to live, work and build their future.

Outcome 7: Children and young people are happy, healthy and achieve their potential.

- We will support the effective delivery of the Children and Young People's Plan by ensuring that young people are at the heart of everything we do.
- We will consider the offer to and impact for children and young people throughout our work to grow the economy, improve health, strengthen neighbourhoods and address climate change.

The Wakefield District Children and Young People's Plan 2025–2028 sets out a shared vision and priorities for improving the lives of children and young people across the district; providing a coordinated, long-term approach to supporting children from early years through to adulthood.

The four key priority areas are:

Safety and Feeling Loved

Ensuring children have a secure environment, protection from harm (e.g. bullying, digital risks), and feel valued emotionally.

Health and Wellbeing

Providing robust mental and physical health support - covering early intervention, mental health services, school wellbeing hubs, digital tools, and targeted services.

Education

Elevating educational outcomes, tackling digital poverty, closing attainment gaps, tailoring Special Educational Needs support, and enhancing school readiness.

Futures

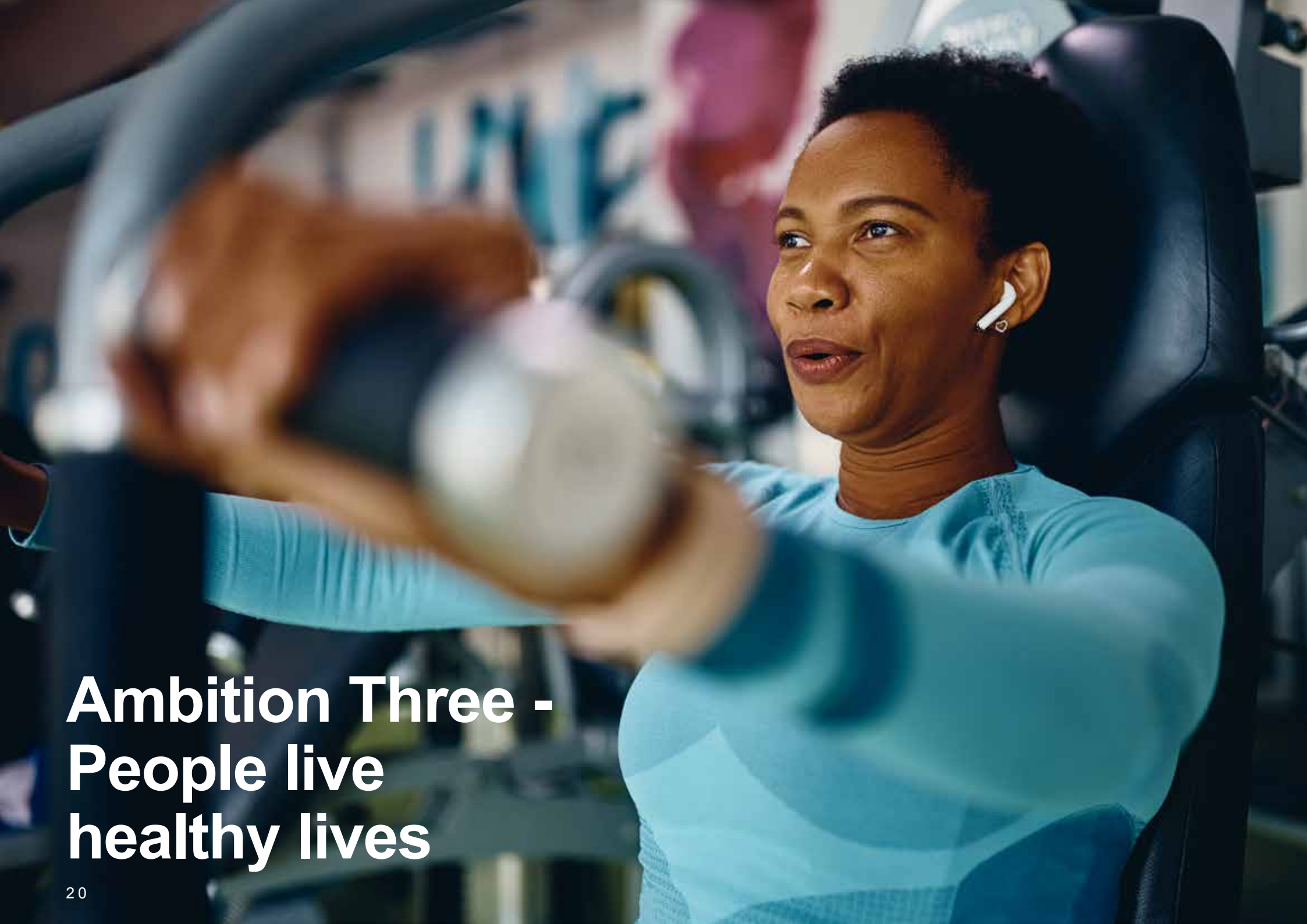
Building support around career planning, life skills, and transitions - all rooted in young people's aspirations and ideas.

Our offer to children and young people in the Wakefield District

We want Wakefield to be an attractive place for children and young people to live, work and build their future. We will make sure that:

- The places you live and the town centres you spend time in are thriving, safe, secure and welcoming.
- There are strong local services, especially for the most vulnerable.
- You can access great quality education and training to meet your needs and interests.
- There are pathways into credible jobs that give you a great quality of life with a good standard of living.
- There is a diverse and affordable housing offer for you, to suit a range of needs at different stages of your life.
- You have access to a cultural, creative and leisure experiences which are exciting, inclusive and enrich your life.
- You can easily travel around the District, into Leeds, London and other parts of the country for learning, work and leisure.
- You can access the right emotional well-being support and services to stay healthy and make positive choices about your life.
- Bold, inclusive, and just solutions are taken to address the root causes of climate change and sustainability challenges, and we will actively involve you in shaping those solutions.



A woman with short dark hair, wearing a light blue long-sleeved shirt and white earbuds, is seated on a black exercise machine in a gym. She is looking off to the side with a focused expression. In the foreground, a blurred arm and hand are visible, suggesting another person is also exercising. The background shows gym equipment and a blurred sign with the word "LIVE" in blue letters.

Ambition Three - People live healthy lives

Aim: By 2035, we will create fairer opportunities for everyone to enjoy good health and respond to what matters most to people in terms of their health and wellbeing – enabling people to Live Well and Age Well.

Outcome 8: Healthy life expectancy is improved across all parts of our communities.

- We will make equal opportunities to improved health a core principle in the design and enhancement of all services.
- We will offer targeted support to those who are most vulnerable.
- We will focus on improving digital inclusion and ensuring equal access for everyone.

Outcome 9: People are empowered and supported to live well.

- We will work together to maximise independence and prevent and delay the onset of ill health. To do this effectively, we will work in partnership with people, their families, and communities to promote long-term health
- We will prioritise prevention and early intervention to promote long term health and enable everyone to benefit from the opportunities the district has to offer, including being able to work and be active in their communities
- We will actively engage with residents in decisions about their care, meaning they will own their health journey.

Outcome 10: Health and care services will be shaped around the needs of neighbourhoods.

- A new joined-up model of neighbourhood health teams will be developed.
- 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 and promote personalised care.

What does this mean for Children and Young People?

- Young people will be empowered to maintain their own long-term health and will have equal access to support and services.



Ambition Four - Tackling climate change together

Aim: By 2035, we will reduce the district's carbon footprint on the journey to net zero, improve public health and help our residents and businesses adapt to a changing climate. And we will ensure that the impacts of climate change are addressed in a fair, just and inclusive manner.



Outcome 11: Renewable energy powers homes, industry and innovation.

- We will support the decarbonisation and retrofit of domestic, commercial and public sector buildings across the district by 2038, reinforcing our dedication to achieving a net-zero, climate-resilient future for the district.
- We will work with Wakefield businesses to help them maximise the opportunities of decarbonisation, reducing energy costs and developing circular economy principles of reducing, reusing, and recycling their goods.
- Wakefield is committed to a just transition that empowers residents with green skills and supports fossil-fuel-reliant sectors to decarbonise.
- We will look for opportunities to invest in infrastructure around mine water, solar panels, a district heating network and community energy schemes.
- Residents benefit from access to green spaces and sustainable resources, actively participating in circular economy practices and adopting environmentally conscious diets.

Outcome 12: Emissions from travel are reduced.

- We will work towards active travel (walking or cycling) or travel via public transport being the primary method of commuting, including through repurposing space for residential developments in our urban centres.
- Infrastructure will be more environmentally friendly, including pedestrianised areas, cycle lanes and equitable distribution of electric vehicle charging points.

Outcome 13: There is greater resilience to the impacts of climate change.

- We will work with senior leaders to implement an approach to policy, strategy and commissioning that embeds climate change adaptation and mitigation as standard.
- We will develop a multi-media strategy and action plan with a common language, to create a shared understanding of the co-benefits of taking action to build resilience.
- We will encourage restoration of hedgerows, tree planting, conservation of wetlands for natural flood prevention.

“It really makes a difference to [students]... that they were being “listened to, rather than just being told stuff.”

Minsthorpe Community College



Outcome 14: The District has a thriving natural environment.

- We will ensure that Wakefield District residents benefit from access to good quality green spaces and sustainable resources.
- We will support biodiversity in our greenspaces, parkland and wider countryside and protect wildlife and their natural habitats.

What does this mean for Children and Young People?

- Young people are increasing environmentally conscious. Outcomes will support access to green skills and careers which will provide opportunities for young people to participate in the green economy, provide more opportunities for cleaner, greener transport options that pollute less, and protect the natural environment for future generations.



Ambition Five - Thriving, welcoming, and safe communities

Aim: We will put communities at the heart of everything we do, building on our existing neighbourhood strengths alongside residents and partners to work collectively towards shared goals, utilising our assets and Community Anchors to do so.



Outcome 15: Neighbourhoods are thriving and vibrant.

- We will introduce a new integrated model, bringing partners and communities together to solve problems and improve local areas.
- Our new model will bring key services together to build knowledge and address local issues.
- We will use culture, creativity and physical activity to improve the wellbeing of our communities.

Outcome 16: Community strengths and their potential are realised.

- We will focus on the strengths in our communities and organisations that allows them to build resilience and wellbeing at a community level.
- We will provide and promote opportunities for residents to play a greater role in decision making, through active and regular engagement and access to opportunities.
- We will empower and inform individuals to make sustainable lifestyle choices, using language accessible and understandable to all residents and businesses.
- We will work together with communities to achieve shared goals.

Outcome 17: Communities are cohesive and connected.

- We will foster a shared sense of community, and work towards everyone living and working in harmony and able to participate in and contribute to society.
- We will develop a distinct Community Cohesion Strategy to recognise and celebrate the diversity of communities, and support community integration, collaboration and engagement.
- We will recognise and engage with communities of interest to make sure their voices are heard and their needs are understood; working together to build trust and create fair outcomes.

Outcome 18: Neighbourhoods are safer and people feel safer.

- We will work in partnership to tackle anti-social behaviour and learn from the Anti-Social Behaviour task force set up in Wakefield City Centre.
- We will review and improve local Police and Communities Together (PACT) meetings, to ensure an action focused approach from the police and all community partners and service providers towards tackling local community safety. This will be supported by the development of the neighbourhood model of working.

“We have a strong and vibrant voluntary and community sector which plays a key role in our communities.”

Key Line of Enquiry feedback



Outcome 19: Voluntary and community organisations are strong and resilient.

- We will recognise the vital role played by the voluntary and community sector and will work collectively to build capacity and cross-sector networking.
- We will support our voluntary and community organisations to grow sustainably, including through wider commissioning activity and the Community Investment Gateway.

What does this mean for Children and Young People?

- Outcomes will provide safe, vibrant, and welcoming spaces for young people – spaces that actively engage them in decision-making, and help them feel connected and valued - while also breaking cycles of inequality and complexity to ensure such challenges aren't passed on to future generations.

Outcome 20: Integrated services are shaped around the needs of our population.

- We will ensure Wakefield is a trauma informed and responsive system by 2030 and develop a whole system approach to tackling multiple disadvantage.
- We will join up services around neighbourhoods and proactively empower people to be in control of their own lives, empowering people to maximise their independence.
- We will target support at those with complex lives where the need for co-ordinated intervention is greatest, addressing the root causes and complexity of need. This will be through a series of pilot approaches.
- We will make prison release more effective to reduce re-offending, by building on a departure lounge approach to ensure that professionals can put full and supported transition arrangements in place, in person.



Ambition Six - Strong local services that work for people and place



Aim: By 2035 our local services will be working together in a smarter way, aligned to a set of common causes and goals, and utilising the scarce resources we have more effectively to deliver better outcomes for our District.



Outcome 21: Social value is part of the way we do business.

- We will embed social value in our decision-making and ways of working, ensuring the Wakefield pound benefits local businesses, communities, the environment, and society as a whole.

Outcome 22: Public and community services work together as one system.

- We will support each other to take steps to enable better outcomes for the district's residents, places and businesses; reducing bureaucracy, breaking down barriers, commissioning jointly, and seeking out innovation.
- We will improve the productivity of our major organisations and economy.
- We will use the strength of our collective voice and power to make the case for the resources and investment we need to deliver better outcomes for residents and businesses.
- We will share data and insights to solve problems more effectively.

What does this mean for Children and Young People?

- Improved local services will be better placed to deliver better outcomes for young people, reducing barriers and bureaucracy and being able to effectively meet young people's needs.

Ways of working

Our communities will be at the heart of everything we do - active, engaged, and empowered to shape their future. To achieve this, the outcomes and ambitions in our Plan are built on a set of principles that will guide the way we - partner agencies, networks and communities - work.

We will:

1. Take an asset-based approach

We have many strengths. Our staff. Our volunteers. Our communities. Our businesses and entrepreneurs. Our partnerships and networks. Let's build on them together.

2. Empower our residents

Our residents do not need to be told what to do, or want to have things done to them. We will shape our work so that it supports people to take charge of their own future.

3. Tackle inequality

Not everyone has the same start in life. We will champion fairness, celebrate differences, and make sure everyone is included.

4. Have a positive environmental impact

Residents recognise the importance of protecting our environment for future generations. Plans and decisions will be driven by our ambition to have a positive environmental impact, reducing and off-setting emissions as far as possible through methods that will stop carbon leaking into our atmosphere.

5. Take a trauma informed approach

Past trauma can affect a person's well-being, behaviour, and ability to engage. We will focus on creating safe, supportive environments that avoid re-traumatization and help people feel understood and empowered.

6. Have an outcome focus

Actions and decisions need to lead to meaningful results rather than just activity. Instead of getting caught up in the process, we will keep attention on what actually matters, and base our activity on evidence.

7. Build on what works

Not everything requires a new approach. We are already doing some great stuff. We need to share learning around what works, build upon these opportunities and celebrate our successes.

8. Be aspirational in what we do

While we are already doing some things well, there are other areas where a new approach may be needed. We need to be more aspirational, innovative and collaborative, having no fear in trying new things and breaking down barriers that get in the way of working together. We should aim high, push boundaries, and team up for success.

9. A stronger focus on prevention and early help

Demand for services is at an all-time high, impacting health care, social and community support for children and older people, education, and emergency services. We will use our collective resources and commission more effectively to focus on prevention and early assistance to create better outcomes across all our services.



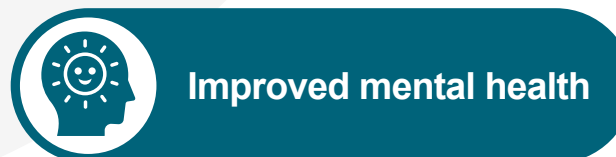
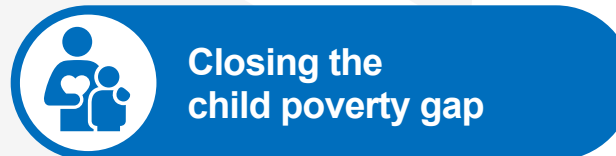
Measuring success

So, how will we know we have made a difference?

This Plan is our high-level vision and ambition for the District. It sets out a clear direction of travel for the next 10 years, what we will strive to achieve.

More detailed actions will need to be drafted that will create the step change needed over the next year, two years, and 10 years, to achieve each of the outcomes included in this Plan. Some of this will be achieved through the normal business of our partnership boards and networks, and where needed delivery plans will be created to set out the additional actions and interventions required.

Our outcomes will be underpinned by a set of high-level measures, that will demonstrate the impact of the work we will undertake to achieve this Plan:



These measures will be monitored and communicated through the governance mechanisms outlined in Section 3, and shared transparently via the annual wider partnership State of the District event, ensuring broader accountability, collective ownership, and a clear demonstration of progress across stakeholders.

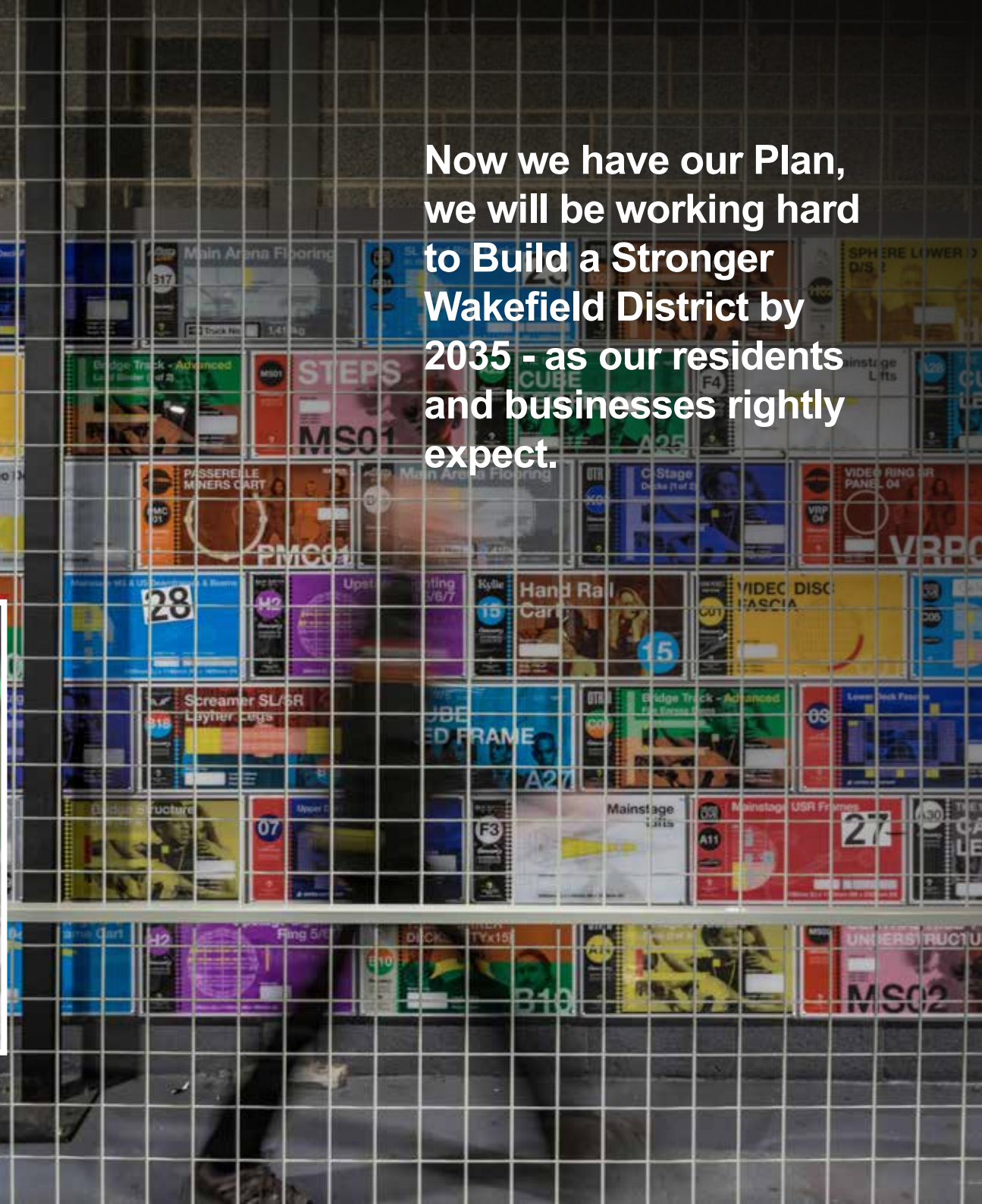
Delivery plans (where needed) will be underpinned by a separate set of more specific and detailed metrics, and considered through the most relevant partnership delivery mechanism.

And there are other ways that we can measure the impact of what we are doing. We will work with our academic partners, such as through the Health Determinants Research Collaboration and the Yorkshire and Humber Policy Engagement and Research Network, to evaluate the impact of some of the activities and interventions we put in place – particularly those new approaches we are seeking to pilot or widen to other areas – to achieve our outcomes.



What happens next

Now we have our Plan, we will be working hard to Build a Stronger Wakefield District by 2035 - as our residents and businesses rightly expect.



We are excited to be embarking on this journey with you over the next ten years - we know we achieve more and better things when we work as a team.

Collaboratively, positively and with the passion and Wakefield spirit we all have.

We will deliver the Plan's ambitions through a number of methods:

- Much will be delivered through the day-to-day activity of individual partner organisations. Partners will make sure their corporate plans reflect or contain the ambitions in this Plan, committing resources to deliver the outcomes.
- Our many Partnership Boards and networks will take forward actions as part of their work programmes. Our Boards will be reviewed to consider how they work together to eliminate duplication and bridge gaps.
- The Wakefield Strategic Partnership will commission task and finish activity where needed.

Where appropriate delivery plans will be developed, which will include timescales, milestones, measures for difference made, and clear accountability.

Chief executives and chief officers of some of our major organisations and networks will come together regularly to oversee the work of the Plan, to ensure the resources are made available to deliver on our ambitions, and to challenge progress where needed.

Each year, the Wakefield Together Partnership will hold a State of the District Summit to understand the progress made, hear about some of the good practice, provide suggestions to challenges experienced, and consider emerging local and national issues and how Wakefield might respond to these.



Our Pledge

As a core partner of the Wakefield Together Partnership we pledge to:

- Endorse the vision and ambitions set out in the District Plan.
- Commit to working in partnership and playing our part in achieving the agreed outcomes, making the resources available to achieve success.
- Agree to be held accountable - collectively and individually - for delivery of our vision.
- Ensure that decisions we make as a Partnership are shaped by the views of our residents and communities.

Immediate actions

The outcomes in the Plan will be delivered over a ten-year period, however, many actions needed to achieve these outcomes will be progressed much sooner - within one to five years.

These will include pilot schemes, different ways of working together, and immediate collaboration between partners involved in working in our neighbourhoods. Some of the actions we will take over the next 12 months are set out below:

Our Vision: Building a stronger Wakefield

- Ensure that anti-poverty considerations are built into economic, social and health strategies and into service delivery.
- Review of Help at the Hubs model and future focus.





Ambition One: An economy that works for everyone

- Implement and deliver major regeneration and repurposing work around urban centres through the Wakefield and Castleford Strategic Regeneration Partnerships, applying lessons learnt to other Towns across the district.
- Consider and implement the recommendations of the Wakefield Futures Commission.
- Promote and influence the West Yorkshire Fair Work Charter and consider a workplace health and support charter.
- Drive economic growth through the establishment of an Economic Board and the development of a Growth Plan for the District.



Ambition Two: A place where children and young people grow and thrive

- Implementation of the Children and Young People's Plan 2025-2028.
- Further development of our Children and Young People Offer.

Ambition Three: People live healthy lives

- Review processes for sharing information between agencies about people who are most at risk of poor health and sign-posting people to support to maximise their independence.
- Roll out partnership work and approaches to increase digital inclusion.



Ambition Four: Tackling climate change together

- Focus on delivery of the Climate Emissions Reduction Plan.
- Agree a common language to use around climate change.
- Develop a multi-media strategy and action plan which is universally used by all organisations and partners within the Wakefield district, e.g. case studies, social media.
- Provide information and awareness on home energy initiatives.
- Consider the opportunities for investing in infrastructure around mine water, solar panels, a district heating network and community energy schemes.

Ambition Five: Thriving, welcoming, and safe communities

- New Neighbourhood Coordination Model to be developed, which will be complemented by targeted neighbourhood support, where insight from a small number of places helps develop a long-term plan to tackle deep-rooted inequalities.
- Develop a distinct Community Cohesion Strategy to support community integration, collaboration and engagement.
- Review and improve local police and communities together meetings, to ensure there is an action focused approach to tackling community safety at a local level.
- Establish neighbourhood health teams to deliver coordinated care to people with complex health and care needs, long term conditions and frailty in their communities.
- Work will be taken forward to look at opportunities for greater and more effective data sharing.
- Develop a series of pilot approaches to target support at those with complex lives, where the need for co-ordinated intervention is greatest.
- Make prison release more effective to reduce re-offending, by building on a departure lounge approach.



Ambition Six: Strong local services that work for people and place

- Develop a joint approach to social value to use our collective scale to deliver greater outcomes.
- The Wakefield Together Partnership could achieve more together if it identifies some key messages for lobbying and influencing, both through the West Yorkshire Combined Authority and national Government. This is particularly pertinent in relation to transport. A lobbying and influencing strategy will be developed, considering who we need to influence, how, and on what.





Keeping in touch

The Partnership will send updates on the activities and progress of the Plans ambitions through regular newsletters. To keep to date with newsletter and hear more as it happens, please get in contact with the Partnership Team here:

together@wakefield.gov.uk

Please sign Our Pledge to show your support for the Wakefield District Plan. You can do so [here](#).

Glossary of terms and useful information

Asset-based approach

An asset-based approach focuses on identifying, leveraging, and building upon the existing strengths, resources, and capabilities of individuals, communities, and organisations - rather than concentrating on their needs, problems, or deficiencies.

Big Conversation

A community engagement initiative in 2021 to gather input from residents. The engagement team spoke with 1,327 people in the district this involved individual, face-to-face conversations.

They asked people what they liked about their area. And what they would like to see in the future to improve things for the next generation.

[The Big Conversation leaflet](#)

Children and Young People's Partnership Board (CYPP)

Through the CYPP, partners work together to improve the lives of children and young people in Wakefield. The CYPP provides direction for decision-making about services for children and young people in Wakefield and strategic leadership across relevant organisations to make progress against agreed ambitions and the priorities and outcomes to deliver them.

The main function of the CYPP is to develop and own an overarching strategic partnership plan for children and young people in Wakefield - "The Children and Young People's Plan 2025-28" - hold each other to account for its delivery and implementation and ensure that the voices of children and young people are heard and acted upon.

The Children and Young People's Plan can be found here:

[Wakefield Children and Young People's Plan 2025](#)

Circular economy principles

Practices focused on reducing waste by reusing and recycling materials. keeps A circular economy keeps resources in use as long as possible, extracting maximum value from them, minimizing waste and promoting resource efficiency.

Climate Emissions Reduction Plan

A strategy to reduce carbon emissions in the district.

Community Anchors

Local organisations that act as hubs for community activity and support. Each anchor offers differing types of support depending on local need, but examples include Food Banks/Pantries, Baby Banks, Citizens Advice drop-ins, training and skills support, employment support and activities for families and young people and social groups/activities.

Community energy schemes

Community energy schemes refer to initiatives that are led by communities to develop renewable energy projects, reduce energy demand, and supply energy. These schemes can be wholly owned by communities or developed in partnership with commercial or public sector partners.

Community Investment Gateway

A mechanism to help voluntary and community organisations access funding.

Community Safety Partnership

The Crime and Disorder Act 1998 places statutory duties on agencies to come together to address crime and community safety through a Community Safety

Partnership. The Partnership brings together agencies who are working to make the Wakefield District a safer place for local people and communities.

Community wealth building principles

Strategies to ensure local economic benefits are retained within the community.

Departure lounge approach

A method to support individuals transitioning out of prison to reduce reoffending.

District heat network

A system for distributing heat generated in a centralised location to residential and commercial buildings.

Economic Growth Board

A new Partnership Board that will be established to drive economic development and productivity.

Growth Corridor

A designated area that is planned for significant development and infrastructure improvements to accommodate population growth and economic expansion.

Growth Plan

A strategic document that will outline opportunities for economic growth and investment.

Health and Wellbeing Board

The Health and Social Care Act 2012 placed a requirement on local authorities to establish a Health and Wellbeing Board to bring together key leaders, including Healthwatch, to improve the health and wellbeing of the local population.

Collaboration is at the heart of Health and Wellbeing Board role. Its purpose is to provide a forum for the Council to work with the NHS, with local people and with wider system partners to improve population health by addressing and tackling ill health and health inequalities.

The Health and Wellbeing Board has a specific responsibility for bringing together the local authority and NHS to jointly assess population health need through a Joint Strategic Needs Assessment and for developing a Joint Local Health and Wellbeing Strategy for the District.

Help at the Hubs

The Help at Hubs project offers support with the cost of living including advice on money, debt, energy bills, housing, and jobs and skills. [Help at the Hubs](#)

Help at the Hubs advice is delivered by a mix of Community Anchors and local community centres.

Just transition

Ensuring fairness in the shift to a green economy, supporting affected communities and industries.

Neighbourhood Coordination Model

A framework for integrating services and community efforts to address local issues.

Net Zero Partnership

The Net Zero Partnership is a broad coalition of partners in the District who have or want to set targets for the low carbon transition to net zero. They come from the voluntary and community, public and private sectors and are united by the goal of joining up actions to achieve sustainable jobs, communities, places and travel. The target is to be net zero as a District by 2038.

Police and Community Together meetings

Meetings with local Neighbourhood Police Team, Councillors, residents and businesses to discuss issues in the community.

Outcome-focused plan

A strategy designed to achieve specific, measurable results rather than just activities.

T-Levels

Technical qualifications in England designed to prepare students for skilled employment or further study. Typically, T-Levels are studied within Further Education environments and are equivalent to three A levels.

Trauma-informed approach

A method of working that recognizes and responds to the impact of trauma on individuals and is increasingly underpinning partners approaches to supporting service-users across every field of health and social care. Trauma-informed practice is an approach to health and care interventions which is grounded in the understanding that trauma exposure can impact an individual's neurological, biological, psychological and social development.

Wakefield and District Safeguarding Adults Board

The Wakefield and District Safeguarding Adults Board has a statutory duty under the Care Act 2014 to ensure that agencies work together to protect vulnerable adults or those with care and support needs.

Wakefield District Health & Care Partnership

A partnership of NHS, Wakefield Council, Healthwatch Wakefield, health, care, housing, voluntary and community sector organisations working together to plan and deliver services and improve the health and wellbeing of the 350,000 people who live in the district. With the aim of making a real difference to the health of communities by reducing health inequalities, providing continuity of care and improving services.

Wakefield District VCSE Collaborative

The VCSE Collaborative is a strategic group that brings together senior leaders across the VCSE and statutory sectors, to work towards our common goals of supporting local people.

Wakefield Futures Commission

The Wakefield Futures Commission was launched in 2025 and brings together eight leading national experts from education, economic policy and business sectors. The Commission will carry out research and determine how the district can attract and retain high-level skilled workers.

Wakefield Health Determinants Research Collaboration

An initiative dedicated to tackling health inequalities through evidence-informed decision-making. Launched in January 2024, HDRC Wakefield is a five-year project bringing together key partners, including:

- Wakefield Metropolitan District Council
- Voluntary and community sector organisations
- Sheffield Hallam University
- Leeds Beckett University

Wakefield Safeguarding Children Partnership

Wakefield Safeguarding Children Partnership supports all organisations in the district who work or volunteer with children and their families, to ensure children are safeguarded and their well-being is promoted.

Wakefield Strategic Partnership

The Wakefield Strategic Partnership brings together key partners in the health, education, emergency services, business, public, and voluntary and community sectors, to collaborate and work together for the overall success of the District, and oversees the Wakefield Together Partnership.

It consists of 12 chief executives and senior officers who meet regularly to steer the development and future direction of the Partnership through the development of the District Plan.

Wakefield Together Partnership

The Wakefield Together Partnership is the family of partnerships that operate across the District to enable better outcomes for place.

West Yorkshire Fair Work Charter

A regional initiative promoting fair employment practices.

Yorkshire and Humber Policy Engagement and Research Network

The Yorkshire and Humber Policy Engagement and Research Network brings together universities and policy making organisations to collaborate on inclusive, place-based policies.

Find out more

Find out more about the Wakefield District via the following sources:

Census 2021

The census is undertaken by the Office for National Statistics every 10 years. It presents a societal picture of people and households in England and Wales.

[Census - Office for National Statistics](#)

Office for National Statistics Local Indicators

Provides local statistics and indicators across multiple aspects of population, economy and health.

[Local indicators for Wakefield - ONS](#)

Wakefield Joint Strategic Needs Assessment

The Wakefield Joint Strategic Needs Assessment is a source of information about the health and wellbeing needs and characteristics of the Wakefield District population, including services and initiative that support this.

[Welcome to the Wakefield JSNA - Wakefield District JSNA](#)

Wakefield State of the District Report

The State of the District report provide a comprehensive description of the Wakefield District. It draws statistics from a wide range of government departments and local organisations to show the extent to which society and life is changing, as well as some of the factors which may be driving these trends.

[State of the district report - Wakefield District JSNA](#)

Yorkshire & Humber Office for Data Analytics (YHODA)

YHODA supports data-driven decision-making through open-access data and analytics. Based in the University of Sheffield, it forms part of the UK Research Innovation funded Yorkshire Policy Innovation Partnership.

[Yorkshire & Humber Office for Data Analytics \(YHODA\)](#)

ITEM 10

Meeting name:	Wakefield District Health and Care Partnership Committee
Agenda item no:	10
Meeting date:	Tuesday 9 September 2025
Report title:	Development of Provider Alliance Arrangements for the Wakefield District
Report presented by:	Ruth Unwin, Director of Strategy
Report approved by:	Ruth Unwin, Director of Strategy
Report prepared by:	Ruth Unwin, Director of Strategy

Purpose and Action			
Assurance ☒	Decision ☐ (approve/recommend/ support/ratify)	Action ☐ (review/consider/comment/ discuss/escalate)	Information ☐
Previous considerations:			
The Committee has previously discussed proposals to establish a Provider Alliance for the Wakefield District at development sessions and formal meetings			
Executive summary and points for discussion:			
The purpose of this presentation is to update the committee on progress towards establishing a Provider Alliance for the Wakefield District. Work began in Autumn 2024 to develop a Provider Alliance for Wakefield involving Voluntary, Community and Social Enterprise (VCSE), statutory NHS organisations and the Council – building on existing collaborations. Provider Alliances will take on some of the traditional functions of the Integrated Care Board (ICB) for bringing together partners to ensure coordination of services across organisations. In March 2025 NHS West Yorkshire ICB asked providers in each place to agree appropriate place provider partnership model by September 2025. This was subsequently confirmed as the national direction of travel in the NHS Ten Year Health Plan. Each place will have a separate Provider Alliance/Partnership. A working group has been established under the leadership of the Chair of the Mental Health Alliance to take this work forward in Wakefield. A sponsor group of accountable officers for Calderdale, Kirklees and Wakefield (CKW) has also been established to ensure alignment across the three places. Work is on-going to establish the functions that will be delegated to the provider alliance and the benefits to be derived from increased collaboration across providers. There is broad agreement that the initial focus of the Provider Alliance will be neighbourhood health services. Complementary work is taking place through a group of CKW governance leads, taking into			

account past experience of establishing partnership agreements, to consider potential governance arrangements.

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

- Note the work that is underway to develop a Provider Alliance and agree any follow up action.

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

BAF 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.

Appendices

1. Presentation

Acronyms and Abbreviations explained

1. VCSE – Voluntary, Community and Social Enterprise
2. ICB – Integrated Care Board
3. CKW – Calderdale, Kirklees and Wakefield

What are the implications for?

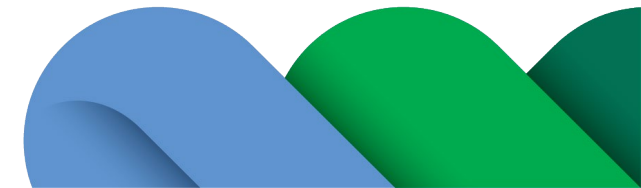
Residents and Communities	The establishment of a Provider Alliance Plan will ensure stronger alignment of services for residents and communities
Quality and Safety	None directly
Equality, Diversity and Inclusion	No direct implications
Finances and Use of Resources	The Provider Alliance will have delegated responsibility for resources, to be determined by the partner organisations.
Regulation and Legal Requirements	Legal advice is being sought on potential governance arrangements
Conflicts of Interest	None
Data Protection	None
Transformation and Innovation	The plan describes a way of working between partner organisations to deliver improvements to services

Environmental and Climate Change	None
Future Decisions and Policy Making	The proposals will result in changes to the arrangements for decision making in the district.
Citizen and Stakeholder Engagement	Work is underway to develop arrangements for ensure all stakeholders to be involved in shaping future plans.

Development of the Wakefield Provider Alliance

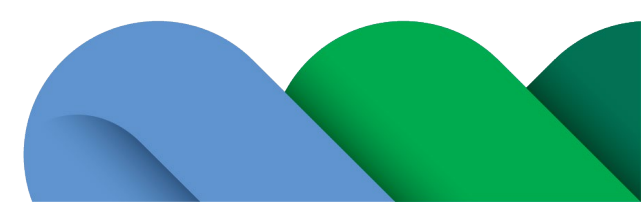
Background

- ◆ Work began in Autumn 2024 to develop a provider alliance for Wakefield involving VCSE, statutory NHS organisations and the Council – building on existing collaborations
- ◆ Provider alliances will take on more of the traditional role of the ICB for bringing together partners to ensure coordination of services across organisations
- ◆ March 2025 - NHS West Yorkshire ICB asked providers in each place to agree appropriate place provider partnership model by September 2025
- ◆ ICB Place Accountable Officers responsible for overseeing the developments in each place
- ◆ Arrangements to be implemented April 2026 (shadow from Q3 this year)
- ◆ July 2025 this was confirmed as the national direction in the Ten Year Health Plan
- ◆ Each place will have a separate provider alliance/partnership



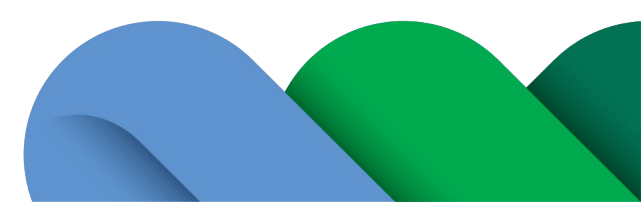
Collaborative work across Calderdale, Kirklees and Wakefield

- Some work is being done jointly across the three places to share learning and ensure consistency of function and form
- Each place is at different stages of development & has different challenges
- Focus will be the six core components neighbourhood health - population health management, modern general practice, standardising community health services, neighbourhood MDTs, integrated intermediate care & urgent neighbourhood services
- Long term aspiration - connecting people with health/care needs to wider public services and third sector support, including public health and other local government services
- Community & out of hospital budgets to be included initially
- Additional services that are central to neighbourhood health approach may come into scope in future years eg: some aspects of primary care, urgent treatment and same day emergency care
- Supports preventative work and alternatives to delivering primary and community health care closer to people's homes
- Alliances will include physical, social and mental health statutory and VCSE providers



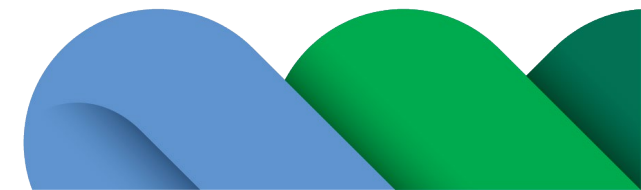
Progress to date

- ◆ Senior officer group set up across CKW & governance leads working together
- ◆ Lead NHS organisations identified to take forward the work in each place
- ◆ Gathered intelligence from the work done over the years (legal advice already exists for provider collabs, places have MOUs in place)
- ◆ Working group set up in each place. Involving all key organisations including General Practice, Local Authorities, NHS providers and will look to remove duplication for providers over multi locations
- ◆ Stakeholder mapping to ensure robust approach to co-produced model
- ◆ Each place (ICB) is working on being clear what they want their provider partnership to be responsible for. Clear KPIs and budget responsibility from commissioners.
- ◆ Working at pace to meet to be operational and reacting to national guidance.



Next steps

- Places to confirm what provider partnership to be responsible for delivering (money and outcomes).
- Establish shadow arrangements by December 2025
- Clear on measurable outcomes for ICB and partnerships.
- Respond to additional 10 Year plan guidance on Integrated Health (blueprints expected).
- Place provider partnerships to be confident they are mature enough to take on the new responsibilities.
- Clarity needed on relationship between ICB and provider collabs and expected governance – legal advice commissioned
- Steering group to work through scenarios to explore benefits of alternative decision-making approaches
- Further work on stakeholder mapping to confirm core membership and wider inclusion of stakeholders in decision making



ITEM 11

Meeting name:	Wakefield District Health and Care Partnership Committee
Agenda item no:	11
Meeting date:	Tuesday 9 September 2025
Report title:	Financial Plan
Report presented by:	Amy Whittaker, Chief Finance Officer, Mid Yorkshire Teaching NHS Trust and Jenny Davies, Deputy Director of Operational Finance, Wakefield Place
Report approved by:	Ian Currell, Operational Finance Director, Wakefield Place
Report prepared by:	Jenny Davies, Deputy Director of Operational Finance, Wakefield Place

Purpose and Action			
Assurance ☐	Decision ☐ (approve/recommend/ support/ratify)	Action ☐ (review/consider/comment/ discuss/escalate)	Information ☒
Previous considerations:			
N/A			
Executive summary and points for discussion:			
The paper gives a summary of the Wakefield Place financial plans submitted and the process followed. Plans were submitted earlier in the year and accepted/approved. Subsequent changes have since occurred such as additional allocations and distributions of financial support/ICB surplus.			
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 acknowledge the paper which is for information.			
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. Presentation attached
Acronyms and Abbreviations explained
N/A

What are the implications for?

Residents and Communities	N/A
Quality and Safety	N/A
Equality, Diversity and Inclusion	N/A
Finances and Use of Resources	How budgets have been calculated and allocations apportioned in accordance with NHSE Guidance and statutory obligations fulfilled.
Regulation and Legal Requirements	How budgets have been calculated and allocations apportioned in accordance with NHSE Guidance and statutory obligations fulfilled.
Conflicts of Interest	N/A
Data Protection	N/A
Transformation and Innovation	N/A
Environmental and Climate Change	N/A
Future Decisions and Policy Making	N/A
Citizen and Stakeholder Engagement	Information shared transparently



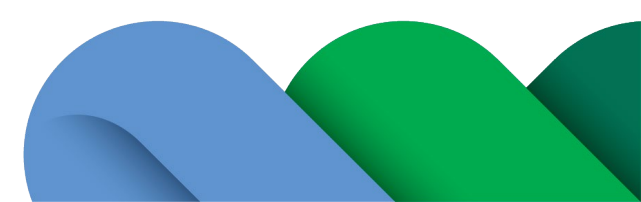
Wakefield District
Health & Care
Partnership

Wakefield Place Financial Plan 2025/26



Planning Process

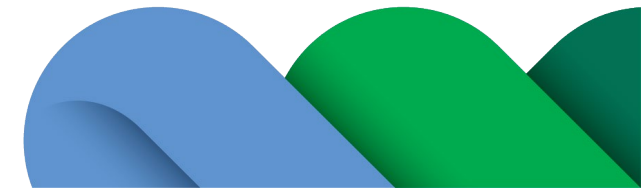
- ◆ NHSE submissions 2025: February and March.
- ◆ Consistency checks across ICB Place and across provider sectors
- ◆ Peer to Peer reviews
- ◆ ICB/ICS scrutiny – Mutual Accountability Meetings.
- ◆ Extra challenge and scrutiny for deficit Trusts and Systems
- ◆ Further improvement discussions at Board level – possible efficiencies.
- ◆ Additional target of £33m savings apportioned across all places and organisations
- ◆ 2025/26 budgets implemented.



Final Submitted Plans

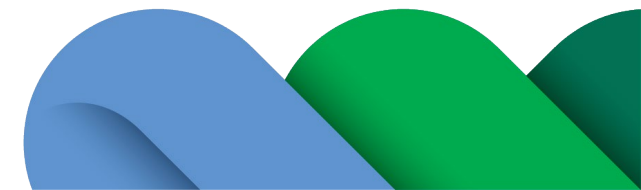
25/26	Allocation	Submitted Expenditure Plan	Submitted Plan +surplus/(- deficit)	Efficiency	Efficiency
	£m	£m	£m	£	%
W- ICB	918.6	916.0	2.6	11.5	3.9%
MYTT	849.2	857.3	-8.1	41.2	4.9%
SWYPFT	410.1	410.1	0	28.2	6.8%
Total	2,177.9	2,183.4	-5.5	80.9	

Please note the ICB Efficiency percentage is calculated on a different basis which is around third of the allocation as it excludes NHS to NHS spend.



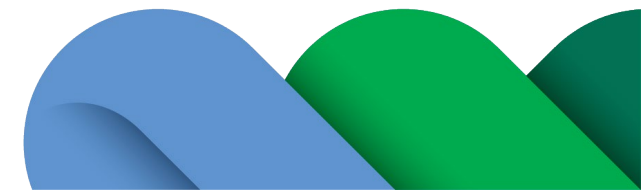
Assumptions included in Health Plans

- ◆ All health plans assume growth and inflation as per national guidance however there are concerns this is understated. Growth 4.3% & Convergence 0.11%
- ◆ Significant waste reduction/efficiency in all organisations plans (from 3% - 7%).
- ◆ Cost Uplift Factor of 4.15% (less 2% national efficiency); net 2.15% uplift
- ◆ MHIS – 4.4%
- ◆ FNC – 11.2% (all growth)
- ◆ CHC – 8.8% (all growth)
- ◆ Medicines – 3.3% (primary care)
- ◆ BCF – 1.7% (with 3.9% as minimum growth on social care element – in effect nil growth on NHS component)



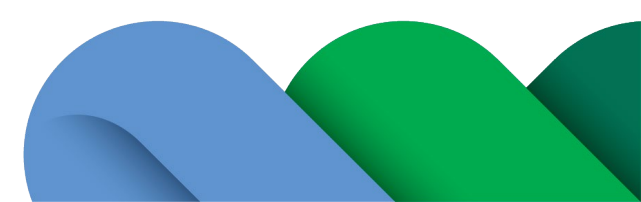
Our Risks & Challenges

- ◆ Efficiency Targets – Delivery and any unidentified
- ◆ Rising unplanned demand and ability to manage expected growth
- ◆ Delivery of elective recovery and productivity improvements
- ◆ Pace of change and ability to remove costs within 25/26, especially ICB staff costs of 45%
- ◆ Reductions in workforce in providers
- ◆ Rising out of area placements
- ◆ Prescribing cost growth
- ◆ Increasing complex packages of care – adults and children's
- ◆ S117s – demand and increased costs
- ◆ Neurodiversity waiting lists
- ◆ Increase in children needing EHCP's



Next Steps

- Continue with the development of efficiency savings – closing the gap.
- Continue financial recovery action plans to incorporate vacancy control panels, investment review panels, and discretionary spend controls.
- Organisation risks to be understood at system level, to incorporate sharing risk and supporting partners. o C
- Review of NHSE revised grip and control framework and ONF supporting 'Surviving to Thriving' documentation
- Review of National Oversight Framework published ratings and impact on organisations.



ITEM 12

Meeting name:	Wakefield District Health and Care Partnership Committee
Agenda item no:	12
Meeting date:	Tuesday 9 September 2025
Report title:	Summary of 2025/26 Quarter 1 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:	West Yorkshire Integrated Care Board, 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 and Care Partnership have been produced and presented at the Wakefield Integrated Assurance Sub-Committee with a summary report being shared with the Wakefield District Health and Care Partnership Committee (WDHCP).			
Executive summary and points for discussion:			
The WDHCP is presented with a summary of the 2025/26 Q1 Quality, Safety and Experience report for Wakefield place which was presented to the Wakefield Integrated Assurance Sub-Committee on 22 July 2025. The report presents information from various sources including regulators, commissioners, service providers and our population. In 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, Patient Safety 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 and Applaud (AAAA) alongside an accessible version of the Q1 Assurance Wheels aligned to the Partnership's Strategic Delivery Plan.			

ITEM 13

To ensure the report is as current as possible the report includes relevant updates since the Wakefield Integrated Assurance Sub-Committee.
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 note the: a) full report was presented to the Integrated Assurance Committee on 22 July 2025; and current place risks and assurances related to quality, safety and experience presented in the AAAA 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 2025/26 Quarter 1 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

ITEM 13

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 24 July 2025.

Appendix One

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

Report from: Quarter 1 Quality, Safety and Experience Report
Date of meeting: 9 September 2025
Report to: Wakefield District Health and Care Partnership Committee
Report completed by: Laura Elliott, Senior Head of Quality
Date: 5 August 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 ([West Riding Care Home](#)). The service is under significant scrutiny from local Authority and ICB commissioners with input from the aligned GP Practice. The home 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 weekly meetings with the provider and visits from the integrated quality team.

Advise:

Mid Yorkshire Teaching Trust (MYTT)

- In January 2025, following the **Paediatric Audiology** Service Review, MYTT were de-escalated from a low assurance site being monitored, to a partial assurance site. Since then a late diagnosis of childhood deafness case (classed as moderate harm) has been identified and reviewed by the Regional Lead Scientist. The Trust has been requested to undertake an audit of all children on the permanent childhood hearing impairment (PCHI) register since June 2020 by 30 September 2025. A regional Subject Matter Expert has been allocated to advise and support/oversee the trust with the audit.
- Since the previous report the **use of temporary escalation spaces** for patient care has reduced. On 10 June 2025, a follow-up meeting to the Rapid Quality Review meeting took place where the Trust updated on the improvements in urgent and emergency care performance (including improved ambulance handover times, and 4 hour A&E waiting times, and a decrease in waits longer than 12 hours) and quality measures (reduction in deteriorating patient, falls and

hospital acquired pressure ulcer patient safety events as a result of TES care and long waits). The Trust presented on the three areas of operational improvement – pre-admission/front door (including the concordat being developed following the ECIST visit); inpatient flow (supported by the new structured management quality system - Improving Together); and discharge.

It was agreed that further meetings were not required and monitoring and governance will continue through existing place quality oversight and governance processes. The ICB were invited to visit the Trust to see first-hand the impact of the quality improvement work. This visit has been arranged for early October 2025 and will include assurance on preparations for the forthcoming winter period.

- **Learning from Deaths** mortality data up to January 2025 shows the overall 12-month rolling Hospital Standardised Mortality Ratio (HSMR) is at 106.6 (above expected) with year to date (YTD) of 106.87 (in line with expected) – high monthly HSMRs in December 2025 and January 2025 has impacted on the 12-month rolling and YTD position. The Summary Hospital Mortality Indicator (SHMI) for February 2024 – January 2025 (latest data) remains ‘as expected’ at 1.14.

Fracture of neck of femur – benchmarking has been undertaken using 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, As well as mortality the Trust flags as an outlier for timely admission to specialist ward (linked to operational challenges and long waits in Emergency Department), overall length of stay, and out of bed promptly after surgery. This was discussed at Quality Committee where a test of change trialling fast-track admission of patients from the ED to the appropriate ward is being progressed.

- The Trust has identified that between 2021 and 2023 some completed **Perinatal Mortality Review Tool (PMRT) reports** were not shared with families. Remedial actions have been agreed and the specialist bereavement midwives continue to contact the families and share the reports if requested. Weekly oversight and monitoring is in place within the Division and progress is reported each month to the Trust’s Quality Committee.

GP Practices

- In January 2025, a local GP Practice (Stuart Road Surgery, Pontefract) was escalated to enhanced quality oversight following a recent Rapid Quality Review meeting. Contractual action was taken and the quality and primary care teams continue to support the practice and closely monitoring progress. The CQC undertook an [assessment](#) in early May 2025 and the rating moved from Good to Requires improvement

Adult Social Care

- As previously reported, the CQC took urgent enforcement action against a nursing and residential care home in the district (Manor Park in Castleford). The provider instigated a voluntary suspension on new admissions, and all residents received a safe and well check from the social work or continuing healthcare teams. Progress with improvements were closely monitored through weekly meetings with the provider and visits from the integrated quality team.

The home was supported by a regional manager and an experienced interim manager. The most recent quality visits evidenced significant improvements in all areas. In July 2025 a new manager commenced in post and the Council agreed the voluntary suspension on new admissions be partially lifted.

Assure:

Neighbourhood Health

- Insight reports for Neighbourhood Health MDTs** - In June 2025 a Neighbourhood MDT workshop was held to strengthen the proactive care offer and MDT approach to the three priority cohorts identified using the population health management approach and linked data model (Chronic Obstructive Pulmonary Disease (COPD), dementia and end of life). To inform the workshop, and complement the quantitative data, the Quality and Involvement Teams produced three Insight reports focused on experiences of care for people in these cohorts. The reports analysed and themed information from Quality Intelligence Group, local and West Yorkshire involvement work, and national reports/audits. The reports provided a summary of insight for each cohort and identified key opportunities to inform the development of Neighbourhood MDTs.

Quality Impact Assessments (QIA)

- The list of proposed 2025/26 efficiency schemes for Wakefield place has been confirmed. These are being reviewed with Alliance/Programme Leads to ensure that QIAs not already completed, are being undertaken to identify any impact on the quality and safety of services, experience of care (for people or staff), or any population groups or health inequalities, and ensure mitigations are put in place to reduce negative impact.

Assurance has also been received from MYTT and South West Yorkshire Partnership Foundation Trust (SWYPFT) regarding 2025/26 processes for QIA of their internal efficiency (cost reduction) programmes.

Mid Yorkshire Teaching Trust (MYTT)

- In May 2025 the CQC published the latest Children and Young People's Survey for 2024. The survey looks at the experiences of children, young people (agreed up to 15) and their parents and carers admitted to hospital (day case or inpatient) during March-May 2024. Responses were received from 160 people at MYTT.

The majority of [MYTT's results](#) were 'about the same' as other Trusts, however no questions scored 'worse or 'much worse' than expected. MYTT scored:

- 'much better than expected' for the type of ward the child stayed on and for having enough food and drink in the waiting area.
- 'better than expected' for staff trying to distract your child during the operation or procedure.
- 'somewhat worse than expected' for staff explaining how well an operation or procedure went; children understanding what happen next with their care and treatment; and staff seeming aware of the child's medical history.

Independent providers

- In May a Patient Safety Walkabout was carried out at Community Health and Eye Care services (CHEC) outpatient service based at the Grange Medical Centre. Overall, the walkabout provided valuable insight into the organisation's patient pathway, post-operative care, and governance processes. Their outcomes data indicate strong clinical performance, with complication rates below national benchmarks.

GP Practices

- At the end of Quarter 4 2024/25, 86.8% of people had received their Learning Disability Annual Health Check which means that the targets both nationally (75%) and at PCN level (80%) had been exceeded. An audit of the quality of Annual Health Checks is being completed and outcomes will be shared during Quarter 2.

Wakefield Council

- **Inspection of local Authority Children's Service (ILACS)** - The latest Ofsted inspection carried out in March 2025 has confirmed that Wakefield continues to deliver a **Good** overall service for children and young people, with support for children in care rated as **Outstanding**. Support for care leavers was judged as 'Requires Improvement'. The full Ofsted report is [available here](#).
- In June 2025 the Council completed their Youth Justice inspection which was carried out by His Majesty's Inspectorate of Prisons (HMIP). The lead inspector has shared their draft judgements and some detailed narrative feedback which indicates a strong position in relation to this work for Wakefield and a significant improvement on the previous (2021) inspection outcome. The full report and judgements are due to be published week beginning 8 September 2025.

Applaud:

GP Practices

- [Trinity Medical Centre](#) was inspected by CQC in May 2025. In July 2025 the CQC report was published with an overall rating of **Good** – with Good in all

domains, except Well-led which has been rated **Outstanding** - “as leaders had an inspiring shared approach and strove to deliver and motivate staff to succeed”.

Other

- The Integrated Quality Team hosted their second Sharing and Learning event in May at Wakefield Town Hall. It was attended by colleagues working in care homes and supported living facilities as well as people who work alongside our adult social care providers with 16 local providers represented. The event was an opportunity to share, learn and network with peers across Wakefield district with a focus on improving quality and experience of care for residents and staff. The session was interactive - speakers presented on a range of topics including medicines management and safety; oral health; and end of care planning.
- The Calderdale, Kirklees, Wakefield (CKW) Patient Safety Network was relaunched in May 2025 after a 12 month pause. The focus of the session was to reflect on providers' experiences and progress over the past 18 months of the Patient Safety Incident Reporting Framework (PSIRF) journey. Novus Health and Locala delivered presentations on their PSIRF journeys, highlighting the challenges they faced, key learning points, and areas of improvement. The ICB's Patient Safety Specialist also spoke about their role in the ICB and the support available to providers.
- Our latest Experience of Care Network was held in June 2025, hosted by the Prince of Wales Hospice in Pontefract. We discussed 'what are people telling us about their experience of waiting for neurodevelopmental assessment and diagnosis?'. Colleagues from the Children's Alliance shared the extensive range of support in place for children, young people, parents, carers and professionals like Wakefield Early Support Advice Information Liaison (WESAIL) and Wakefield Awareness Support Project (WASP) delivered by individuals with lived experience of neurodiversity. Healthwatch Wakefield told us about the impact of the Parent and Carer Panels set up across the district and SEND Fest they hosted in May 2025.

We also 'closed the loop' on one of our previous topics about 'experience of waiting for planned care' and were updated on initiatives such as Interface Liaison; Evidence Based Interventions (EBI); HealthPathways; redesigned PhysioWakefield service; and MYTT's new Surgical Hub and Community Diagnostic Centre.

- The opening ceremony for Learning Disability Week 2025 was held at Wakefield Cathedral for a second year. The theme was “Can you see me?” and families, friends, carers and people from across the district who have learning disabilities attended. There were performances from a local Makaton choir, a dance performance from people with a learning disability and their carers.

Quality, Safety and Experience Report

2025/26 Quarter 1

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

- In Q1 the Medicines Optimisation Team started their annual Practice Prescribing Visits.
- NHS England have published the latest Healthcare-associated infections (HCAI) objectives for 2025-26. The new objectives are lower than 2024/25 thresholds.
- In May 2025 a Teenage Pregnancy Toolkit 2025 was produced.
- Learning Disability Week 2025 was held in June and the theme for this year was *"Can you see me?"*
- At the end of Quarter 4 2024/25, 86.8% of people received their Learning Disability Annual Health Check above the national and PCN level targets.

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

- A Quality Visit was undertaken at Middlestown Medical Centre in April 2025.
- After a recent CQC inspection Stuart Road Surgery was rated Requires Improvement.
- Eight care homes are under formal enhanced quality surveillance and are being supported in line with the Quality Assurance Framework for Adult Social Care.
- 15 resident safety walkabouts and 11 engagement visits to care homes were carried out during the quarter
- In May the second Sharing and Learning Event took place for Care Homes.
- In May Patient Safety Walkabouts were undertaken at Wakefield Intermediate Care Unit (WICU) at Pontefract Hospital and Community Health and Eye Care services (CHEC) based at The Grange Medical Centre.
- To inform the Neighbourhood MDTs, three Insight reports were produced focused on experiences of care linked to COPD, Dementia and End of Life Care.

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

- In May the Outpatient department at Pontefract Hospital was visited and in June visits to three wards at Pinderfields Hospital took place.
- The use of temporary escalation spaces (TES), along with other UEC measures, has improved during Q1.

- Learning from deaths – 12 month HSMR is above expected overall and for fractured neck of femur.
- The 2024 results of the PLACE audit for the non-clinical aspects of healthcare settings and Staff Survey results were published for MYTT and SWPFT in Q1.

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

- During Q1 our Embedding Quality and Involving People (EQulP) programme held a Workshop which explored experience of care and a 'Share and Learn' session focused on the peer leadership Stronger Together group.
- The Experience of Care Network in June focused on 'experience of waiting for neurodevelopmental assessment and diagnosis' and the 'look back' topic focused on experiences of waiting for planned care.
- 445 items were shared in Q1 Quality Intelligence Group meetings and ten key themes were identified.
- In May 2025 the CKW Patient Safety Network relaunched. Providers were asked to reflect on their experiences and progress over the past 18 months of the PSIRF journey.

ITEM 13

Meeting name:	Wakefield District Health and Care Partnership Committee
Agenda item no:	13
Meeting date:	Tuesday 9 September 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. 2025/26 National Priorities are: • Reduce the time people wait for elective care • To improve RTT performance by 5% to 66.5% by March 26 • Improve A&E waiting times and ambulance response times compared to 2024/25 • With a 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 increasing the number of GP appointments by 2% • Improve patient flow through mental health crisis and acute pathways • Reducing average length of stay in adult acute beds • Improve access to children and young people's (CYP) mental health services • To achieve the national ambition for 345,000 additional CYP aged 0 to 25 compared to 2019 The performance methodology applied is based on the NHS 'Making Data Count'.			
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 - Aug 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

NHS ICB - Wakefield Place Performance Exception Report

Period –June / July 2025

How is Performance Measured

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.

Assurance icons

Blue indicates where improvement lies

Orange indicates concerning special cause variation requiring action

Grey indicates no significant change (common cause variation)

Variation	
	Common cause - no significant change.
 	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values.
 	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values.

Introduction

The purpose of this performance report is to provide an overview of Wakefield place performance against the core NHS constitutional standards set out in the NHS Operating Plan and key priority metrics identified for discussion at West Yorkshire ICBs System Oversight Assurance Group (SOAG).

The report focuses on the themes identified within the NHS Operating Plan with particular focus on the 2025/26 national priorities, which are:

Reduce the time people wait for elective care

- To improve RTT performance by 5% to 66.5% by March 26

Improve A&E waiting times and ambulance response times compared to 2024/25

- With a 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 increasing the number of GP appointments by 2%

Improve patient flow through mental health crisis and acute pathways

- Reducing average length of stay in adult acute beds

Improve access to children and young people's (CYP) mental health services

- To achieve the national ambition for 345,000 additional CYP aged 0 to 25 compared to 2019

Executive Summary

Wakefield Place key performance - unplanned care and patient flow

Pre-Hospital

- This year we have seen a small decrease in the proportion of calls to NHS 999 that were conveyed to ED compared to last year, with 54% of ambulance responses being conveyed to ED between April to July 25 (55.3% same period last year). 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 attendances to King Street Walk-In-Centre remain below plan and the levels seen in previous years.
- The number of GP appointments delivered per 1,000 registered practice population remains above the national average. Of the appointments booked, 46.2% of appointments were attended on the same day as booking and 69.1% were delivered face-to-face.
- The GP patient survey results for 2025 reported positively for Wakefield, with 77% of patients reporting a positive overall experience. Against the overall experience measure, Wakefield's performance reported above the West Yorkshire average by 0.8% and above the national average by 2%. We also reported a 2.9% improvement against last years overall experience results.

In- Hospital

- A&E attendances to date report 0.5% above the level planned, with July seeing a slight increase above plan. Whilst attendances are overall in-line with plan, activity at Pontefract UTC reports 2% above plan .
- A&E 4-hour performance in July reported at 75%, which is an improved position from June. Performance across WYAAT reported at 79.4%, with Mid Yorkshire benchmarking the 2nd lowest performance.
- 0.3% of patients in A&E with a decision to admit waited longer than 12 hours. Ambulance performance remains positive with no over 60-minute handovers reporting in July. Average handover time reports at 17 mins against a plan of 21 minutes.
- Medical Outliers remained static last week, averaging 13 per day.

Patient Flow

- Bed occupancy remains stable at 95% in July (93.4% in June) with average length of stay reporting at 6.2 days in June for Wakefield patients residing in a hospital bed. 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 remains stable. For Wakefield patients, the trend continues to reduce reporting an average of 65 patients per day in June from 74 in January.

Executive Summary

Wakefield Place 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 June was 46,142. This was a reduction of 384 from the previous month. The number of patients waiting over 52 weeks for treatment reported at 460 which is a decrease from the previous month. Of these, 34 patients were waiting over 65 weeks.
- The focus for 2025/26 is to deliver a 5% improvement in RTT 18-week performance by March 2026. Wakefield currently reports performance of 65.5%.
- Whilst RTT remains a challenge, the proportion of patients receiving a diagnostic test within 6 weeks continues to achieve the operational target for Wakefield (94.8 % in June 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 95.9% and the 62-day referral to treatment standard reported at 70.3% which is above the operating plan of 70%, yet below the national ambition of 85%.
- Mid Yorkshire did not achieve the two-week waiting standard for June with performance measuring 91.1% against a compliance of 93%, with the position expected to deteriorate further due to pressures within the Breast, Urology and ENT service.

Key Performance - mental health

- Of the seven 2025/26 key performance indicators only one is not being met currently: active inappropriate adult acute mental health out of areas placements (OAPs) is reported for across the SWYPFT footprint and is reporting 6 placements in June compared to a target of 5.

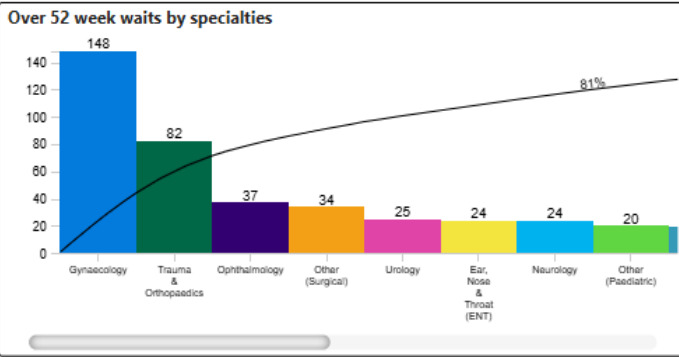
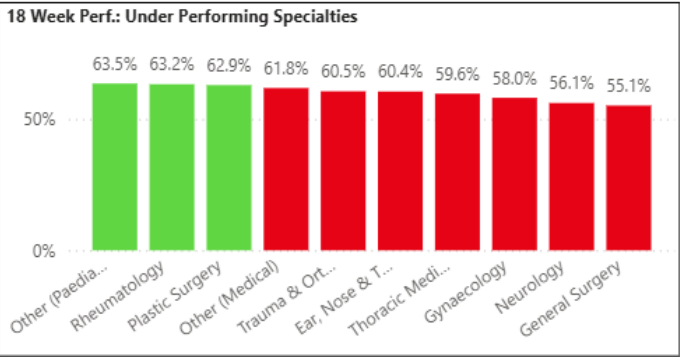
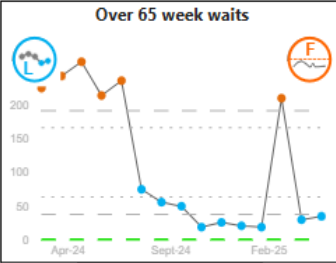
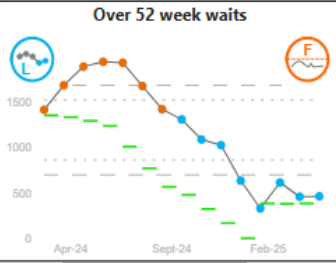
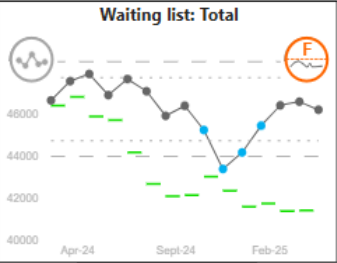
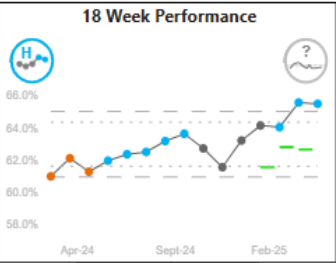
Key Performance – community services: children & young people

- The community services waiting list for children & young people continues to increase (5,101 in June compared to 4,9110 in May), with 1,056 waiting over 52 weeks.

Planned Care

2026/26 Ambition: To improve RTT performance by 5% to 66.5% by March 26

	July 2024	August 2024	September 2024	October 2024	November 2024	December 2024	January 2025	February 2025	March 2025	April 2025	May 2025	June 2025
18 Week Perf.	61.9%	62.3%	62.5%	63.1%	63.6%	62.7%	61.5%	63.2%	64.1%	64.0%	65.5%	65.5%
Target										61.5%	62.8%	62.6%



Performance Highlights:

- 18 Week Performance in June was 65.5%, which is above the operational plan target of 62.6%.
- Long waiters remain (78wk+) in Pioneer, Doncaster & Bassetlaw and Leeds Teaching Hospitals.
- Pressured specialities across providers with the highest number of patients waiting over 65 weeks remain Ophthalmology, T&O and Gynaecology.

What is driving this performance (Mid Yorkshire):

- 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.
- 65% of the 52-week backlog are patients on non-admitted pathways. This is being driven by demand exceeding activity and the need to balance RTT with acute, cancer and follow up patients.
- Some key services have seen high volume of medical sickness and vacancies which have limited capacity and flexibility to do additional work.
- Urology have a number of paediatric long waiters; the service is working with FCSS to increase capacity on the day surgery unit.
- Vascular capacity from Leeds and Bradford has reduced. Alternative service options are being explored.
- Vascular pressure is being driven by vacant clinical PA's in the service.
- General Surgery is being driven by increased demand and competing clinical priorities.

What actions are being taken (Mid Yorkshire):

- The new Surgical Hub at Dewsbury has fully opened for outpatient and day case activity. This will provide a significant opportunity to increase outpatient activity going forwards and ringfence activity.
- Recruitment in key service is being progressed with new consultants in anaesthetics being appointed to offset long term vacancies and WLIs. Consultant interviews are scheduled in ENT.
- Services are working with clinical and booking teams with a focus on patient level detail and productivity to support RTT recovery.
- Trauma & orthopaedic surgeons have agreed to pick up alternative outpatient activity in lieu of their lost theatre sessions.
- Requests for regional mutual aid support continue
- A triage exercise with primary care regarding ENT service model and opportunity to repatriate some work back to GPs.

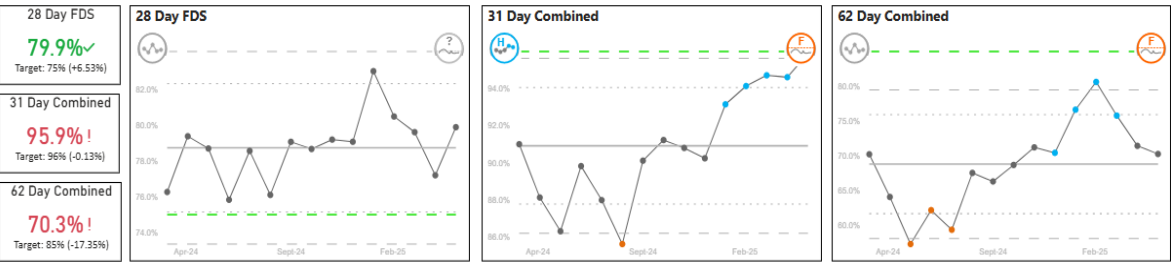
Planned Care

Constitutional Watch Metrics

Wakefield Diagnostic Performance:



Wakefield Cancer Performance:



Diagnostic Performance Highlights:

Wakefield

- Performance was 94.8% in June, which is below the 95% operational plan target and below the 99% national target. Overall performance is impacted by waiting times within the independent sector.
- In June, the independent sector performance was 81.2% which is driven by sleep studies, colonoscopy, MRI, non-obstetric ultrasounds, CT, audiology assessments and flexi sigmoidoscopy.

Mid Yorkshire

- The June performance was 98.4% against the constitutional target of 99% and the new improvement target of 95%.
- In June, Mid Yorkshire ranked 11th out of 134 NHS Acute Providers and above the NHS Acute average of 78.1%.

Cancer Performance Highlights (Mid Yorkshire):

- 2WW** performance has improved significantly over recent months, with July's performance measuring 92.3% against a compliance of 93%.
- Although the 2WW standard is below the previously measured 93% compliance, huge improvements have been made in the Breast TSSG with booking reaching <10 days currently. However, there is an emerging risk in the skin TSSG with the wait for first appointment exceeding 14 days.
- 28 FDS** performance for July currently measures 82.3% against a planning pack objective of 80%.
- July **31-day** performance currently measures 96.9% against a target of 96%.
- 62-day** performance for July measures 75.6%, final performance is expected to finish between 75% and 76.5%
- Current 62-Day Backlog measures 110 patients with Urology and Lower GI accounting for 45% of the 62-day backlog.

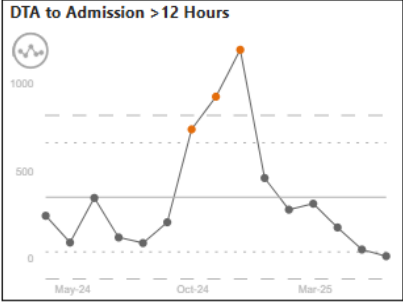
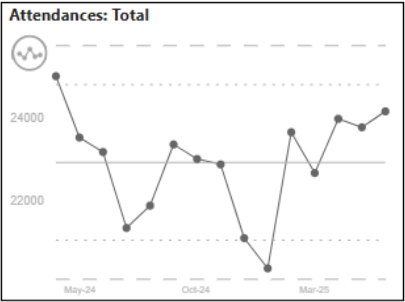
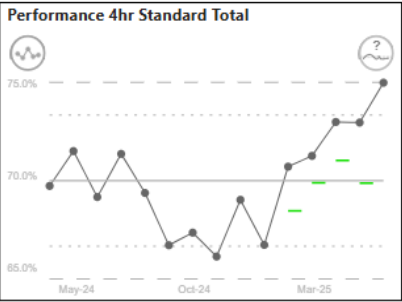
What actions are being taken (Mid Yorkshire):

- 2WW:** Continued review of the organisations 2WW position through the newly established Cancer A&P has helped drives cancer performance improvements. Modelling of data indicates that routinely offering patients first appointments/diagnostic test within 10 days of referral has a direct correlation with organisational 62-day performance.
- Pathology:** Outsourcing of specimens continues via Cancer Alliance funding. An additional 75k of 2025/26 funding has been provided to the pathology team to maintain the current turn around times for pathology specimens.
- Urology:** Urology performance is significantly challenged with a similar breach trend expected for August. Additional equipment has been purchased to improve diagnostic capacity (prostate biopsy waiting times) with a view to improve organisational 62-day performance.

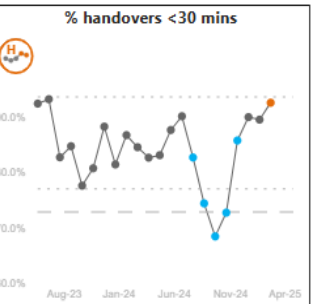
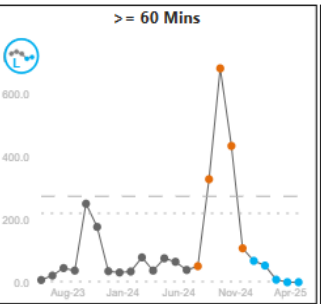
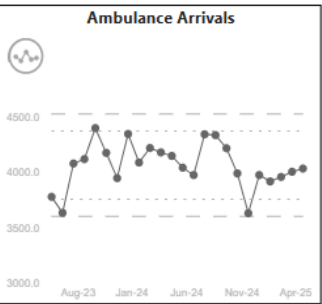
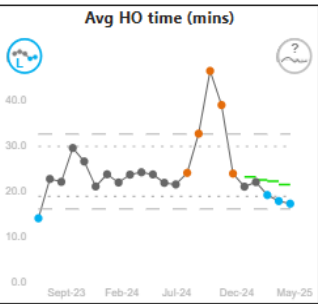
Unplanned Care

2025/26 Ambition: Improve A&E waiting times and ambulance response times compared to 2024/25

	August 2024	September 2024	October 2024	November 2024	December 2024	January 2025	February 2025	March 2025	April 2025	May 2025	June 2025	July 2025
Performance 4hr Standard Total	71.2%	69.1%	66.2%	66.9%	65.6%	68.7%	66.3%	70.5%	71.1%	72.9%	72.9%	75.0%
Op. Plan									68.1%	69.6%	70.8%	69.6%



	September 2024	October 2024	November 2024	December 2024	January 2025	February 2025	March 2025	April 2025	May 2025	June 2025	July 2025
Avg HO time (mins)	21.3	23.9	32.4	46.1	38.7	23.7	20.8	21.9	19.0	17.7	17.1
Target								23.0	22.3	22.0	21.3



How are we performing:

- Mid Yorkshire performance against the 4-hour standard in July was 75% (all types).
- There were 11 12-hour RTA trolley breaches reported in July; a reduction compared to 49 in June.
- Mid Yorkshire declared 0 >60-minute YAS handover breaches in July.
- In July the average ambulance handover time was 17.1 minutes, a small reduction from June.

What is driving this performance:

- Organisational flow challenges remained throughout July, although admitted performance improved to 28%, there remained high ED length of stay, crowding in the departments and long waits for admission.
- The volume of ambulance arrivals remained relatively static in July compared to June, and Mid Yorkshire continues to receive a high volume of ambulance conveyances when compared to the rest of the region, an overall benchmark of second in the region (128 arrivals on a daily average).
- Increased conveyances during peak times of the day continue to challenge ambulance handover performance, although there was a significant improvement in % >60-minute handovers and % handovers >30 minutes compared to June activity.
- 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.
- Robust systems are in place to proactively plan resource aligned to forecast activity levels.

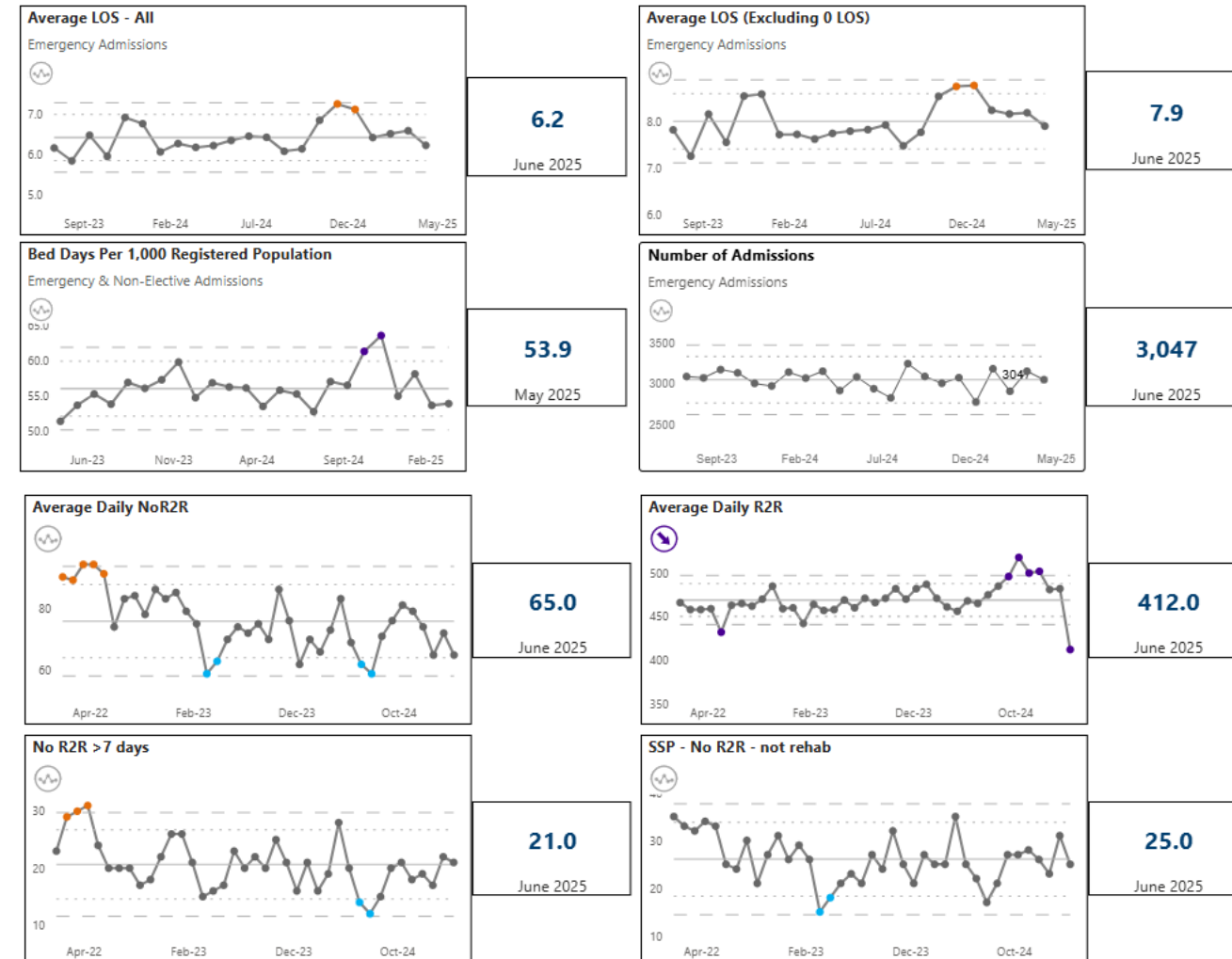
What actions are being taken:

- Further EM medical recruitment in progress – with consultant, middle grade, GPSI and FY2 roles currently advertised.
- Ongoing work with commissioners in relation to the Pontefract Urgent Treatment Centre staffing model and alignment to current activity levels; increased staffing at the UTC throughout May has yielded significant improvement in performance against the 4-hour standard.
- Type 3 activity being reported internally as a separate measure to drive focus and improvement, ECDS submissions now reflective of the changes.
- GP in place in the Dewsbury Urgent Integrated Care stream has continued to contribute to the improvement of Type 3 performance.
- Ongoing work in relation to YAS direct pathways.
- Transfer of Care policy in place since 11th June. Ambulance handover remains well below 45 minutes ceiling in July.

Unplanned Care – Patient Flow

2026/26 Driver Metrics: Supporting the Delivery of the National Priorities

Wakefield performance:



Performance Highlights

Wakefield

- The average length of stay reduced in June 25 with performance reporting at 6.2 days or 7.9 days when patients with a zero length of stay are excluded.
- The average number of days patients spent with no reason to reside during June on pathway 3 was 13 days, which was an increase from 7.8 days in May 25.
- Super stranded patients with no R2R (not in rehab) remains stable following an increase since November 24.
- The average number of days delayed for patients not discharged on their discharge ready date (Mid Yorkshire performance) has decreased from 7 in June to 6.2 in July.

What is driving the performance?

- Acuity of patients is increasing with multiple co-morbidities.
- High acuity of patients with R2R and high numbers of enhanced care across all areas.
- Community capacity for P1 patients is limited across both Kirklees and Wakefield localities. This is due to a shift in home first model.

What mitigations are in place to support?

Operational Actions

- Daily outlier MDT continues.
- Long stay review with system partners for patients over 7 days with NR2R each week.
- Super stranded review of patients that have reason to reside over 14 days by senior nursing team in the Division of Medicine.

System

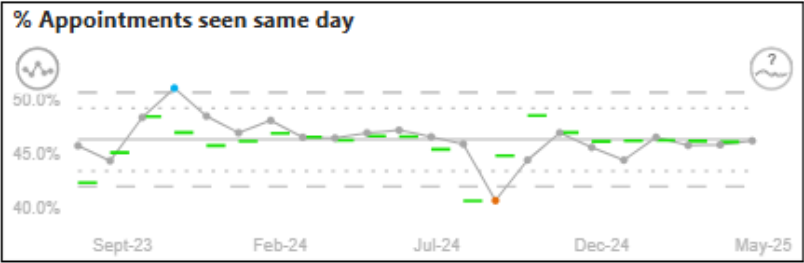
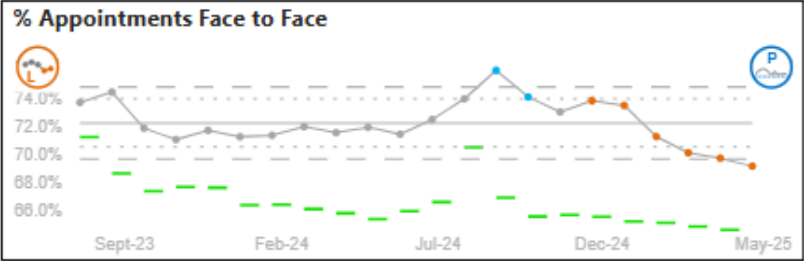
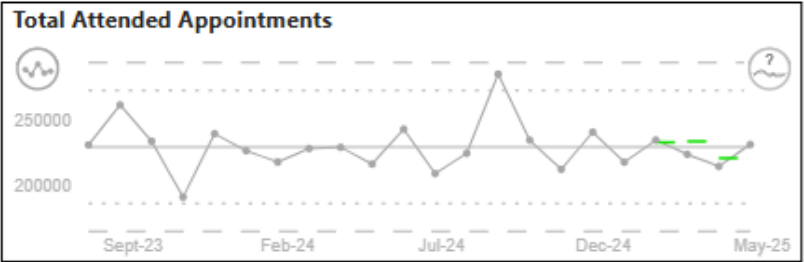
- Currently phase one of a pilot merging shared capacity across ICT and reablement.
- Moving towards ICE referrals into integrated transfer of care hub (ITOCH) streamlining processes.
- Launch of ITOCH Dewsbury early September.

Primary care

2026/26 Ambition: To increase the number of GP appointments by 2% by March 26

June 2025:

Total Appointments 230,914 ✓ Goal: 220,326 (+4.81%)	Delivery Rate of 24/25 Apts 106.9%	Attended Appointments 210,533
% Attended Same Day 46.2%	% Attended FTF 69.1%	
Overall DNA Rate 3.4%	DNA Appointments 7,420	



How are we performing?

- GP Appointments:** The number of appointments available in GP practices (rate per 1,000) remains above the national average at 577.2 in June. 81.61% appointments were booked within 2 weeks.
- Digital:** The number of patients registered to use the NHS App is increasing, with all Wakefield Practices having at least 50% of patients registered to use it (April 2025). Online Consultation rates continue to increase across all PCNs. There continues to be variation between practices in terms of the number of online consultations being performed.
- Community Pharmacy:** All Practices within Wakefield are utilising the Pharmacy First service, however lags in data make it difficult to evaluate current performance. However, current data suggests that Wakefield is not an outlier in performance across WY. Signposting rates to the contraception service is increasing across Wakefield.
- 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.
- Health inequalities:** There is a clear focus on improving health inequalities within the Wakefield Practice Premium Contract (WPPC) for 2025/26, with the inclusion of Learning Disabilities, SMI, and CVD indicators, along with indicators relating to identification and support of veterans and patient engagement. A CVD event is planned for the district in September 2025, to bring together practices, partners and clarification on the asks of contracts.

What is driving the performance?

- GP Appointments:** Wakefield continue to have the lowest rate of appointments booked within 2 weeks, per 1000 patients, across WY. This has been identified as a data quality issue, and the digital team continue to investigate.
- GP Patient Survey:** The latest GP Patient Survey results were published in July 2025. Detailed analysis of the results and actions is in development.

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.

The General Practice Indicators Dashboard has been developed, which enables benchmarking nationally and locally for a number of indicators. Working groups have been established to review the use of this across WY.

An action plan for General Practice has been submitted to the regional team which outlines WY ICB's approach to meeting the 2025/26 Operational Planning Guidance requirement to put in place an action plan for General Practice by June 2025.

Working groups have been attended across WY for the CATs dashboard.

Online Consultations: The General Practice Indicators Dashboard has been developed, one of the indicators on which highlights the use of online consultations and enables benchmarking nationally and locally. Across WY, there are three Wakefield Practices in the top 20 and none in the bottom 20 for online consultation utilisation.

Community Pharmacy: Practices continue to be supported by the team and CPWY to increase uptake of and referrals to Pharmacy First. The national launch date of the SystmOne integrated referral solution for Pharmacy First has not yet been confirmed.

MGPA: A webinar aimed at ICB colleagues and partners was held on 16th July 2025, and a number of WYICB colleagues were in attendance. The intention of the webinar was to broaden understanding of MGPA across the ICB to support Practices in their development and delivery of MGPA. The webinar shared that a new tool, AT MGP, was being released to support Practices and ICBs in identifying where they are on the implementation of MGPA, and we await publication of this. Once released, the team will review the tool and consider how it can be used to support practices in their implementation of MGPA.

GP Patient Survey 2025

Wakefield Results (and position against West Yorkshire and National)

Question	Selected Place	ICB Total	National	Selected Place Change (% pts) vs Previous Year	WY ICB Change (% pts) vs Previous Year	National Change (% pts) vs Previous Year
Q1 Ease of getting through to someone at practice on phone	53%	51%	53%	5.3%	4.5%	3.3%
Q4 Helpfulness of receptionists at GP practice	84%	84%	83%	0.2%	1.0%	0.7%
Q3 Ease of contacting practice using NHS pp	53%	49%	49%	7.6%	5.7%	4.2%
Q2 Ease of using GP practice website	53%	50%	51%	6.7%	3.7%	3.4%
Q7 Frequency of seeing preferred GP	38%	38%	40%	3.7%	0.6%	0.2%
Q19 Choice of appointment offered	61%	62%	61%	1.3%	2.1%	1.8%
Q16 Overall experience of making appointment	70%	70%	70%	2.7%	2.6%	2.3%
Q24 Healthcare professional listened	89%	87%	87%	0.8%	0.9%	0.2%
Q25 Healthcare professional treated with care and concern	87%	86%	86%	1.0%	1.0%	0.2%
Q26 Healthcare professional understood mental health needs	74%	74%	74%	-1.0%	1.8%	1.1%
Q27 Healthcare professional had all the information they needed about you	93%	93%	92%	1.0%	1.2%	0.3%
Q29 Healthcare professional involved me in decisions	92%	91%	91%	0.3%	0.4%	0.2%
Q28 Had trust and confidence in healthcare professional	93%	93%	93%	1.0%	0.8%	0.2%
Q31 Needs met at last general practice appointment	91%	91%	90%	0.9%	0.6%	0.0%
Q32 Overall experience of GP practice	77%	77%	75%	2.9%	2.7%	1.5%
Q43 Enough support to manage condition from local organisations	72%	70%	69%	1.1%	2.2%	0.8%
Q45 Agreed a plan to manage condition	47%	46%	45%	6.1%	3.2%	0.1%
Q46 Agreed plan has helped manage condition	96%	93%	94%	2.0%	-0.1%	-0.2%

How are we performing?

The GP Patient Survey (GPPS) is an annual England-wide survey about patients’ experiences of their GP practice and is administered by Ipsos on behalf of NHS England.

Overall Wakefield has seen an improvement from last year with one question showing a deterioration from last year- Q26 how well the health professional understood the mental health needs

Wakefield continues to score positively against the West Yorkshire ICB total and the National average for all questions.

Practice level performance

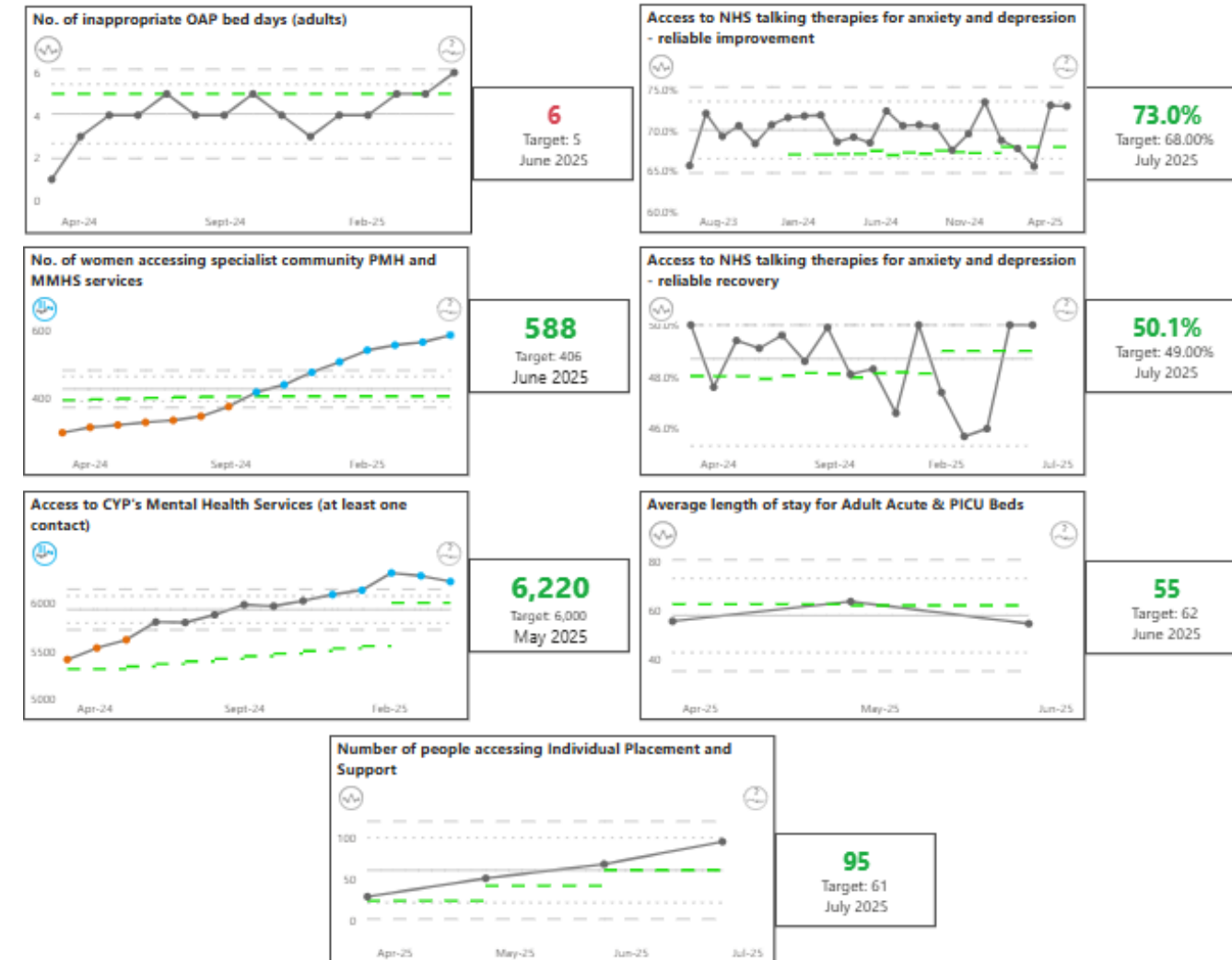
17 GP practices reporting above the Wakefield and national average with 5 GP practices reporting in the 90th percentile (top 10% nationally) and 6 GP practices in the national upper quartile.

2 GP practices reported above the national average but below the Wakefield average

15 GP Practices reported below the Wakefield and National Average with 8 GP practices reporting in the bottom 25% nationally.

Mental Health & Learning Disability

2026/26 Ambition: To Improve access to children and young people's (CYP) mental health services



How are we performing?

Of the seven 25/26 key performance indicators only one is not being achieved which is inappropriate adult acute mental health out of areas placements which is reported for across the SWYPFT footprint and is reporting 6 placements in June compared to a target of 5.

The number of women accessing specialist PMH and MMHS reported 588 against the target of 406.

The latest figures for Wakefield's Talking Therapies reliable recovery rate is positive with July meeting the target with 50.1% performance against the target of 49%. The reliable improvement measure reported performance of 73% compared to the target of 68%.

Contacts with CYP services is meeting the 25/26 target of 6000, with 6220 reported for May.

The average length of stay for Adult Acute & PICU Beds was 55 days for the rolling 3 months ending in June, compared to the target of remaining under 63 days.

The number of people accessing Individual Placement and Support is 95 for this year compared to a target of 61.

What is driving the performance?

- Targeted previous Investment by the Mental Health Alliance has enabled sufficient staffing to meet the performance targets for accessing Individual Placement and Support and women accessing specialist PMH and MMHS. IPS has now well established within community mental health teams and the PCNs.

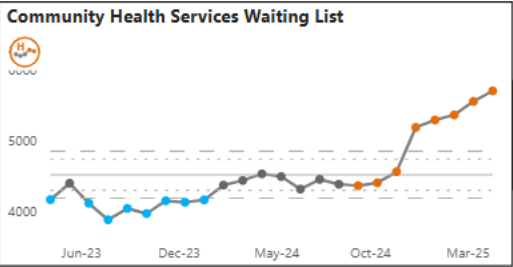
What mitigations are in place to support?

Active inappropriate adult acute mental health out of areas placements (OAPs) SWYPFT Wide This is the first time in the 15 months we have been monitoring this that the target has been missed and no additional action needed at this time.

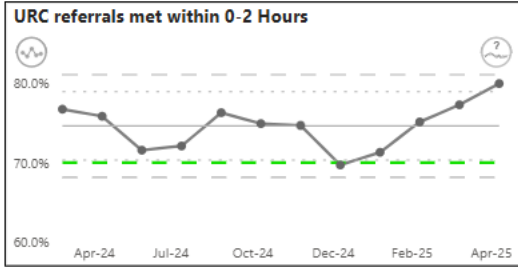
Community Services: Adult

2026/26 Driver Metrics: Supporting the Delivery of the National Priorities

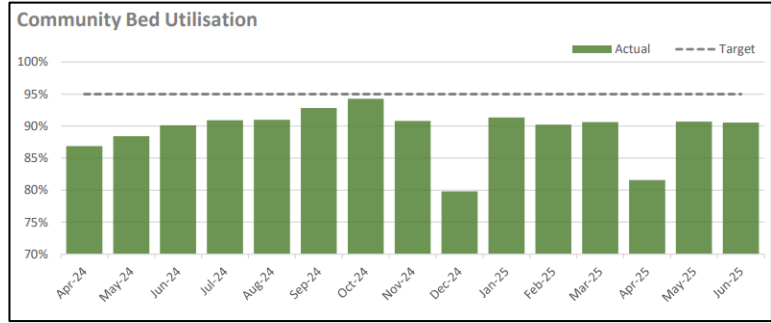
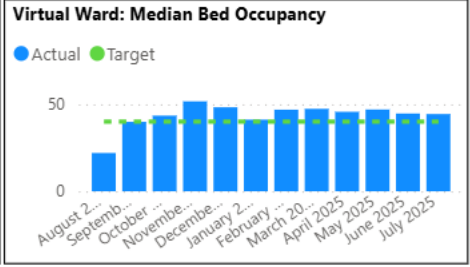
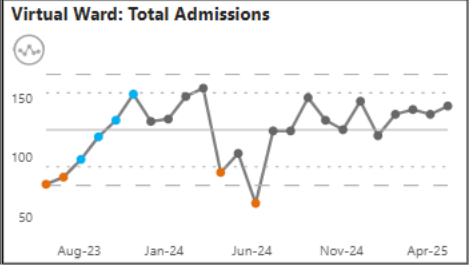
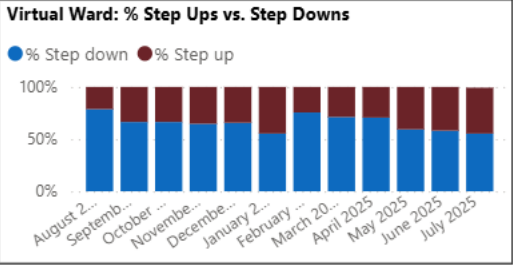
Metric Name	July 2024	August 2024	September 2024	October 2024	November 2024	December 2024	January 2025	February 2025	March 2025	April 2025	May 2025	June 2025
Community Health Services Waiting List	4,492	4,316	4,452	4,384	4,364	4,404	4,560	5,182	5,286	5,357	5,547	5,694



5,694
June 2025



79.9%
May 2025



Performance Highlights (Mid Yorkshire)

- UCR 2hr response information is now based on nationally reported data. This has shown an improvement for a fourth consecutive month and reported 79.9% in May 25 (most recent available).
- Avoiding admissions within 7 days saw a slight decrease to 94.1% compared to 94.7% the previous month.
- The frailty virtual ward has noted a slight drop in the average caseload size to 44 in July from 45 in June. This remains above the planned caseload size.

What is driving the performance?

- Divisional focus on response times across networks has commenced.
- Frailty virtual ward seen an increase in step up patients increasing acuity on the caseload to support admission avoidance.

What mitigations are in place to support?

- Divisional focus across processes and standard work for triage and allocation has commenced to support sustained improvements and efficiencies.
- The Hospital at Home improvements continue with a focus on admission avoidance linking with EAT and primary care. Planned workforce efficiencies to commence.

ITEM 14

Meeting name:	Wakefield District Health and Care Partnership Committee
Agenda item no:	14
Meeting date:	Tuesday 9 September 2025
Report title:	Finance report, Month 3
Report presented by:	Amy Whittaker, Chief Finance Officer, Mid Yorkshire Teaching NHS Trust and Jenny Davies, Deputy Director of Operational Finance, Wakefield Place
Report approved by:	Ian Currell, Director of Operational Finance, Wakefield Place
Report prepared by:	Jenny Davies, Deputy Director of Operational Finance, Wakefield Place

Purpose and Action			
Assurance ☐	Decision ☐ (approve/recommend/ support/ratify)	Action ☐ (review/consider/comment/ discuss/escalate)	Information ☒
Previous considerations:			
N/A			
Executive summary and points for discussion:			
The paper gives a summary of the Wakefield Place financial position as at the end of June 2025. This is the first quarter of the year and as it is so early some forecasting information isn't available yet such as the Prescribing data which is always 2 months in arrears.			
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 acknowledge the paper which is for information.			
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. Presentation attached
Acronyms and Abbreviations explained
N/A

What are the implications for?

Residents and Communities	N/A
Quality and Safety	N/A
Equality, Diversity and Inclusion	N/A
Finances and Use of Resources	Note the Month 3 Financial Position
Regulation and Legal Requirements	N/A
Conflicts of Interest	N/A
Data Protection	N/A
Transformation and Innovation	N/A
Environmental and Climate Change	N/A
Future Decisions and Policy Making	N/A
Citizen and Stakeholder Engagement	Information shared transparently

NHS West Yorkshire ICB

Wakefield Place Financial Position

Month 03 2025/26



ICB in Wakefield Month 03



NHS West Yorkshire
Integrated Care Board

	YTD Plan	YTD Spend	YTD Variance	Annual Plan	Forecast Spend	Annual Variance
	£000	£000	£000	£000	£000	£000
RESOURCE						
Allocation - Programme	214,280.7	214,280.7	-	851,774.0	851,774.0	-
Allocation - Primary Care Co-Commissioning	22,475.4	22,475.4	-	89,901.5	89,901.5	-
Allocation - Running Costs	600.3	600.3	-	2,401.0	2,401.0	-
Allocation - Specialist Commissioning	-	-	-	-	-	-
TOTAL RESOURCE	237,356.3	237,356.3	-	944,076.6	944,076.6	-
SPEND						
Acute	130,088.9	130,185.1	(96.2)	520,355.6	520,740.6	(385.0)
Mental Health	23,486.7	23,487.0	(0.3)	93,946.8	93,947.9	(1.1)
Community	23,543.1	24,126.0	(582.8)	94,079.9	94,237.8	(157.9)
Continuing Care Services	12,857.5	12,881.6	(24.1)	51,430.2	51,415.2	15.0
Prescribing and Primary Care	22,731.2	22,716.7	14.5	90,924.8	90,910.2	14.6
Primary Care Co-Commissioning	23,423.0	23,423.0	-	93,691.8	93,691.8	-
Other	625.6	575.7	49.9	2,502.5	2,387.5	115.0
Specialised Commissioning	-	-	-	-	-	-
Programme Reserves	-	(239.8)	239.8	(5,255.9)	(5,255.9)	-
Subtotal Programme spend	236,756.1	237,155.3	(399.2)	941,675.6	942,075.2	(399.5)
Running Costs	600.2	523.9	76.4	2,400.9	2,200.2	200.7
TOTAL SPEND	237,356.3	237,679.1	(322.8)	944,076.6	944,275.4	(198.8)
Surplus / (Deficit)	-	(322.8)	(322.8)	-	(198.8)	(198.8)

Proud to be part of West Yorkshire
Health and Care Partnership

Wakefield Place - Month 03 Financial Position



NHS West Yorkshire

Organisation	YEAR TO DATE - M3			FORECAST - M01 to M12		
	I&E reported Month 03 24/25			I&E forecast		
	Plan £m	Actual Surplus / (Deficit) £m	Reported Variance £m	FOT Plan £m	FOT Surplus / (Deficit) £m	FOT Variance £m
Wakefield ICB	0.0	(0.3)	(0.3)	0.0	(0.2)	(0.2)
Mid Yorkshire Hospitals NHS Trust	(2.1)	(2.8)	(0.7)	(22.8)	(22.8)	0.0
South West Yorkshire Partnership NHS Foundation Trust	(1.9)	(2.0)	(0.1)	0.0	(0.0)	(0.0)
Wakefield Place Total	(4.0)	(5.1)	(1.1)	(22.8)	(23.0)	(0.2)

At Month 3 as it's very early in the year all providers are predominantly reporting on plan although year to date has an adverse variance as some savings schemes will deliver in the latter half of the year.

Wakefield ICB has a small forecast deficit due to cost pressures within acute regarding delays in implementing savings plans and over trading on independent sector activity. There is also a potential cost pressure within Neuro Rehab due to activity significantly increasing.

West Yorkshire ICS Financial position - Month 03



NHS West Yorkshire
Integrated Care Board

	YEAR TO DATE - M3			FORECAST - M01 to M12						
	I&E reported Month 3 25/26			I&E forecast			Scenarios - Organisation assessment			
Organisation	Plan £m	Actual Surplus / (Deficit) £m	Reported Variance £m	FOT Plan £m	FOT Surplus / (Deficit) £m	FOT Variance £m	Best Case Variance £m	Likely Case Variance £m	Likely Case (Mitigated) £m	Worse Case Variance £m
Bradford ICB	0.0	(0.9)	(0.9)	0.0	(4.0)	(4.0)	0.0	0.0	(3.9)	(18.7)
Calderdale ICB	0.4	0.5	0.1	1.7	1.7	0.0	0.0	0.0	0.0	(3.8)
Kirklees ICB	0.9	0.9	0.0	3.5	3.5	0.0	(0.0)	0.0	0.0	(5.7)
Leeds ICB	0.0	0.0	0.0	(0.0)	(0.0)	(0.0)	0.0	0.0	(0.0)	(20.7)
Wakefield ICB	0.0	(0.3)	(0.3)	0.0	(0.2)	(0.2)	0.0	0.0	(0.2)	(8.2)
WY ICB	22.8	20.9	(2.0)	91.4	95.6	4.2	0.0	0.0	4.1	(15.2)
West Yorkshire ICB Total	24.1	21.0	(3.1)	96.5	96.5	0.0	0.0	-	0.0	(72.3)
Airedale NHS Foundation Trust	(6.5)	(6.6)	(0.2)	(14.6)	(14.6)	0.0	0.0	0.0	(5.2)	(8.2)
Bradford District Care NHS Foundation Trust	(0.6)	(0.6)	0.0	0.0	0.0	0.0	0.0	0.0	(4.6)	(5.8)
Bradford Teaching Hospitals NHS Foundation Trust	(9.2)	(8.7)	0.5	(17.0)	(17.0)	0.0	0.0	0.0	(4.0)	(19.0)
Calderdale And Huddersfield NHS Foundation Trust	(11.9)	(11.6)	0.3	(42.1)	(42.1)	(0.0)	0.0	0.0	0.0	(19.2)
Leeds and York Partnership NHS Foundation Trust	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	(4.1)
Leeds Community Healthcare NHS Trust	0.0	0.0	(0.0)	0.0	0.0	0.0	0.0	0.0	0.0	(3.6)
Leeds Teaching Hospitals NHS Trust	(11.8)	(12.7)	(0.9)	0.0	0.0	0.0	0.0	0.0	(51.0)	(97.2)
Mid Yorkshire Hospitals NHS Trust	(2.1)	(2.8)	(0.7)	(22.8)	(22.8)	0.0	0.0	0.0	(6.0)	(11.8)
South West Yorkshire Partnership NHS Foundation Trust	(1.9)	(2.0)	(0.1)	0.0	(0.0)	(0.0)	0.0	0.0	0.0	(9.9)
Yorkshire Ambulance Service NHS Trust	0.1	0.4	0.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0
West Yorkshire Provider Total	(43.9)	(44.7)	(0.9)	(96.5)	(96.5)	(0.0)	-	-	(70.8)	(178.8)
West Yorkshire ICS Total	(19.7)	(23.7)	(4.0)	0.0	(0.0)	(0.0)	0.0	-	(70.8)	(251.0)

Proud to be part of West Yorkshire
Health and Care Partnership

West Yorkshire ICS Month 03 – Key Headlines

West Yorkshire Integrated Care System (ICS)

- The month 3 **year-to-date** position for the ICS was an **actual £23.7m deficit** against a **planned £19.7m deficit**; a shortfall/adverse variance against plan of **£4.0m**.
- The month 3 adverse variance of **£4.0m** has deteriorated from the adverse variance at month 2 of **£0.8m**, a deterioration of **£3.2m**.
- The deterioration in month is driven predominantly by the **clarified approach to reporting the system improvement target in the ICB**
- The other drivers of the month 3 adverse variance continue to be **slippage on delivery of waste reduction/efficiencies**, part offset by underspends in other areas.
- Above position includes **assumed receipt of Deficit Support funding of £12.3m** (3/12ths of total annual value of £49.2m)
- The ICS continues to forecast a balanced plan to NHSE at Month 3

Item 15

Committee Escalation and Assurance Report – Alert, Advise, Assure

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

Date of meeting: 22 July 2025

Report to: Wakefield District Health and Care Partnership Committee

Report completed by: Jemma Harris, Governance Manager

Date: 23 July 2025

Key escalation and discussion points from the meeting

Alert:

Nothing to Alert

Advise:

- In June 2025 the sub-committee undertook a deep dive into **Risk 2495: Reduction in the Availability of Nursing and Dementia Care Home Beds in the District**, led by the Quality and Safety Team at Wakefield Place and the Joint Commissioning Team at Wakefield Council. The group took assurance from the wide-ranging improvement activity underway to support market stability and service retention through staff and care home education. However, it was acknowledged that further significant work was required to meet district level needs. The notes from the deep dive are recorded as appendix one for oversight.
- The **Quality, Safety and Experience Report** was reviewed with continued progress noted since the last meeting, including the following:
 - **Risk 2501 risk of poor outcomes, safety and experience for patients in the district due to overcrowding in the emergency departments and ward areas at Mid Yorkshire Teaching NHS Trust** was reduced from a score of 16 to 12 following successful Rapid Improvement Events. While progress continued it was also recognised that winter pressures may present challenge therefore close monitoring would continue.
 - A site visit to the **Community Health and Eye Care Services** based at the Grange Medical Centre provided valuable insight into the patient pathway and clinical governance. The service demonstrated strong commitment to safety through structured follow up, incident reporting, and clinical review processes and the outcomes data indicated strong clinical performance, with complication rates below the national benchmarks.

- At the end of Quarter 4 2024/25, 86.8% of people had received their **Learning Disability Annual Health Check** which means that the targets both nationally (75%) and at PCN level (80%) had been exceeded.

There was however an element of concern highlighted as below:

- **Risk 2495**, while the sub-committee took some assurance following the recent deep dive specific concerns remain, particularly regarding Manor Park Care Home following a recent inadequate rating, and West Park House, currently under Care Quality Commission review due to emerging issues. Both remain under active monitoring.
- The **Quarterly Risk Register and Board Assurance Framework (BAF)** update was received. It confirmed that there remained **19 active risks** on the register with **1 reducing in score** and **5 high scoring risks**. The risk that reduced in score was **risk 2501** reported above.

The sub-committee were information that BAF **risk 3.1: 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** had increased in score from 9 to 12. This brought the score in line with the ICB position.

- The Continuing Healthcare (CHC) Performance Report was received for the first time and would now be provided on a quarterly basis. Several improvement initiatives were noted to be progressing well however, significant risks remained due to service vacancies which continue to present operational challenge. Financial risks also persist, though positive steps were being taken to strengthen the recharge process and reduce the gap. A backlog of appeal reviews was also an issue but with additional support now in place good progress to clear the backlog was underway.

Assure:

- Specific escalations were made from the **Performance Exception Report** with particular note to the following:
 - The report had been reformatted
 - Rising waiting lists at Mid Yorkshire Teaching NHS Trust (MYTT) reported month on month since April 2025
 - Long waiters remained an area of prevalence with 29 patients waiting over 65 weeks. The key pressure areas are ophthalmology, trauma and orthopaedics and gynaecology.
 - The A&E four-hour performance target in June achieved above the local trajectory
 - There have been no recorded 12-hour trolley breaches throughout July 2025
 - The Dewsbury Elective Surgery Hub now fully operational
 - Recent GP survey results: 15 practices scored below the national average and 8 of those were in the bottom 25% nationally
 - Bed occupancy at MYTT high with an average length of stay of 6 days

- An update was received on the overall ICB financial position and the Wakefield position at month 3. There were no issues or concerns identified at this stage providing assurance that the year to date position remained relatively on track and where expected.

APPENDIX ONE:

Wakefield District Health and Care Partnership

Notes of the Wakefield Integrated Assurance Sub-Committee Deep Dive held on Thursday 26 June 2025 from 10.00am held in the Boardroom, White Rose House, Wakefield

Present:

Richard Hindley (RH)	Chair of the Wakefield Integrated Assurance Sub-Committee and Non-Executive Member, Wakefield Place
Stephen Hardy	Non-Executive Member, Wakefield Place
Laura Elliot (LE)	Senior Head of Quality, Wakefield Integrated Care Board
Siana Reddish (SR)	Service Manager, Joint Commissioning Team, Wakefield Council
Jenny Lingrell (JL)	Service Director for Children's Health and Wellbeing, Wakefield Council
Ian Currell (IC)	Director of Operational Finance, Wakefield Place
Steve Knight (SK)	Chief Executive, Conexus Wakefield
Becky Barwick (BB)	Associate Director of Partnership and System Development, Wakefield Place
Jayne Mullen (JM)	Service Manager, Innovation, Performance and Business, Wakefield Council
Sarah Leason-Hurley (SLM)	Interim General Manager, Community Mental Health Services
Jemma Harris (JH)	Governance Manager, Wakefield Place

Administration

D001/25 Welcome and Apologies

RH welcomed everyone to the deep dive which commenced at 10.00am and accepted apologies on behalf of Ruth Unwin, Penny McSorley, Darryl Thompson, Talib Yaseen, Dasa Farmer, Melanie Brown and Angela Hemingway.

D002/25 Quorum and Declarations of Interest

The meeting was quorate in line with the terms of reference; there were no declarations of interest associated to agenda items recorded.



Focused Topics – Deep Dive

D003/25 Risk 2495: Reduction in the Availability of Nursing and Dementia Care Home Beds in the District

LE and SR took those present through slides distributed with the agenda highlighting broader system challenges affecting service delivery alongside the reduction of nursing and dementia care home beds in the district. A shared understanding across partners regarding the issues and the necessary actions to address them.

They noted the importance of a proactive, preventative approach to sustaining and improving the care market. A collaborative, system wide effort was underway to support longer term market resilience with progress being made to ensure clear visibility of the market for effective planning and response. Building contracts that support system level delivery and outcomes was emphasised as a priority alongside coproduction of services from market providers to meet the needs of people and improve the quality of care. The market was noted as engaged and responsive providing a strong foundation for continued collaboration and relationship building.

Quality oversight processes had identified areas of inadequacy with inspections prioritised based on the level of risk. However, the system had shown resilience in responding to inspection findings with providers working swiftly with the quality team to improve care standards. Maintaining those standards was noted as something that would remain a focus.

Ongoing work included embedding information sharing processes across partners, aligning contracts to support system outcomes and sustainability, and maintaining focus on quality improvement and meaningful market engagement to share the future service provision.

Discussion followed focused on the support provided to care homes to help them sustain improvements over time. BB raised a question about the typical time period between a care home being rated as good and subsequently being rated as inadequate. LE confirmed that the typical time period can be four years between inspections undertaken by the Care Quality Commission (CQC) and SR emphasised the importance of supporting care homes to grow and develop talent and leadership within the sector to support and maintain care home management and sustain improvements. IC felt that if typically inspecting once every four years



that it was critical that there is strong leadership in place and he was pleased to hear that there was focus on this. He queried however whether the district had a higher proportion of care homes requiring improvement than the national average, for example would a more affluent area have more care homes rated as good. SR said that this was not necessarily the case explaining that some private care homes also delivered poor or unsafe care due to, for example, unstable management, or difficulties in recruitment.

JL said that it would be good to share learning with Children's services who were undertaking similar work at the moment. SR welcomed this and would link with JL outside the meeting.

ACTION: JL and SR to progress discussion and share learning between adults and children's.

BB recognised the complexity around dementia care and asked if there were enough beds in the district. LE confirmed there was not enough currently which meant that some patients are moved out of region which had a financial impact. SR noted a shortage nationally making it important to support and upskill staff and increase dementia capacity within care homes and also support businesses to change their purpose alongside growth.

SK noted the difficulty in obtaining formal dementia diagnosis and asked what the criteria was to access a dementia bed. He said that in some cases an information diagnosis from a GP may be used. SR said that she would share the criteria outside the meeting for clarity.

ACTION: dementia diagnosis criteria to be shared.

RH said he was assured that the relationships and involvement of the quality teams from both the ICB and Local Authority were contributing to system resilience. SR recognised this and said that whilst there was a good level of sustainability across the market there was ongoing challenges in certain areas. She noted that recent increases in national insurance and wider financial pressures had a significant impact. Efforts to support providers either to remain open or manage staff transition would continue as well as continued annual review of rates and JM added that they do work with providers and offer support with fee rates which are aligned to Continuing Healthcare.

IC asked about GP involvement in care homes and SK confirmed that this fell under the responsibility of Primary Care Networks (PCNs) with



multidisciplinary teams in place and working in line with advanced care contracts with further improvement expected through ongoing neighbourhood work. LE added that pharmacy reviews also took place within care homes with SK identifying dietetic support as a current area for improvement.

RH asked how input from residents and their families was gathered. SR explained that during visits there were active discussions with residents and their families with LE also confirming that there were regular planned meetings held between residents and care home managers. SR added the importance of improving feedback mechanisms and confirmed that was an area being incorporated into the development of care home managers.

BB raised concern about wrap around care especially when an out of area resident, particularly dental. LE also said that there can often be inconsistency with support from adult community nursing particularly in areas like pressure care.

SK pointed out challenges in end of life care especially around the use of ReSPECT forms and SR agreed to follow that up with JM who advised that the hospital based social care team may have intelligence to share.

ACTION: SR and JM to gain and share intelligence on the use of ReSPECT forms in care homes.

SR and LE confirmed that next steps and priorities would be to continue and engage openly and transparently with providers about current resources, service gaps and needs, and ensure robust quality driven services were in place.

Final Items and Closing

D004/25 Escalations to the Wakefield District Health and Care Partnership Committee

RH confirmed no items for escalation but for oversight notes from the deep dive would be shared with the next Wakefield District Health and Care Partnership Committee for oversight.

D005/25 Any Other Business

There were no items of other business.

ITEM 16

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

Purpose

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

Progress on our Neighbourhood Health programme

Population Health Management

The Data and Analytics Team continues to enhance its population health linked data model. Following approval from NHS England to flow non-NHS data into the data model, work has commenced with Vico Homes (formerly Wakefield District Housing) to flow pseudonymised patient level independent living scheme housing data into the model along.

The priority focus over the last few weeks has been to support the Neighbourhood Multidisciplinary Teams (NMDT) by developing a risk stratification model that predicts the risk of a patient from the NMDT cohorts (Chronic Obstructive Pulmonary Disease, dementia and end of life) being admitted in an emergency.

The Wakefield Data and Analytics Service has now risk stratified cohort into high risk, rising risk and low risk categorise using patient level data from the linked data model. Wakefield's risk stratification approach uses Random Forest machine learning models to predict the risk of future emergency admissions within the next three months. We have modelled using variables including demographic factors, healthcare utilisation, and prescribing records. Our emerging NMDTs will apply these models to carry out targeted person-centred interventions in quarter 3 and quarter 4 2025-6 with those identified. The models are between 86-94% accurate at predicting the correct risk group for an individual.

The Team has produced an overarching Wakefield data insight pack which was shared at the NMDT Steering Group. Individual Primary Care Network (PCN) data packs have

been produced and shared to enable our emerging NMDTs to carry out targeted person-centred interventions in quarter 3 and quarter 4 2025-6.

Modern General Practice

The Modern General Practice Access (MGPA) programme in Wakefield is focused on improving patient access to primary care by blending digital innovations with traditional service models. The current priorities include enhancing online consultation capacity, increasing NHS App uptake, and supporting practices through transition funding, training, and guidance materials. While all practices have adopted online registration and cloud-based telephony, there remain challenges around data quality, appointment mapping, and consistent utilisation of care navigation principles. Targeted engagement is underway for practices with lower digital uptake or care navigation performance, alongside system-wide collaboration through events and workshops to share best practices and address weaker areas such as online consultation capping.

Digital enablement forms a major part of the strategy, with strong local uptake of the NHS App and plans for “Digital Champions” across practices. However, work continues to improve accuracy in datasets and ensure up-to-date performance monitoring via business intelligence dashboards. Community pharmacy services, including Pharmacy First, contraception provision, and blood pressure checks, are being actively promoted, though referral processes and data reliability remain barriers.

Looking forward, the programme aims to finalise and share comprehensive MGPA guidance, strengthen dashboard integration for more accurate performance tracking, and continue developing collaborative relationships between practices, pharmacies, and secondary care. West Yorkshire-wide initiatives will provide practical support for online consultation improvements, while targeted follow-up will address underperformance in specific services or geographic areas. By combining data-driven monitoring, system-level coordination, and practice-level support, the MGPA work in Wakefield is laying the foundations for more timely, equitable, and effective patient access to care.

Neighbourhood Multidisciplinary Teams (NMDTs) – Adults

Good progress has been made in developing NMDTs across the district, focusing on our three priority population cohorts; those with a dementia diagnosis, those with a Chronic Obstructive Pulmonary Disease diagnosis and those on the General Practice palliative care register.

- We have had robust data on each of our three cohorts and rich intelligence from what people have been telling us about their experience of care.
- We have co-designed priorities for improving proactive care and strengthening NMDT approaches in our neighbourhoods.

- We have explored the concept of what multidisciplinary teams are and what they are not. This has been an important step in the process in developing a shared understanding and vision for neighbourhood working.
- We have an innovative risk stratification tool which uses machine learning technology, accessing data from our linked data model, to predict the risk of an emergency admission within the next 3 months, with over 90% certainty. Our three cohort groups have been categorised into high risk, medium risk and low risk. This tool generates patient lists for neighbourhoods to work more effectively with people in our cohorts.

Using the risk stratification data, our six neighbourhoods will now develop implementation plans to shape the NMDT. The aim is for the neighborhood multidisciplinary teams to be implemented to deliver the year one aims, in November 2025.

Wakefield has put in successful bid for System Development Funding to bring in specialist change management expertise who can help improve the way our local health and care teams work with each neighbourhood to form the multidisciplinary teams. These experts will support each Neighbourhood Health Team to find better ways of working and make sure different health and care professionals work as one team. They will focus on key areas we've already identified as most important for improving care and support.

An evaluation framework has been drafted so that we are able to assess the effectiveness and value for NMDTs. This will draw upon qualitative and quantitative methods to identify areas of strength and areas for improvements and to ensure we are using our resources effectively and providing a good experience of care for people.

Children's Neighbourhood Multidisciplinary Teams (CMDT)

Wakefield has an existing system to convene multi-agency conversations to support the needs of children and young people. The Team Around the School and Team Around the Early Years meetings take place regularly; schools and early years providers identify children where they feel that there are vulnerabilities that would benefit from a multi-agency response. This methodology aligns with the guidance for Children's Multi-Disciplinary Teams that was published in February, although the membership of the Multi-Disciplinary Team is different. Within the guidance there are case studies identifying good practice. The Children's Alliance is progressing with several key lines of enquiry that align with the guidance and also support the Department for Education policy direction outlined in the Families First Partnership Programme Guide.

A critical key line of enquiry include using developing linked data sets to identify where there are overlapping vulnerabilities presenting in different systems, including school, primary care, secondary care and the 0-19 Growing Healthy offer.

Other key lines of enquiry are:

- Developing (prototyping) and CMDT to explore how this meets need more effectively and has the potential to complement the 'Team Around' approach
- Developing clear pathways to support child development services, particularly where there is a functional need that is currently presenting in secondary care. The e-consult model that connects paediatricians to General Practices is expanding with positive feedback from professionals. Qualitative and quantitative review of outcomes will inform next steps.
- Developing better early intervention for asthma and respiratory conditions
- Working with the council to pilot new approaches to working with vulnerable young people
- Developing a partnership single point of access for emotional and mental wellbeing services
- Expanding the needs-led offer to support children with neurodiverse conditions and reducing the importance of a clinical diagnosis.

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, with a holistic approach involving various health and social care professionals.

In Wakefield we recognise 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. We have therefore approached this work through establishing an 'Intermediate Care' working group which is made up of key leads from the West Yorkshire Integrated Care Board, Mid-Yorkshire Hospitals Teaching Trust and Wakefield Council who have leadership and direct responsibility for a range of Intermediate Care services and is focused on reviewing the model for Home First and right sizing bed base across Wakefield.

The vision is '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 the most appropriate setting, prioritising recovery and wellbeing.'

Urgent Neighbourhood Services

The ask is to standardise and scale urgent neighbourhood services for people with an escalating or acute health need. This means ensuring urgent community response and hospital at home (virtual ward) services are aligned to local demand and work together (with access increasingly through a single point of access) to deliver a co-ordinated service. These urgent neighbourhood services should align with services at the front door of the hospital, such as urgent treatment centres and same day emergency care, which are also increasingly accessed through a single point of access (SPOA).

Our Urgent Community Response (UCR) service in Wakefield is well embedded. Yorkshire Ambulance Service (YAS) refer directly into UCR. Calls are managed via Local Care Direct (LCD) which is a SPOA for a number of UCR services across WY. Work is ongoing on a WY level review the SPOA model for YAS/111/999/LCD. Local VW and UCR models are being reviewed as part of hospital at home model to extend the cohort and secure specialist input. Hours of operation are being revisited to link to demand both current and anticipated.

[Proud to be part of West Yorkshire Health and Care Partnership](#)

ITEM 17

Meeting name:	Wakefield District Health and Care Partnership Committee
Agenda item no:	17
Meeting date:	Tuesday 9 September 2025
Report title:	Better Care Fund Section 75 Partnership Agreement
Report presented by:	Melanie Brown, Interim Accountable Officer, Wakefield Place
Report approved by:	Melanie Brown, Interim Accountable Officer, Wakefield Place
Report prepared by:	Melanie Brown, Interim Accountable Officer, Wakefield Place

Purpose and Action			
Assurance ☒	Decision ☒ (approve/recommend/ support/ratify)	Action ☐ (review/consider/comment/ discuss/escalate)	Information ☐
Previous considerations:			
N/A			
Executive summary and points for discussion:			
The aim of this paper is to seek approval from Wakefield District Health and Care Partnership Committee for West Yorkshire Integrated Care Board (Wakefield Place) and Wakefield Council to enter into a one year Better Care Fund (BCF) partnership agreement for key functions of work in the Better Care Fund Plan which is outlined in the attached appendix one. This joint commitment for these functions has in place since 2014 across Wakefield Adult Services in Wakefield Council and the NHS in Wakefield Place. Wakefield District Health and Care Partnership Committee is being asked to support both organisations to enter into a one year section 75 partnership agreement for the Better Care Fund and for the start of this agreement to commence in 1 April 2025 to 31 March 2026. The BCF policy guidance published in quarter 4 of 2025-26 asked all areas to mobilise one year BCF partnership delivery plans and BCF partnership agreements and all areas were asked to have these signed between local ICB's and Local Authorities by 30 September 2025. Wakefield Council legal team has developed the BCF section 75 partnership agreement for both parties since policy commenced in 2014 and has updated the proposed BCF section 75 partnership agreement with support from members of the joint BCF working group across Wakefield Council and West Yorkshire ICB (Wakefield Place). This will enable us to put in place the final conditions of the BCF policy requirements which NHSE have outlined in their letter to our system on 30 May 2025 when they informed the Wakefield District our BCF plan for 2025-26 had been approved. The letter requests all systems to enter into Section 75 partnership agreements and that these must be in place across all Health and Wellbeing Board areas by 30 September 2025. The working group across Wakefield Place NHS and Wakefield Council and the legal team support has put us in a strong position to meet this NHSE and Local Government Association			

deadline and the updated BCF section 75 partnership agreement is outlined in appendix 1. Following approval by Wakefield District Health and Care Partnership Committee and Health and Wellbeing Board, the partnership agreement will be forwarded to both organisations for our legal and contracting teams to obtain signatories for the agreement to ensure Wakefield District can advise the BCF regional team that this condition of the policy has been met.

It has been made clear that the BCF policy from April 2026, will be significantly reframed and streamlined and further information about this isn't known yet from NHSE and Local Government Association. There has been formal confirmation BCF plans will be asked to be put in place for April 2026 and that guidance on the revised BCF framework will be shared in due course with local areas.

This decision has been delegated from West Yorkshire ICB to local place committees for 2025-26.

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 approve that West Yorkshire ICB can enter into a section 75 partnership agreement between Wakefield Council and West Yorkshire ICB (Wakefield Place) for the delivery of the Better Care Fund 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:

Not applicable.

Appendices

1. Wakefield Council & Wakefield ICB s75 Partnership Agreement – Better Care Fund
 - a. Schedule 1: Scheme Schedule and Annex A
 - b. Schedule 2: Governance
 - c. Schedule 3: Risk Share
 - d. Schedule 4: Information Governance
 - e. Schedule 5: Performance
 - f. Schedule 6: BCF Plan
 - g. Schedule 7: Policy Management Conflicts of Interest

Acronyms and Abbreviations explained

1. BCF – Better Care Fund
2. ICB – Integrated Care Board

What are the implications for?

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

Dated

2025

THE COUNCIL OF THE CITY OF WAKEFIELD

and

NHS WEST YORKSHIRE INTEGRATED CARE BOARD

**FRAMEWORK PARTNERSHIP AGREEMENT RELATING
TO THE COMMISSIONING OF HEALTH AND SOCIAL
CARE SERVICES UNDER THE BETTER CARE FUND FOR
2025-2026**

Contents

Item	Page
PARTIES	1
BACKGROUND	1
1 DEFINED TERMS AND INTERPRETATION	2
2 TERM	7
3 GENERAL PRINCIPLES	7
4 PARTNERSHIP FLEXIBILITIES	7
5 FUNCTIONS	8
6 COMMISSIONING ARRANGEMENTS	8
7 ESTABLISHMENT OF A POOLED FUND	9
8 POOLED FUND MANAGEMENT	9
9 NON POOLED FUNDS	11
10 FINANCIAL CONTRIBUTIONS	11
11 NON FINANCIAL CONTRIBUTIONS	11
12 RISK SHARE ARRANGMENTS, OVERSPENDS AND UNDERSPENDS	11
13 CAPITAL EXPENDITURE	12
14 VAT	12
15 AUDIT AND RIGHT OF ACCESS	12
16 LIABILITIES AND INSURANCE AND INDEMNITY	12
17 STANDARDS OF CONDUCT AND SERVICE	13
18 CONFLICTS OF INTEREST	13
19 GOVERNANCE	14
20 REVIEW	14
21 COMPLAINTS	15
22 TERMINATION AND DEFAULT	15
23 DISPUTE RESOLUTION	16
24 FORCE MAJEURE	16
25 CONFIDENTIALITY	17
26 FREEDOM OF INFORMATION AND ENVIRONMENTAL PROTECTION REGULATIONS	17
27 OMBUDSMEN	17
28 INFORMATION SHARING	17
29 NOTICES	18
30 VARIATION	18
31 CHANGE IN LAW	18
32 WAIVER	19
33 SEVERANCE	19
34 ASSIGNMENT AND SUB CONTRACTING	19
35 EXCLUSION OF PARTNERSHIP AND AGENCY	19
36 THIRD PARTY RIGHTS	19

37	ENTIRE AGREEMENT	19
38	COUNTERPARTS	19
39	GOVERNING LAW AND JURISDICTION	20

SCHEDULE

SCHEDULE 1 SCHEME SPECIFICATION

SCHEDULE 2 GOVERNANCE

SCHEDULE 3 RISK SHARE AND OVERSPEND

SCHEDULE 4 INFORMATION GOVERNANCE PROTOCOL

SCHEDULE 5 PERFORMANCE ARRANGEMENTS

SCHEDULE 6 BETTER CARE FUND PLAN

SCHEDULE 7 POLICY FOR THE MANAGEMENT OF CONFLICTS OF INTEREST

THIS AGREEMENT is made on day of

2025

PARTIES

- (1) **THE COUNCIL OF THE CITY OF WAKEFIELD** of County Hall, Bond Street, Wakefield, WF1 2QW (the "**Council**")
- (2) **NHS WEST YORKSHIRE INTEGRATED CARE BOARD** of White Rose House, West Parade, Wakefield WF1 1LT (the "**ICB**")

BACKGROUND

- (A) The Council has responsibility for commissioning and/or providing social care services on behalf of the population of the metropolitan district of Wakefield.
- (B) The ICB has the responsibility for commissioning health services pursuant to the 2006 Act in the metropolitan district of Wakefield.
- (C) The Better Care Fund has been established by the Government to provide funds to local areas to support the integration of health and social care and to seek to achieve the National Conditions and Local Objectives. It is a requirement of the Better Care Fund that the ICB and the Council establish a pooled fund for this purpose.
- (D) Section 75 of the 2006 Act gives powers to local authorities and integrated care boards to establish and maintain pooled funds out of which payment may be made towards expenditure incurred in the exercise of prescribed local authority functions and prescribed NHS functions.
- (E) The purpose of this Agreement is to set out the terms on which the Partners have agreed to collaborate and to establish a framework through which the Partners can secure the future position of health and social care services through lead or joint commissioning arrangements. It is also means through which the Partners will pool funds and align budgets as agreed between the Partners.
- (F) The aims and benefits of the Partners in entering in to this Agreement are to:
 - improve the quality and efficiency of the Services;
 - meet the National Conditions and Local Objectives;
 - make more effective use of resources through the establishment and maintenance of a pooled fund for revenue expenditure on the Services; and
 - meet the vision set by the Wakefield Health and Wellbeing Board that communities in the Wakefield District achieve the best possible outcomes for themselves and their families, facilitated by co-ordinated services, provided as close to home as possible.
- (G) The Partners have jointly carried out consultations on the proposals for this Agreement with all those persons likely to be affected by the arrangements.
- (H) The Partners are entering into this Agreement in exercise of the powers referred to in Section 75 of the 2006 Act and/or Section 13Z(2) and 14Z(3) of the 2006 Act as applicable, to the extent that exercise of these powers is required for this Agreement.

1 DEFINED TERMS AND INTERPRETATION

- 1.1 In this Agreement, save where the context requires otherwise, the following words, terms and expressions shall have the following meanings:

2000 Act means the Freedom of Information Act 2000.

2004 Regulations means the Environmental Information Regulations 2004.

2006 Act means the National Health Service Act 2006.

2012 Act means the Health and Social Care Act 2012.

2018 Act means the Data Protection Act 2018.

Affected Partner means, in the context of Clause 24, the Partner whose obligations under the Agreement have been affected by the occurrence of a Force Majeure Event.

Agreement means this agreement including its Schedules and Appendices.

Approved Expenditure means any additional expenditure approved by the Partners in relation to an Individual Scheme above any Contract Price and Performance Payments.

Annual Reporting Template means the annual reporting template and guidance issued and published by the Better Care Fund Task Force as amended or replaced from time to time,

Authorised Officers means an officer of each Partner appointed to be that Partner's representative for the purpose of this Agreement.

BCF Quarterly Report Template means the quarterly report template and guidance contained in the National Conditions as amended or replaced from time to time,

Better Care Fund means the Better Care Fund as described in NHS England Publications Gateway Ref. No.00314 and NHS England Publications Gateway Ref. No.00535 as relevant to the Partners.

Better Care Fund Plan means the plan attached at Schedule 6 setting out the Partners plan for the use of the Better Care Fund.

Change in Law means the coming into effect or repeal (without re-enactment or consolidation) in England of any Law, or any amendment or variation to any Law, or any judgment of a relevant court of law which changes binding precedent in England after the date of this Agreement.

Commencement Date means 00:01 hrs on 1st April 2025.

Confidential Information means information, data and/or material of any nature which any Partner may receive or obtain in connection with the operation of this Agreement and the Services and:

- (a) which comprises Personal Data or Sensitive Personal Data or which relates to any patient or his treatment or medical history;
- (b) the release of which is likely to prejudice the commercial interests of a Partner or the interests of a Service User respectively; or
- (c) which is a trade secret.

Connecting Care Executive means the Partnership Board.

Contract Price means any sum payable to a Provider under a Service Contract as consideration for the provision of Services and which, for the avoidance of doubt, does not include any Default Liability or Performance Payment.

Data Protection Legislation: all applicable data protection in force from time to time in the UK including the UK GDPR; the Data Protection Act 2018 (DPA 2018) (and regulations made thereunder) as amended and the guidance and codes of practice issued by the Information Commissioner or other relevant regulatory authority and applicable to a Partner.

Default Liability means any sum which is agreed or determined by Law or in accordance with the terms of a Services Contract) to be payable by any Partner(s) to the Provider as a consequence of (i) breach by any or all of the Partners of an obligation(s) in whole or in part) under the relevant Services Contract or (ii) any act or omission of a third party for which any or all of the Partners are, under the terms of the relevant Services Contract, liable to the Provider.

Dispute means any failure to agree or difference or dispute between the Partners arising out of or in connection with this Agreement.

Financial Contributions means the financial contributions made by each Partner to a Pooled Fund in any Financial Year.

Financial Year means each financial year running from 1 April in any year to 31 March in the following calendar year.

Force Majeure Event means one or more of the following:

- (a) war, civil war (whether declared or undeclared), riot or armed conflict;
- (b) acts of terrorism;
- (c) acts of God;
- (d) fire or flood;
- (e) industrial action;
- (f) prevention from or hindrance in obtaining raw materials, energy or other supplies;
- (g) any form of contamination or virus outbreak; and
- (h) any other event,

in each case where such event is beyond the reasonable control of the Partner claiming relief

Functions means the NHS Functions and the Health Related Functions.

Health Related Functions means those of the health related functions of the Council, specified in Regulation 6 of the Regulations as relevant to the commissioning of the Services and which may be further described in the relevant Scheme Specification.

Host Partner means for each Pooled Fund the Partner that will host the Pooled Fund and for each Aligned Fund the Partner that will host the Aligned Fund.

Health and Wellbeing Board means the Health and Wellbeing Board established by the Council pursuant to Section 194 of the Health and Social Care Act 2012.

ICB Statutory Duties means the Duties of the ICB pursuant to Sections 14P to 14Z2 of the 2006 Act.

Indirect Losses means loss of profits, loss of use, loss of production, increased operating costs, loss of business, loss of business opportunity, loss of reputation or goodwill or any other consequential or indirect loss of any nature, whether arising in tort or on any other basis.

Individual Scheme means one of the schemes which is agreed by the Partners to be included within this Agreement using the powers under Section 75 as documented in a Scheme Specification.

Initial Term: the period commencing on the Commencement Date and ending on the anniversary of the Commencement Date.

Integrated Commissioning means arrangements by which both Partners commission Services in relation to an individual Scheme on behalf of each other in exercise of both the NHS Functions and Council Functions through integrated structures.

Joint (Aligned) Commissioning means a mechanism by which the Partners jointly commission a Service. For the avoidance of doubt, a joint (aligned) commissioning arrangement does not involve the delegation of any functions pursuant to Section 75.

Joint Strategic Needs Assessment means the ICB and Council assessments of the health needs of the population in the Wakefield District in order to improve the physical and mental health and wellbeing of persons and communities within the Wakefield District.

Law means any applicable law, statute, bye-law, regulation, order, regulatory policy, guidance or industry code, rule of court, directives or requirements of any Regulatory Body, delegated or subordinate legislation, or notice of any Regulatory Body.

Lead Commissioning Arrangements means the arrangements by which one Partner commissions Services in relation to an Individual Scheme on behalf of the other Partner in exercise of both the NHS Functions and the Council Functions.

Lead Commissioner means the Partner responsible for commissioning an Individual Scheme under a Scheme Specification.

Losses means all damage, loss, liabilities, claims, actions, costs, expenses (including the cost of legal and/or professional services), proceedings, demands and charges whether arising under statute, contract or at common law but excluding Indirect Losses and "Loss" shall be interpreted accordingly.

Month means a calendar month.

National Conditions mean the national conditions as set out in the National Guidance as amended or replaced from time to time.

National Guidance means any and all policy and guidance in relation to the Better Care Fund as issued from time to time by NHS England, the Department of Health and Social Care, the Department for Levelling Up, Housing & Communities and the Local Government Association either collectively or separately. As at the date of this Agreement the most recent National Guidance is contained in the government's policy paper 2023-2025 Better Care fund policy framework (including Addendum) published and updated 12 April 2024.

NHS Functions means those of the NHS functions listed in Regulation 5 of the Regulations as are exercisable by the ICB as are relevant to the commissioning of the Services and which may be further described in each Service Schedule.

Non Pooled Fund means the budget detailing the financial contributions of the Partners which are not included in a Pooled Fund in respect of a particular Service as set out in the relevant Scheme Specification.

Non-Recurrent Payments means funding provided by a Partner to a Pooled Fund in addition to the Financial Contributions pursuant to arrangements agreed in accordance with Clause 10.3.

Overspend means any expenditure from a Pooled Fund in a Financial Year which exceeds the Financial Contributions for that Financial Year.

Partner means each of the ICB and the Council, and references to "**Partners**" shall be construed accordingly.

Partnership Board means the partnership board responsible for review of performance and oversight of this Agreement as set out in Schedule 2 also known as the “Connecting Care Executive”.

Performance Payment Arrangement means any arrangement agreed with a Provider and one of more Partners in relation to the cost of providing Services on such terms as agreed in writing by all Partners.

Performance Payments means any sum over and above the relevant Contract Price which is payable to the Provider in accordance with a Performance Payment Arrangement.

Permitted Budget means in relation to a Service where the Council is the Provider, the budget that the Partners have set in relation to the particular Service.

Permitted Expenditure has the meaning given in Clause 7.3.

Personal Data means Personal Data as defined by the 2018 Act and UK GDPR.

Pooled Fund means any pooled fund established and maintained by the Partners as a pooled fund in accordance with the Regulations.

Pooled Fund Manager means such officer of the Host Partner which includes a Section 113 Officer for the relevant Pooled Fund established under an Individual Scheme as is nominated by the Host Partner from time to time to manage the Pooled Fund in accordance with Clause 10.

Provider means a provider of any Services commissioned under the arrangements set out in this Agreement.

Quarter means each of the following periods in a Financial Year:

1 April to 30 June

1 July to 30 September

1 October to 31 December

1 January to 31 March

and “**Quarterly**” shall be interpreted accordingly.

Regulations means the means the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 No 617 (as amended).

Regulatory Body means those government departments and regulatory, statutory and other entities, committees and bodies that, whether under statute, rules, regulations, codes of practice or otherwise, are entitled to regulate, investigate or influence the matters dealt with in this Agreement, or any other affairs of the Partners.

Scheme Specification means a specification setting out the arrangements for an Individual Scheme agreed by the Partners to be commissioned under this Agreement.

Sensitive Personal Data means Sensitive Personal Data as defined in the 2018 Act and UK GDPR.

Services means such health and social care services as agreed from time to time by the Partners as commissioned under the arrangements set out in this Agreement and more specifically defined in each Scheme Specification.

Services Contract means an agreement for the provision of Services entered into with a Provider by one or more of the Partners in accordance with the relevant Individual Scheme.

Service Users means those individual for whom the Partners have a responsibility to commission the Services.

Term means the period of the Initial Term as may be varied by:

- (a) any extensions to this Agreement that are agreed under Clause 2.2; or
- (b) the earlier termination of this Agreement in accordance with its terms.

Third Party Costs means all such third party costs (including legal and other professional fees) in respect of each Individual Scheme as a Partner reasonably and properly incurs in the proper performance of its obligations under this Agreement and as agreed by the Partnership Board.

UK GDPR has the meaning given to it in section 3(10) (as supplemented by section 205(4)) of the Data Protection Act 2018.

Wakefield District GP means a GP practice within the ICB area.

Wakefield District means the metropolitan district of Wakefield.

Working Day means 8.00am to 6.00pm on any day except Saturday, Sunday, Christmas Day, Good Friday or a day which is a bank holiday (in England) under the Banking & Financial Dealings Act 1971.

- 1.2 In this Agreement, all references to any statute or statutory provision shall be deemed to include references to any statute or statutory provision which amends, extends, consolidates or replaces the same and shall include any orders, regulations, codes of practice, instruments or other subordinate legislation made thereunder and any conditions attaching thereto. Where relevant, references to English statutes and statutory provisions shall be construed as references also to equivalent statutes, statutory provisions and rules of law in other jurisdictions.
- 1.3 Any headings to Clauses, together with the front cover and the index are for convenience only and shall not affect the meaning of this Agreement. Unless the contrary is stated, references to Clauses and Schedules shall mean the clauses and schedules of this Agreement.
- 1.4 Any reference to the Partners shall include their respective statutory successors, employees and agents.
- 1.5 In the event of a conflict, the conditions set out in the Clauses to this Agreement shall take priority over the Schedules.
- 1.6 Where a term of this Agreement provides for a list of items following the word "including" or "includes", then such list is not to be interpreted as being an exhaustive list.
- 1.7 In this Agreement, words importing any particular gender include all other genders, and the term "person" includes any individual, partnership, firm, trust, body corporate, government, governmental body, trust, agency, unincorporated body of persons or association and a reference to a person includes a reference to that person's successors and permitted assigns.
- 1.8 In this Agreement, words importing the singular only shall include the plural and vice versa.
- 1.9 In this Agreement, "staff" and "employees" shall have the same meaning and shall include reference to any full or part time employee or officer, director, manager and agent.
- 1.10 Subject to the contrary being stated expressly or implied from the context in these terms and conditions, all communication between the Partners shall be in writing.
- 1.11 Unless expressly stated otherwise, all monetary amounts are expressed in pounds sterling but in the event that pounds sterling is replaced as legal tender in the United Kingdom by a different currency then all monetary amounts shall be converted into such other currency at the rate prevailing on the date such other currency first became legal tender in the United Kingdom.

- 1.12 All references to the Agreement include (subject to all relevant approvals) a reference to the Agreement as amended, supplemented, substituted, novated or assigned from time to time.

2 TERM

- 2.1 This Agreement shall come into force on the Commencement Date and shall continue for the Term.
- 2.2 The Partners may extend this Agreement beyond the Initial Term for such period and on such varied terms as they may agree in writing in accordance with Clause 30.
- 2.3 The duration of the arrangements for each Individual Scheme shall be as set out in the relevant Scheme Specification.

3 GENERAL PRINCIPLES

- 3.1 Nothing in this Agreement shall affect:
- 3.1.1 the liabilities of the Partners to each other or to any third parties for the exercise of their respective functions and obligations (including the Functions); or
 - 3.1.2 any power or duty to recover charges for the provision of any services (including the Services) in the exercise of any local authority function.
- 3.2 The Partners agree to:
- 3.2.1 treat each other with respect and an equality of esteem;
 - 3.2.2 be open with information about the performance and financial status of each; and
 - 3.2.3 provide early information and notice about relevant problems.
- 3.3 For the avoidance of doubt, the aims and outcomes relating to an Individual Scheme may be set out in the relevant Scheme specification.

4 PARTNERSHIP FLEXIBILITIES

- 4.1 This Agreement sets out the mechanism through which the Partners will work together to establish one or more of the following:
- 4.1.1 Lead Commissioning Arrangements;
 - 4.1.2 Joint (Aligned) Commissioning;
 - 4.1.3 the establishment of one or more Pooled Funds;
- in relation to Individual Schemes (the "Flexibilities")
- 4.2 The Council delegates to the ICB and the ICB agrees to exercise, on the Council's behalf, the Health Related Functions to the extent necessary for the purpose of performing its obligations under this Agreement in conjunction with the NHS Functions.
- 4.3 The ICB delegates to the Council and the Council agrees to exercise on the ICB's behalf the NHS Functions to the extent necessary for the purpose of performing its obligations under this Agreement in conjunction with the Health Related Functions.
- 4.4 Where the powers of a Partner to delegate any of its statutory powers or functions are restricted, such limitations will automatically be deemed to apply to the relevant Scheme Specification and the Partners shall agree arrangements designed to achieve the greatest degree of delegation to the other Partner necessary for the purposes of this Agreement which is consistent with the statutory constraints.

5 FUNCTIONS

- 5.1 The purpose of this Agreement is to establish a framework through which the Partners can secure the provision of health and social care services in accordance with the terms of this Agreement.
- 5.2 This Agreement shall include such functions as shall be agreed from time to time by the Partners.
- 5.3 Where the Partners add a new Individual Scheme to this Agreement a Scheme Specification for each Individual Scheme shall be in the form set out in Schedule 1 and shall be completed and agreed between the Partners. The initial scheme specification is set out in Schedule 1.
- 5.4 The Partners shall not enter into a Scheme Specification in respect of an Individual Scheme unless they are satisfied that the Individual Scheme in question will improve health and well-being in accordance with this Agreement.
- 5.5 The introduction of any Individual Scheme will be subject to business case approval by the Partnership Board.

6 COMMISSIONING ARRANGEMENTS

Lead Commissioning and Joint (Aligned) Commissioning

- 6.1 Where there are Lead Commissioning and/or Joint (Aligned) Commissioning arrangements in respect of an Individual Scheme, both Partners shall work in cooperation and shall endeavour to ensure that the NHS Functions and Health Related Functions are commissioned with all due skill, care and attention.
- 6.2 The Partners shall comply with the arrangements in respect of the Joint (Aligned) Commissioning as set out in the relevant Scheme Specification.
- 6.3 Each Partner shall keep the other Partners and the Partnership Board regularly informed of the effectiveness of the arrangements including the Better Care Fund and any Overspend or Underspend in a Pooled Fund or Non Pooled Fund.
- 6.4 The Partnership Board will report back to the Health and Wellbeing Board as required by its Terms of Reference.

Appointment of a Lead Commissioner

- 6.5 Where there are Lead Commissioning Arrangements in respect of an Individual Scheme the Lead Commissioner shall:
 - 6.5.1 exercise the NHS Functions in conjunction with the Health Related Functions as identified in the relevant Scheme Specification;
 - 6.5.2 endeavour to ensure that the NHS Functions and the Health Related Functions are funded within the parameters of the Financial Contributions of each Partner in relation to each particular Service in each Financial Year;
 - 6.5.3 commission Services for individuals who meet the eligibility criteria set out in the relevant Scheme Specification;
 - 6.5.4 contract with Provider(s) for the provision of the Services on terms agreed with the other Partners;
 - 6.5.5 comply with all relevant legal duties and guidance of both Partners in relation to the Services being commissioned;

- 6.5.6 where Services are commissioned using the NHS Standard Form Contract, perform the obligations of the “Commissioner” and “Co-ordinating Commissioner” with all due skill, care and attention and where Services are commissioned using any other form of contract to perform its obligations with all due skill and attention;
- 6.5.7 undertake performance management and contract monitoring of all Services Contracts;
- 6.5.8 undertake any enforcement action pursuant to any Services Contracts;
- 6.5.9 make payment of all sums due to a Provider pursuant to the terms of any Services Contract; and
- 6.5.10 keep the other Partner and the Partnership Board regularly informed of the effectiveness of the arrangements including the Better Care Fund and any Overspend or Underspend in a Pooled Fund or Non Pooled Fund.

7 ESTABLISHMENT OF A POOLED FUND

- 7.1 In exercise of their respective powers under Section 75 of the 2006 Act, the Partners have agreed to establish and maintain such pooled funds for revenue expenditure as set out in the Scheme Specifications.
- 7.2 Each Pooled Fund shall be managed and maintained in accordance with the terms of this Agreement.
- 7.3 It is agreed that the monies held in a Pooled Fund for each Individual Scheme recorded in the Scheme Specification and summarised in Annex A of Schedule 1 (Scheme Specification) may only be expended on the following :
 - 7.3.1 the Contract Price;
 - 7.3.2 where the Council is to be the Provider, the Permitted Budget;
 - 7.3.3 Performance Payments;
 - 7.3.4 Third Party Costs;
 - 7.3.5 Approved Expenditure
 ("Permitted Expenditure")
- 7.4 The Partners may only depart from the definition of Permitted Expenditure to include or exclude other revenue expenditure with the express written agreement of each Partner.
- 7.5 For the avoidance of doubt, monies held in the Pooled Fund may not be expended on Default Liabilities unless this is agreed by all Partners.
- 7.6 Pursuant to this Agreement, the Partners agree to appoint a Host Partner for each of the Pooled Funds set out in the Scheme Specifications. The Host Partner shall be the Partner responsible for:
 - 7.6.1 holding all monies contributed to the Pooled Fund on behalf of itself and the other Partners;
 - 7.6.2 providing the financial administrative systems for the Pooled Fund;
 - 7.6.3 appointing the Pooled Fund Manager; and
 - 7.6.4 ensuring that the Pooled Fund Manager complies with its obligations under this Agreement.

8 POOLED FUND MANAGEMENT

- 8.1 When introducing a Pooled Fund in respect of an Individual Scheme, the Partners shall agree:
 - 8.1.1 which of the Partners shall act as Host Partner for the purposes of Regulations 7(4) and 7(5) and shall provide the financial administrative systems for the Pooled Fund;
 - 8.1.2 which officer of the Host Partner shall act as the Pooled Fund Manager for the purposes of Regulation 7(4) of the Regulations.
- 8.2 The Pooled Fund Manager in respect of each Individual Scheme where there is a Pooled Fund shall have the following duties and responsibilities:
 - 8.2.1 the day to day operation and management of the Pooled Fund;
 - 8.2.2 ensuring that all expenditure from the Pooled Fund is in accordance with the provisions of this Agreement and the relevant Scheme Specification;
 - 8.2.3 maintaining an overview of all joint financial issues affecting the Partners in relation to the Services and the Pooled Fund;
 - 8.2.4 ensuring that full and proper records for accounting purposes are kept in respect of the Pooled Fund;
 - 8.2.5 reporting to the Partnership Board as required by the Partnership Board and the relevant Scheme Specification;
 - 8.2.6 ensuring action is taken to manage any projected under or overspends relating to the Pooled Fund in accordance with this Agreement;
 - 8.2.7 preparing and submitting the following reports to the Partnership Board:
 - (a) Quarterly reports (or more frequent reports if required by the Partnership Board) using the BCF Quarterly Report Template; and
 - (b) an annual return /report about the income and expenditure from the Pooled Fund using the Annual Reporting Template

together with such other information as may be required by the Partners and the Partnership Board to monitor the effectiveness of the Pooled Fund and to enable the Partners to complete their own financial accounts and returns. The Partners agree to provide all necessary information to the Pooled Fund Manager in time for the reporting requirements to be met;
 - 8.2.8 preparing and submitting the following reports to the Health and Wellbeing Board for discussion and sign off by the Health and Wellbeing Board
 - (a) Quarterly reports (or more frequent reports if required by the Health and Wellbeing Board) using the BCF Quarterly Report Template; and
 - (b) an annual report using the Annual Reporting Template

together with such other information as may be required by the Health and Wellbeing Board to monitor the effectiveness of the Pooled Fund and to discharge its duty under section 195 of the 2012 Act. The Partners agree to provide all necessary information to the Pooled Fund Manager in time for the reporting requirements to be met;
- 8.3 In carrying out their responsibilities as provided under Clause 8.2 the Pooled Fund Manager shall have regard to the recommendations of the Partnership Board and shall be accountable to the Partners.
- 8.4 The Partnership Board may agree to the viring of funds between Pooled Funds.

9 NON POOLED FUNDS

- 9.1 Any Financial Contributions agreed to be held within a Non Pooled Fund will be notionally held in a fund established for the purpose of commissioning that Service as set out in the relevant Scheme Specification. For the avoidance of doubt, a Non Pooled Fund does not constitute a pooled fund for the purposes of Regulation 7 of the Partnership Regulations.
- 9.2 When introducing a Non Pooled Fund in respect of an Individual Scheme, the Partners shall agree:
- 9.2.1 which Partner if any shall host the Non-Pooled Fund;
 - 9.2.2 how and when Financial Contributions shall be made to the Non-Pooled Fund.
- 9.3 The Host Partner will be responsible for establishing the financial and administrative support necessary to enable the effective and efficient management of the Non-Pooled Fund, meeting all required accounting and auditing obligations.
- 9.4 Both Partners shall ensure that Services commissioned using a Non Pooled Fund are commissioned solely in accordance with the relevant Scheme Specification.
- 9.5 Where there are Joint (Aligned) Commissioning arrangements, both Partners shall work in cooperation and shall endeavour to ensure that:
- 9.5.1 the NHS Functions funded from a Non-Pooled Fund are carried out within the ICB Financial Contribution to the Non- Pooled Fund for the relevant Service in each Financial Year; and
 - 9.5.2 the Health Related Functions funded from a Non-Pooled Fund are carried out within the Council's Financial Contribution to the Non-Pooled Fund for the relevant Service in each Financial Year.

10 FINANCIAL CONTRIBUTIONS

- 10.1 The Financial Contributions of the ICB and the Council to any Pooled Fund or Non-Pooled Fund for the first Financial Year of operation of each Individual Scheme shall be as set out in the relevant Scheme Specification.
- 10.2 Financial Contributions will be paid as set out in each Scheme Specification.
- 10.3 With the exception of Clause 13, no provision of this Agreement shall preclude the Partners from making additional contributions of Non-Recurrent Payments to the Pooled Fund from time to time by mutual agreement. Any such additional contributions of Non-Recurrent Payments shall be explicitly recorded in Partnership Board minutes and recorded in the budget statement as a separate item.

11 NON FINANCIAL CONTRIBUTIONS

The Scheme Specification shall set out non-financial contributions of each Partner including staff (including the Pooled Fund Manager), premises, IT support and other non-financial resources necessary to perform its obligations pursuant to this Agreement (including, but not limited to, management of Service Contracts and the Pooled Fund).

12 RISK SHARE ARRANGMENTS, OVERSPENDS AND UNDERSPENDS

Risk share arrangements

- 12.1 The Partners have agreed risk share arrangements as set out in Schedule 3 and the relevant Scheme Specification, which provide for financial risks arising within the commissioning of services from the

Pooled Funds and the financial risk to the Pooled Funds arising from the payment for performance element of the Better Care Fund.

Overspends in Pooled Fund

- 12.2 Subject to Clause 12.3, the Host Partner for the relevant Pooled Fund for each Individual Scheme shall manage expenditure from the relevant Pooled Fund within the Financial Contributions agreed for each Individual Scheme and recorded in the Scheme Specification and shall ensure that the expenditure is limited to Permitted Expenditure.
- 12.3 The Host Partner shall not be in breach of its obligations under this Agreement if an Overspend occurs PROVIDED THAT the only expenditure from a Pooled Fund has been in accordance with Permitted Expenditure and it has informed the Partnership Board in accordance with Clause 12.4.
- 12.4 In the event that the Pooled Fund Manager identifies an actual or projected Overspend the Pooled Fund Manager must ensure that the Partnership Board is informed as soon as reasonably possible and the provisions of the relevant Scheme Specification and Schedule 3 shall apply.

Overspends in Non Pooled Funds

- 12.5 Where in Joint (Aligned) Commissioning Arrangements either Partner forecasts an overspend in relation to a Partner's Financial Contribution to a Non-Pooled Fund that Partner shall as soon as reasonably practicable inform the other Partner and the Partnership Board.

Underspend in Pooled Fund or Non-Pooled Fund

- 12.6 In the event that expenditure from any Pooled Fund or Non Pooled Fund in any Financial Year is less than the aggregate value of the Financial Contributions made for that Financial Year the Partners agree that the arrangements set out in the relevant Scheme Specification shall apply to the management of underspend. Such arrangements shall be subject to the Law and the Standing Orders and Standing Financial Instructions (or equivalent) of the Partners and the terms of the Performance Payment Arrangement.

13 CAPITAL EXPENDITURE

Neither Pooled Funds nor Non Pooled Funds shall normally be applied towards any one-off expenditure on goods and/or services, which will provide continuing benefit and would historically have been funded from the capital budgets of one of the Partners. If a need for capital expenditure is identified this must be agreed by the Partners.

14 VAT

The VAT arrangements for each of the Schemes are set out in the relevant Scheme Specification.

15 AUDIT AND RIGHT OF ACCESS

- 15.1 All Partners shall promote a culture of probity and sound financial discipline and control. The Host Partner shall arrange for the audit of the accounts of the relevant Pooled Fund and shall require the Audit Commission to make arrangements to certify an annual return of those accounts under Section 20 and 21 the Local Audit and Accountability Act 2014.
- 15.2 All internal and external auditors and all other persons authorised by the Partners will be given the right of access by them to any document, information or explanation they require from any employee, member of the Partner in order to carry out their duties. This right is not limited to financial information or accounting records and applies equally to premises or equipment used in connection with this Agreement. Access may be at any time without notice, provided there is good cause for access without notice.

16 LIABILITIES, INSURANCE AND INDEMNITY

- 16.1 Subject to Clause 16.2, and 16.3, if a Partner ("First Partner") incurs a Loss arising out of or in connection with this Agreement or the Services Contract as a consequence of any act or omission of another Partner ("Other Partner") which constitutes negligence, fraud or a breach of contract in relation to this Agreement or the Services Contract then the Other Partner shall be liable to the First Partner for that Loss and shall indemnify the First Partner accordingly.
- 16.2 Clause 16.1 shall only apply to the extent that the acts or omissions of the Other Partner contributed to the relevant Loss. Furthermore, it shall not apply if such act or omission occurred as a consequence of the Other Partner acting in accordance with the instructions or requests of the First Partner or the Partnership Board.
- 16.3 If any third party makes a claim or intimates an intention to make a claim against either Partner, which may reasonably be considered as likely to give rise to liability under this Clause 16. the Partner that may claim against the other indemnifying Partner will:
- 16.3.1 as soon as reasonably practicable give written notice of that matter to the Other Partner specifying in reasonable detail the nature of the relevant claim;
 - 16.3.2 not make any admission of liability, agreement or compromise in relation to the relevant claim without the prior written consent of the Other Partner (such consent not to be unreasonably conditioned, withheld or delayed);
 - 16.3.3 give the Other Partner and its professional advisers reasonable access to its premises and personnel and to any relevant assets, accounts, documents and records within its power or control so as to enable the Indemnifying Partner and its professional advisers to examine such premises, assets, accounts, documents and records and to take copies at their own expense for the purpose of assessing the merits of, and if necessary defending, the relevant claim.
- 16.4 Each Partner shall ensure that they maintain policies of insurance (or equivalent arrangements through schemes operated by the National Health Service Litigation Authority) in respect of all potential liabilities arising from this Agreement.
- 16.5 Each Partner shall at all times take all reasonable steps to minimise and mitigate any loss for which one party is entitled to bring a claim against the other pursuant to this Agreement.

17 STANDARDS OF CONDUCT AND SERVICE

- 17.1 The Partners will at all times comply with Law and ensure good corporate governance in respect of each Partner (including the Partners respective Standing Orders and Standing Financial Instructions).
- 17.2 The Council is subject to the duty of Best Value under the Local Government Act 1999. This Agreement and the operation of the Pooled Fund is therefore subject to the Council's obligations for Best Value and the ICB will co-operate with all reasonable requests from the Council which the Council considers necessary in order to fulfil its Best Value obligations.
- 17.3 The ICB is subject to the ICB Statutory Duties and these incorporate a duty of clinical governance, which is a framework through which they are accountable for continuously improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish. This Agreement and the operation of the Pooled Funds are therefore subject to ensuring compliance with the ICB Statutory Duties and clinical governance obligations.
- 17.4 The Partners are committed to an approach to equality and equal opportunities as represented in their respective policies. The Partners will maintain and develop these policies as applied to service provision, with the aim of developing a joint strategy for all elements of the Services.

18 CONFLICTS OF INTEREST

The Partners shall comply with the agreed policy for identifying and managing conflicts of interest as set out in Schedule 7.

19 GOVERNANCE

- 19.1 Overall strategic oversight of partnership working between the partners is vested in the Health and Wellbeing Board, which for these purposes shall make recommendations to the Partners as to any action it considers necessary.
- 19.2 The Partners have established a Partnership Board to:
- 19.2.1 work in partnership to shape, promote and support the agenda on integration of social care and health in the Wakefield District and to commission relevant, accessible, high quality and value for money services for people living in the Wakefield District in response to their individual needs and priorities determined by the Joint Strategic Needs Assessment and national policy priorities;
 - 19.2.2 deliver the key joint and aligned commissioning plans for people living in the Wakefield District in line with the priorities of the Council, ICB and Health and Wellbeing Board and local joint and aligned commissioning strategies; and
 - 19.2.3 oversee the Better Care Fund programme of individual schemes and their associated Pooled Funds and performance monitoring and management arrangements.
- 19.3 The Partnership Board is based on a joint working group structure. Each member of the Partnership Board shall be an officer of one of the Partners and will have individual delegated responsibility from the Partner employing them to make decisions which enable the Partnership Board to carry out its objects, roles, duties and functions as set out in this Clause 19 and Schedule 2.
- 19.4 The terms of reference of the Partnership Board shall be as set out in Schedule 2.
- 19.5 Each Partner has secured internal reporting arrangements to ensure the standards of accountability and probity required by each Partner's own statutory duties and organisation are complied with.
- 19.6 The Partnership Board shall be responsible for the overall approval of the Individual Schemes, ensuring compliance with the Better Care Fund Plan and the strategic direction of the Better Care Fund.
- 19.7 Each Scheme Specification shall confirm the governance arrangements in respect of the Individual Scheme and how that Individual Scheme is reported to the Partnership Board and Health and Wellbeing Board.

20 REVIEW

- 20.1 Save where the Partnership Board agree alternative arrangements (including alternative frequencies) the Partners shall undertake an annual review of the operation of this Agreement, any Pooled Fund and Non Pooled Fund and the provision of the Services within 3 Months of the end of the Financial Year ("**Annual Review**").
- 20.2 Subject to any variations to this process required by the Partnership Board, Annual Reviews shall be conducted in good faith and, where applicable, in accordance with the governance arrangements set out in Schedule 2.
- 20.3 The Partners shall within 20 Working Days of the Annual Review prepare a joint annual report documenting the matters referred to in this Clause 20. A copy of this report shall be provided to the Partnership Board and the Health and Wellbeing Board.

- 20.4 In the event that the Partners fail to meet the requirements of the Better Care Fund Plan and NHS England the Partners shall provide full co-operation with NHS England to agree a recovery plan.

21 COMPLAINTS

The Partners' own complaints procedures shall apply to this Agreement. The Partners agree to assist one another in the management of complaints arising from this Agreement or the provision of the Services.

22 TERMINATION AND DEFAULT

- 22.1 This Agreement may be terminated by any Partner giving not less than 3 Months' notice in writing to terminate this Agreement provided that such termination shall not take effect prior to the termination or expiry of all Individual Schemes which are operational at the date of such notice being given.
- 22.2 Each Individual Scheme may be terminated in accordance with the terms set out in the relevant Scheme Specification provided that the Partners ensure that the Better Care Fund requirements continue to be met.
- 22.3 If any Partner ("Relevant Partner") fails to meet any of its obligations under this Agreement, the other Partner may by notice require the Relevant Partner to take such reasonable action within a reasonable timescale as the other Partner may specify to rectify such failure. Should the Relevant Partner fail to rectify such failure within such reasonable timescale, the matter shall be referred for resolution in accordance with Clause 23.
- 22.4 Either Partner may terminate this Agreement in relation to a Force Majeure Event in accordance with Clause 24.4.
- 22.5 In the event of termination of this Agreement, the Partners agree to cooperate to ensure an orderly wind down of their joint activities and to use their best endeavours to minimise disruption to the health and social care services which is provided to the Service Users.
- 22.6 Upon termination of this Agreement for any reason whatsoever the following shall apply:
- 22.6.1 the Partners agree that they will work together and co-operate to ensure that the winding down and disaggregation of the integrated and joint activities to the separate responsibilities of the Partners is carried out smoothly and with as little disruption as possible to Service Users, employees, the Partners and third parties, so as to minimise costs and liabilities of each Partner in doing so;
- 22.6.2 where either Partner has entered into a Service Contract which continues after the termination of this Agreement, both Partners shall continue to contribute to the Contract Price in accordance with the agreed contribution for that Service prior to termination and will enter into all appropriate legal documentation required in respect of this;
- 22.6.3 the Lead Commissioner shall use reasonable endeavours to amend or terminate a Service Contract (which shall for the avoidance of doubt not include any act or omission that would place the Lead Commissioner in breach of the Service Contract) where the other Partner requests the same in writing provided that the Lead Commissioner shall not be required to make any payments to the Provider for such amendment or termination unless the Partners shall have agreed in advance who shall be responsible for any such payment;
- 22.6.4 where a Service Contract held by a Lead Commissioner relates all or partially to services which relate to the other Partner's Functions then provided that the Service Contract allows the other Partner may request that the Lead Commissioner assigns the Service Contract in whole or part upon the same terms mutatis mutandis as the original Service Contract;
- 22.6.5 the Partnership Board shall continue to operate for the purposes of functions associated with this Agreement for the remainder of any contracts and commitments relating to this Agreement; and

22.6.6 termination of this Agreement shall have no effect on the liability or any rights or remedies of either Partner already accrued, prior to the date upon which such termination takes effect.

22.7 In the event of termination in relation to an Individual Scheme the provisions of Clause 22.6 shall apply mutatis mutandis in relation to the Individual Scheme (as though references as to this Agreement were to that Individual Scheme).

23 DISPUTE RESOLUTION

23.1 In the event of a Dispute between the Partners arising out of this Agreement, either Partner may serve written notice of the Dispute on the other Partner, setting out full details of the Dispute.

23.2 The Partnership Board shall meet in good faith as soon as possible and in any event within one Month of notice of the Dispute being served pursuant to Clause 23.1, at a meeting convened for the purpose of resolving the Dispute.

23.3 If the dispute is not resolved after the meeting detailed in Clause 23.2 has taken place, the Chief Executive of the Council and Chief Officer of the ICB or nominees shall meet in good faith as soon as possible after the relevant meeting and in any event with fourteen (14) days of the date of the meeting, for the purpose of resolving the Dispute.

23.4 If the Dispute remains after the meeting detailed in Clause 23.3 has taken place, then the Partners will attempt to settle such Dispute by mediation in accordance with the CEDR Model Mediation Procedure or any other model mediation procedure as agreed by the Partners. To initiate a mediation, either Partner may give notice in writing (a "**Mediation Notice**") to the other requesting mediation of the Dispute and shall send a copy thereof to CEDR or an equivalent mediation organisation as agreed by the Partners asking them to nominate a mediator. The mediation shall commence within twenty (20) Working Days of the Mediation Notice being served. Neither Partner will terminate such mediation until each of them has made its opening presentation and the mediator has met each of them separately for at least one (1) hour. Thereafter, paragraph 14 of the Model Mediation Procedure will apply (or the equivalent paragraph of any other model mediation procedure agreed by the Partners). The Partners will co-operate with any person appointed as mediator, providing him with such information and other assistance as he shall require and will pay his costs as he shall determine or in the absence of such determination such costs will be shared equally.

23.5 Nothing in the procedure set out in this Clause 23 shall in any way affect either Partner's right to terminate this Agreement in accordance with any of its terms or take immediate legal action.

24 FORCE MAJEURE

24.1 Neither Partner shall be entitled to bring a claim for a breach of obligations under this Agreement by the other Partner or incur any liability to the other Partner for any losses or damages incurred by that Partner to the extent that a Force Majeure Event occurs and it is prevented from carrying out its obligations by that Force Majeure Event.

24.2 On the occurrence of a Force Majeure Event, the Affected Partner shall notify the other Partner as soon as practicable. Such notification shall include details of the Force Majeure Event, including evidence of its effect on the obligations of the Affected Partner and any action proposed to mitigate its effect.

24.3 As soon as practicable, following notification as detailed in Clause 24.2, the Partners shall consult with each other in good faith and use all best endeavours to agree appropriate terms to mitigate the effects of the Force Majeure Event and, subject to Clause 24.4, facilitate the continued performance of the Agreement.

24.4 If the Force Majeure Event continues for a period of more than sixty (60) days, either Partner shall have the right to terminate the Agreement by giving fourteen (14) days written notice of termination to the other Partner. For the avoidance of doubt, no compensation shall be payable by either Partner as a direct consequence of this Agreement being terminated in accordance with this Clause.

25 CONFIDENTIALITY

- 25.1 In respect of any Confidential Information a Partner receives from another Partner (the "**Discloser**") and subject always to the remainder of this Clause 25, each Partner (the "**Recipient**") undertakes to keep secret and strictly confidential and shall not disclose any such Confidential Information to any third party, without the Discloser's prior written consent provided that:
- 25.1.1 the Recipient shall not be prevented from using any general knowledge, experience or skills which were in its possession prior to the Commencement Date; and
 - 25.1.2 the provisions of this Clause 25 shall not apply to any Confidential Information which:
 - (a) is in or enters the public domain other than by breach of the Agreement or other act or omission of the Recipient; or
 - (b) is obtained by a third party who is lawfully authorised to disclose such information.
- 25.2 Nothing in this Clause 25 shall prevent the Recipient from disclosing Confidential Information where it is required to do so in fulfilment of statutory obligations or by judicial, administrative, governmental or regulatory process in connection with any action, suit, proceedings or claim or otherwise by applicable Law.
- 25.3 Each Partner:
- 25.3.1 may only disclose Confidential Information to its employees and professional advisors to the extent strictly necessary for such employees to carry out their duties under the Agreement;
 - 25.3.2 will ensure that, where Confidential Information is disclosed in accordance with Clause 25.3.1, the recipient(s) of that information is made subject to a duty of confidentiality equivalent to that contained in this Clause 25; and
 - 25.3.3 shall not use Confidential Information other than strictly for the performance of its obligations under this Agreement.

26 FREEDOM OF INFORMATION AND ENVIRONMENTAL PROTECTION REGULATIONS

- 26.1 The Partners agree that they will each cooperate with each other to enable any Partner receiving a request for information under the 2000 Act or the 2004 Regulations to respond to a request promptly and within the statutory timescales. This cooperation shall include but not be limited to finding, retrieving and supplying information held, directing requests to the other Partner as appropriate and responding to any requests by the Partner receiving a request for comments or other assistance.
- 26.2 Any and all agreements between the Partners as to confidentiality shall be subject to their duties under the 2000 Act and 2004 Regulations. No Partner shall be in breach of Clause 25 if it makes disclosures of information in accordance with the 2000 Act and/or 2004 Regulations.

27 OMBUDSMEN

The Partners will co-operate with any investigation undertaken by the Health Service Commissioner for England or the Local Government Commissioner for England (or both of them) in connection with this Agreement.

28 INFORMATION SHARING

The Partners will follow the Information Governance Protocol set out in Schedule 4, and in so doing will ensure that the operation of this Agreement complies with Law, in particular Data Protection Legislation.

29 NOTICES

29.1 Any notice to be given under this Agreement shall either be delivered personally or sent by facsimile or sent by first class post or electronic mail. The address for service of each Partner shall be as set out in Clause 29.3 or such other address as each Partner may previously have notified to the other Partner in writing. A notice shall be deemed to have been served if:

29.1.1 personally delivered, at the time of delivery;

29.1.2 sent by facsimile, at the time of transmission;

29.1.3 posted, at the expiration of forty eight (48) hours after the envelope containing the same was delivered into the custody of the postal authorities; and

29.1.4 if sent by electronic mail, at the time of transmission and a telephone call must be made to the recipient warning the recipient that an electronic mail message has been sent to him (as evidenced by a contemporaneous note of the Partner sending the notice) and a hard copy of such notice is also sent by first class recorded delivery post (airmail if overseas) on the same day as that on which the electronic mail is sent.

29.2 In proving such service, it shall be sufficient to prove that personal delivery was made, or that the envelope containing such notice was properly addressed and delivered into the custody of the postal authority as prepaid first class or airmail letter (as appropriate), or that the facsimile was transmitted on a tested line or that the correct transmission report was received from the facsimile machine sending the notice, or that the electronic mail was properly addressed and no message was received informing the sender that it had not been received by the recipient (as the case may be).

29.3 The address for service of notices as referred to in Clause 29.1 shall be as follows unless otherwise notified to the other Partner in writing:

29.3.1 if to the Council, addressed to the Service Director– Commissioning & Workforce Adult Social Care, County Hall, Wakefield, WF1 2QW;

Tel: 01924 303584

E.Mail: angelahemingway@wakefield.gov.uk

and

29.3.2 if to the ICB, addressed to the Director System Reform & Integration, White Rose House, West Parade, Wakefield WF1 1LT;

Tel: 01924 317776

E.Mail: Melanie.brown@nhs.net

30 VARIATION

No variations to this Agreement will be valid unless they are recorded in writing and signed for and on behalf of each of the Partners.

31 CHANGE IN LAW

31.1 The Partners shall ascertain, observe, perform and comply with all relevant Laws, and shall do and execute or cause to be done and executed all acts required to be done under or by virtue of any Laws.

31.2 On the occurrence of any Change in Law, the Partners shall agree in good faith any amendment required to this Agreement as a result of the Change in Law subject to the Partners using all

reasonable endeavours to mitigate the adverse effects of such Change in Law and taking all reasonable steps to minimise any increase in costs arising from such Change in Law.

- 31.3 In the event of failure by the Partners to agree appropriate amendments to the Agreement (as appropriate), Clause 23 (Dispute Resolution) shall apply.

32 WAIVER

No failure or delay by any Partner to exercise any right, power or remedy will operate as a waiver of it nor will any partial exercise preclude any further exercise of the same or of some other right to remedy.

33 SEVERANCE

If any provision of this Agreement, not being of a fundamental nature, shall be held to be illegal or unenforceable, the enforceability of the remainder of this Agreement shall not thereby be affected.

34 ASSIGNMENT AND SUB CONTRACTING

Neither Partner shall sub contract, assign or transfer the whole or any part of this Agreement, without the prior written consent of the other Partner, which shall not be unreasonably withheld or delayed. This shall not apply to any assignment to a statutory successor of all or part of a Partner's statutory functions.

35 EXCLUSION OF PARTNERSHIP AND AGENCY

- 35.1 Nothing in this Agreement shall create or be deemed to create a partnership under the Partnership Act 1890 or the Limited Partnership Act 1907, a joint venture or the relationship of employer and employee between the Partners or render either Partner directly liable to any third party for the debts, liabilities or obligations of the other.

- 35.2 Except as expressly provided otherwise in this Agreement or where the context or any statutory provision otherwise necessarily requires, neither Partner will have authority to, or hold itself out as having authority to:

35.2.1 act as an agent of the other;

35.2.2 make any representations or give any warranties to third parties on behalf of or in respect of the other; or

35.2.3 bind the other in any way.

36 THIRD PARTY RIGHTS

Unless the right of enforcement is expressly provided, no third party shall have the right to pursue any right under this Contract pursuant to the Contracts (Rights of Third Parties) Act 1999 or otherwise.

37 ENTIRE AGREEMENT

- 37.1 The terms herein contained together with the contents of the Schedules constitute the complete agreement between the Partners with respect to the subject matter hereof and supersede all previous communications representations understandings and agreement and any representation promise or condition not incorporated herein shall not be binding on any Partner.

- 37.2 No agreement or understanding varying or extending or pursuant to any of the terms or provisions hereof shall be binding upon any Partner unless in writing and signed by a duly authorised officer or representative of the parties.

38 COUNTERPARTS

This Agreement may be executed in one or more counterparts. Any single counterpart or a set of counterparts executed, in either case, by both Partners shall constitute a full original of this Agreement for all purposes.

39 GOVERNING LAW AND JURISDICTION

- 39.1 This Agreement and any dispute or claim arising out of or in connection with it or its subject matter or formation (including non-contractual disputes or claims) shall be governed by and construed in accordance with the laws of England and Wales.
- 39.2 Subject to Clause 23 (Dispute Resolution), the Partners irrevocably agree that the courts of England and Wales shall have exclusive jurisdiction to hear and settle any action, suit, proceedings, dispute or claim, which may arise out of, or in connection with, this Agreement, its subject matter or formation (including non-contractual disputes or claims).

IN WITNESS WHEREOF this Agreement has been executed by the Partners on the date of this Agreement

Signed for and on behalf of **THE COUNCIL
OF THE CITY OF WAKEFIELD**

.....
Authorised Signatory

.....
Authorised Signatory

Signed for and on behalf of the **NHS WEST
YORKSHIRE INTEGRATED CARE
BOARD**

.....
Authorised Signatory

.....
Name (Print in Capitals)

.....
Position (Print in Capitals)

Annex bSCHEDULE 1 – SCHEME SPECIFICATION



Section 75 Agreement 2025-2026

NHS West Yorkshire Integrated Care Board (ICB) &

The Council of the City of Wakefield (Council)

(together the “Partners” and references to “Partner” in this Schedule 1 shall be construed accordingly)

SCHEDULE 1 – SCHEME SPECIFICATION

Unless the context otherwise requires, the defined terms used in this Scheme Specification shall have the meanings set out in the Agreement.

The Scheme Specification comprises the following five individual schemes:

1. Enhanced Care and Support (Proactive Care)
2. Whole Population Prevention
3. Community Solutions
4. Mental Health
5. ICES & Wheelchair Services
6. Discharge Grant

The specification for each of the Individual Schemes 1, 2, 3, 4, 5 and 6 referred to above are set out below:

1. ENHANCED CARE AND SUPPORT

1.1. OVERVIEW OF INDIVIDUAL SERVICE

Name of Individual Scheme: Enhanced Care and Support (Proactive Care)

Context and Background: The model will deliver integrated service provision ensuring that care is coordinated and seamless between providers, preventing unnecessary admission to hospital and supporting discharge back into the community. This scheme is focused on improved resident experience with particular focus on those who are frail or caring for another person. The services in this scheme aim to improve outcomes of care and to avoid gaps and duplication between services facilitated by a shared record (PIC file) to support better co-ordination by improving information-sharing.

Central to this will be the principle of supporting people to self-care and manage their own conditions. It is recognised that despite the best possible support to citizens they will experience health and social care 'crisis' which will require an urgent response from the scheme to assess and if an admission is necessary. If this is required then it will be as planned an approach as possible. This scheme also includes the reablement service, iBCF and Winter Grant Monies.

Pooled Funds: Yes. The Host Partner for Pooled Fund Connecting Care - Enhanced Care and Support is the ICB and the Pooled Fund Manager, being an officer of the Host Partner is Melanie Brown, Director of System Reform and Integration.

1.2. AIMS AND OBJECTIVES

Citizens will be supported when they need a health or social care response. This includes routine care and in a 'crisis' which will require an urgent response from the scheme to assess and if an admission is necessary it happens in as planned an approach as possible.

The model will deliver integrated service provision ensuring that care is coordinated and seamless between providers, preventing unnecessary admission to hospital contributing to the Connecting Care Outcomes of:

- Care is co-ordinated and seamless
- Nobody is admitted to or kept in hospital or residential care unnecessarily;
- People are supported and in control of their condition and care, enjoying independence for longer;
- Care is cost-effective and within available budgets;
- All staff understand the system and work in it effectively; and
- Unpaid carers are prepared and support to care for longer.

1.3. THE ARRANGEMENTS

Joint (Aligned) Commissioning arrangements and the establishment of a Pooled Fund.

1.4. FUNCTIONS

No delegation of either the Council's Health Related Functions to the ICB or of the ICB's NHS Functions to the Council will be applied for the commissioning of this Individual Scheme.

1.5. SERVICES

Model of Care and Support

The model is predicated upon sustaining and enhancing the current provision of enhanced care and support interventions offered across community services, for example district nursing or case management within social care.

There are integrated health and social care hubs across the district. Covering the whole district, the Hubs are aligned to seven Primary Care Networks, The Hubs allow multiple organisations to work together more seamlessly to support patients with complex needs who could otherwise receive disjointed care, with multiple referrals and handovers. The hubs include community nursing teams, social workers, therapists, community and carers co-ordinators, community pharmacists and primary care mental health worker as

core members. Community Nursing Services are aligned and direct access to district wide specialist teams including secondary care clinicians, specialist mental health services, specialist nursing and therapy.

1.6. COMMISSIONING, CONTRACTING, ACCESS

Commissioning Arrangements

Joint (Aligned) commissioning arrangements will be used. The Council and the ICB will operate a Pooled Fund but not delegate the exercise of any functions to each other (but work to 'align' them). The Council and ICB as commissioning organisations shall each let their own contracts for services (as detailed below under the heading "Contracting Arrangements") and each shall pay providers directly and be reimbursed with monies from the Pooled Fund.

Contracting Arrangements

The following contracting arrangements are included in this Individual Scheme:

NHS West Yorkshire Integrated Care Board	Wakefield Council
MYHT Community Contract	Adults Social care Community Services and Management Team (LA provide In-house)
SWYPFT Community Contract	

The Partners will be responsible for contracting with the Providers of services as outlined above.

Population

The Providers will deliver integrated NHS community health services to individuals registered with a General Practice within the ICB's Wakefield District defined boundaries and in respect of social care services to the population who reside within the boundaries of the Wakefield District (i.e. who pay their Council Tax to Wakefield Council).

Service eligibility

The integrated care programme covers all patients and residents within the Wakefield District focusing on citizens with specific needs, and those who are frail and elderly.

- Individuals eligibility criteria for the service are:
- Individuals must be registered with a Wakefield District GP
- Individuals who are a resident of Wakefield District and those who are eligible for their needs to be met under the Care Act.

- Consideration will be given to providing access to reablement for people who have moderate support needs through care co-ordination, where this is likely to lead to a reduction in demand for social care services. This may include signposting people to other lower level commissioned preventative services within the voluntary and community sector and universal services
- Individuals must be over 18 years of age;

Exclusion Criteria

- Individuals who are not a Wakefield District resident will not receive any social care element of the service from the Council, this will be provided by the Local Authority where the individual normally resides. However, the Council will liaise with the relevant local authority for people who are registered with a Wakefield District GP to ensure that their social care needs can be appropriately considered.
- Anyone under 18 years of age

1.7 FINANCIAL CONTRIBUTIONS AND REVENUE FUNDING PAYMENTS BY THE ICB TO THE COUNCIL

Financial Contributions and Spend for Financial Years 2025/26

Financial Years 2025/26

The financial contributions and spend of the Council and ICB for the Financial Year 2025/26 to the Pooled Fund for this Individual Scheme 1 are set out in Parts 1 and 2 of Annex A of this Schedule 1. The Council and ICB acknowledge and agree that:

Payment of Revenue Funding by the ICB to the Council for Financial Year 2025/26

The ICB shall pay to the Council the revenue funding for Individual Scheme 1 for the Financial Year 2025/26 as detailed in Part 3 of Annex A of this Schedule 1 monthly in arrears or at such other frequency agreed by the ICB and the Council.

1.8 FINANCIAL GOVERNANCE ARRANGEMENTS

Management of the Pooled Fund

The following arrangements shall apply to the management of the pooled fund for this Individual Scheme:

Management of Overspend

The Pooled Fund Manager shall notify the Partners and the Connecting Care Executive as soon as reasonably practicable of any projection of an overspend. Each Partner will have total responsibility

for their own overspend which occurs in relation to the contracts (listed in the table under the heading "Contracting Arrangements" in paragraph 1.6 above) each enters into to deliver their own service schemes unless otherwise agreed by the Partners. For the avoidance of doubt, the Council shall be solely responsible for financing any overspend that occurs from the contracts it enters into for the delivery of services for this Individual Scheme and the ICB will be solely responsible for financing any overspend that occurs from the contracts it enters into for the delivery of services for this Individual Scheme unless otherwise agreed by the Partners.

Management of Underspend

The Pooled Fund Manager shall notify the Partners and the Connecting Care Executive as soon as reasonably practicable of any projection of an underspend, each Partner shall be entitled to retain any underspend which occurs from the contracts (listed in the table under the heading "Contracting Arrangements in paragraph 1.6 above) each enters into to deliver their own service schemes unless otherwise agreed by the Partners. For the avoidance of doubt, the Council shall be entitled to retain any underspend that arises from the contracts It enters into for the delivery of services for this Individual Scheme and the ICB shall be entitled to retain any underspend that arises from the contracts it enters into for the delivery of services for this Individual Scheme unless otherwise agreed by the Partners.

The Host Partner will be responsible for the accounts and audit of the Pooled Fund arrangements and shall appoint an officer who will be Pooled Fund Manager who will be responsible for managing the Pooled Fund and submitting to the Partners monthly reports, and an annual return, about the income of, and expenditure from, the Pooled Fund and other information by which the Partners can monitor the effectiveness of the Pooled Fund arrangements for this Individual Scheme.

Audit Arrangements

The Host Partner shall arrange for the audit of the accounts of the Pooled Fund. All internal and external auditors and all other persons authorised by the Partners will be given the right of access by them to any document, information or explanation they require from any employee, member of the Partner in order to carry out their duties. This right is not limited to financial information or accounting records and applies equally to premises or equipment used in connection with this Agreement. Access may be at any time without notice, provided there is good cause for access without notice.

Financial Management

Financial management of the Pooled Fund by the Pooled Fund Manager will include:

- financial accountability and governance for implementation of the Better Care Fund;
- ongoing monitoring of performance;
- alignment with planning and budget processes, including the process for areas to review non-elective target which needs reviewing every quarter;

1.9 VAT

The Council and ICB as commissioning organisations shall each let their own contracts for services (as detailed above under the heading "Contracting Arrangements") and each shall pay providers directly and be reimbursed with monies from the Pooled Fund and the Council and ICB will be responsible for applying their own VAT arrangements for payments made to their respective providers using monies from the Pooled Fund.

1.10 GOVERNANCE ARRANGEMENTS FOR THE PARTNERSHIP

The Connecting Care Executive (which is the Partnership Board) will be the body that reviews this Individual Scheme and the governance arrangements for the Partnership Board are set out Schedule 2 of the Agreement.

The Connecting Care Executive reports to the Health and Wellbeing Board. The Senior Responsible Officers (The Chief Officer of the ICB and the Service Director – Older People and Physical Disabilities of the Council) will report to the Health and Wellbeing Board in respect of this Individual Scheme.

1.11 ASSURANCE AND MONITORING

This will be implemented in three key ways;

- 1) By a Connecting Care Assurance Framework, which provides a suite of indicators under each outcome. These will give the Connecting Care Executive and the Health and Wellbeing Board a high level strategic picture of what is happening across the Wakefield District and will be reported quarterly. Public Health is co-ordinating the lead reporting this Assurance Framework to the Connecting Care Executive.
- 2) A set of key performance indicators, decided by the integrated care team and based on the patient pathway, which will monitor the operational elements of the integrated care teams. Outlined in schedule 5 of this Agreement.
- 3) Our innovative patient engagement model which will carry out interviews with a representative sample of patients/service users on an on-going basis.

The main measures of health gain are:

- Attendances and emergency admissions metrics;
- Length of stay metrics;
- Emergency re-admissions;
- Delayed transfers of care;
- Re-ablement provision;
- Permanent admissions to residential and nursing care homes; and
- Qualitative interviews with staff to explore their perceptions of changes in health gain.

1.12 LEAD OFFICERS

Partner	Name of Lead Officer	Address	Telephone Number	Email Address	Fax Number
Council	Angela Hemingway	Wakefield Council County Hall Bond Street Wakefield WF1 2QW	01924 303782	angelahemingway@wakefield.gov.uk	n/a
ICB	Melanie Brown	NHS West Yorkshire Integrated Care Board White Rose House West Parade Wakefield WF1 1LT	01924 317776	Melanie.brown18@nhs.net	n/a

1.13 INTERNAL APPROVALS

The ICB and Council have approved the Partnership Agreement (including this Individual Scheme).

1.14 RISK AND BENEFIT SHARE ARRANGEMENTS

The risk and benefit share arrangements for this Individual Scheme are set out in this Scheme Specification for this Individual Scheme and in Schedule 3 of the Agreement.

1.15 REGULATORY REQUIREMENTS

Care Quality Commission regulations should be followed for all NHS commissioned services.

1.16 INFORMATION SHARING AND COMMUNICATION

The information/data sharing arrangements are set out in schedule 4 of the Agreement and each Partner shall bear their own costs in sharing information to the other Partner.

The Connecting Care Executive will have a cross sector communications and engagement workstream which will implement a communications and engagement plan. This will be approved by the Connecting Care Executive.

1.17 DURATION

This Individual Scheme shall be for one year commencing on 1st April 2025 and shall expire automatically on 31st March 2026, unless it is extended or terminated earlier by mutual agreement of the Partners.

2. WHOLE POPULATION PREVENTION

2.1 OVERVIEW OF INDIVIDUAL SERVICE

Name of Individual Scheme: Whole Population Prevention

Pooled Fund: Yes. The Host Partner for the Pooled Fund is the ICB and the Pooled Fund Manager, being an officer of the Host Partner is Melanie Brown, Director of System Reform and Integration.

2.2 AIMS AND OUTCOMES

The aim of this scheme is improving the lifestyle and well-being of the population across Wakefield District, through a range of integrated prevention services. The scheme aims to improve the sustainability of the health and social care sector via delivery of statutory social care prevention

services that reduce upstream pressure on other services and are integrated with our partners. The funding is aligned through statutory services such as Disabled Facilities Grant, Adaptations and Assistive Technology.

2.3 THE ARRANGEMENTS

Joint (Aligned) Commissioning arrangements and the establishment of a Pooled Fund.

2.4 FUNCTIONS

No delegation of either the Council's Health Related Functions to the ICB or of the ICB's NHS Functions to the Council will be applied for the commissioning of this Individual Scheme.

2.5 SERVICES

Model of Care and Support

The model of care will be delivered via a number of services including:

- The Disabled Facilities Grant is included in this scheme.
- Assistive technology is included to enhance home adaptations and support home based care.
- Wakefield Adaptations team and equipment is included which sits alongside the DFG

We are pursuing a programme of development of voluntary sector community anchor organisations focused on areas of highest deprivation. This is to transform our preventative programme to one based on place- based health and wellbeing driven by local communities.

2.6 COMMISSIONING, CONTRACTING, ACCESS

Commissioning Arrangements

Joint (Aligned) commissioning arrangements will be used. The Council and the ICB will operate a Pooled Fund but not delegate the exercise of any functions to each other (but work to 'align' them). The Council and ICB as commissioning organisations shall each let their own contracts for services (as detailed below under the heading "Contracting Arrangements") and each shall pay providers directly and be reimbursed with monies from the Pooled Fund.

Contracting Arrangements

The following contracting arrangements are applicable for this Individual Scheme:

NHS West Yorkshire Integrated Care Board	Wakefield Council
N/a	Disabled Facilities Grant Assistive Technology Adaptations Team and Equipment

The Partners will be responsible for contracting with the Providers of services as outlined above.

Population

The Providers will deliver integrated NHS community health services to individuals registered with a General Practice within the ICB's Wakefield District defined boundaries and in respect of social care services to the population who reside within the boundaries of the Wakefield District (i.e. who pay their Council Tax to Wakefield Council).

Service eligibility

The integrated care programme covers all patients and residents within the Wakefield District focusing on citizens with specific needs, and those who are frail and elderly.

- Individuals eligibility criteria for the service are:
- Individuals must be registered with a Wakefield District GP.
- Individuals who are a resident of Wakefield District and those who are eligible for their needs to be met under the Care Act.
- Consideration will be given to providing access to reablement for people who have moderate support needs through care co-ordination, where this is likely to lead to a reduction in demand for social care services. This may include signposting people to other lower level commissioned preventative services within the voluntary and community sector and universal services.
- Individuals must be over 18 years of age.

Exclusion Criteria

- Individuals who are not a Wakefield District resident will not receive any social care element of the service from the Council, this will be provided by the Local Authority where the individual normally resides. However, the Council will liaise with the relevant local authority for people who are registered with a Wakefield District GP to ensure that their social care needs can be appropriately considered.

- Anyone under 18 years of age

2.7 FINANCIAL CONTRIBUTIONS AND REVENUE FUNDING PAYMENTS BY THE ICB TO THE COUNCIL

Financial Contributions and Spend for Financial Year 2025/26

Financial Year 2025/26

The financial contributions and spend of the Council and ICB for the Financial Year 2025/26 and to the Pooled Fund for this Individual Scheme 2 are set out in Parts 1 and 2 of Annex A of this Schedule 2.

Payment of Revenue Funding by the ICB to the Council for Financial Year 2025/26

The ICB shall pay to the Council the revenue funding for Individual Scheme 2 for the Financial Year 2025/26 as detailed in Part 3 of Annex A of this Schedule 1 monthly in arrears or at such other frequency agreed by the ICB and the Council.

2.8 FINANCIAL GOVERNANCE ARRANGEMENTS

Management of the Pooled Fund

The Host Partner will be responsible for the accounts and audit of the Pooled Fund arrangements and shall appoint an officer who will be the Pooled Fund Manager responsible for managing the Pooled Fund and submitting to the Partners monthly reports, and an annual return, about the income of, and expenditure from, the Pooled Fund and other information by which the Partners can monitor the effectiveness of the Pooled Fund arrangements for this Individual Scheme.

Management of Overspend

The Pooled Fund Manager shall notify the Partners and the Connecting Care Executive as soon as reasonably practicable of any projection of an overspend. Each Partner will have total responsibility for their own overspend which occurs in relation to the contracts (listed in the table under the heading "Contracting Arrangements" in paragraph 2.6 above) each enters into to deliver their own service schemes unless otherwise agreed by the Partners. For the avoidance of doubt, the Council shall be solely responsible for financing any overspend that occurs from the contracts it enters into for the delivery of services for this Individual Scheme and the ICB will be solely responsible for financing any overspend that occurs from the contracts it enters into for the delivery of services for this Individual Scheme unless otherwise agreed by the Partners.

Management of Underspend

The Pooled Fund Manager shall notify the Partners and the Connecting Care Executive as soon as reasonably practicable of any projection of an underspend. Each Partner shall be entitled to retain any underspend which occurs from the contracts (listed in the table under the heading "Contracting Arrangements" in paragraph 2.6 above) each enters into to deliver their own service schemes unless otherwise agreed by the Partners. For the avoidance of doubt, the Council shall be entitled to retain any underspend that arises from the contracts it enters into for the delivery of services for this Individual Scheme and the ICB shall be entitled to retain any underspend that arises from the contracts it enters into for the delivery of services for this Individual Scheme unless otherwise agreed by the Partners.

Audit Arrangements

The Host Partner shall arrange for the audit of the accounts of the Pooled Fund. All internal and external auditors and all other persons authorised by the Partners will be given the right of access by them to any document, information or explanation they require from any employee, member of the Partner in order to carry out their duties. This right is not limited to financial information or accounting records and applies equally to premises or equipment used in connection with this Agreement. Access may be at any time without notice, provided there is good cause for access without notice.

Financial Management

Financial management of the Pooled Fund will be the responsibility of the Host Partner and the appointment of a Pooled Fund Manager to oversee the management of the Pooled Fund and produce monthly reports and annual return. This will include:

- financial accountability and governance for implementation of the Better care Fund;
- ongoing monitoring of performance;
- alignment with planning and budget processes, including the process for areas to review non-elective target which needs reviewing every quarter;

2.9 VAT

The Council and ICB as commissioning organisations shall each let their own contracts for services (as detailed above under the heading "Contracting Arrangements") and each shall pay providers directly and be reimbursed with monies from the Pooled Fund and the Council and ICB will be responsible for applying their own VAT arrangements for payments made to their respective providers using monies from the Pooled Fund.

2.10 GOVERNANCE ARRANGEMENTS FOR THE PARTNERSHIP

The Connecting Care Executive (which is the Partnership Board) will be the body that reviews this Individual Scheme and the governance arrangements for the Partnership Board are set out in schedule 2 of the Agreement.

The Connecting Care Executive reports to the Health and Wellbeing Board. The Senior Responsible Officers (The Chief Officer of the ICB and the Service Director – Adult Social Care) will report to the Health and Wellbeing Board in respect of this Individual Scheme.

2.11 NON FINANCIAL RESOURCES

Not applicable

2.12 ASSURANCE AND MONITORING

This will be implemented in three key ways;

- 1) By a Connecting Care Assurance Framework, which provides a suite of indicators under each outcome. These will give the Connecting Care Executive and the Health and Wellbeing Board a high level strategic picture of what is happening across the Wakefield District and will be reported quarterly. Public Health are co-ordinating the lead reporting this Assurance Framework to the Connecting Care Executive.
- 2) A set of key performance indicators, decided by the integrated care team and based on the patient pathway, which will monitor the operational elements of the integrated care teams. Outlined in schedule 5 of this agreement.
- 3) Our innovative patient engagement model which will carry out interviews with a representative sample of patients/service users on an on-going basis.

The main measures of health gain are:

- Attendances and emergency admissions metrics;
- Length of stay metrics;
- Emergency re-admissions;
- Delayed transfers of care;
- Re-ablement provision;
- Permanent admissions to residential and nursing care homes; and
- Qualitative interviews with staff to explore their perceptions of changes in health gain.

2.13 LEAD OFFICERS

Partner	Name of Lead Officer	Address	Telephone Number	Email Address	Fax Number
Council	Angela Hemingway	Wakefield Council County Hall Bond Street Wakefield WF1 2QW	01924 303782	angelahemingway@wakefield.gov.uk	n/a
ICB	Melanie Brown	NHS West Yorkshire Integrated Care Board White Rose House West Parade Wakefield WF1 1LT	01924 317776	Melanie.brown18@nhs.net	n/a

2.14 INTERNAL APPROVALS

The ICB and Council have approved the Partnership Agreement (including this Individual Scheme).

2.15 RISK AND BENEFIT SHARE ARRANGEMENTS

The risk and benefit share arrangements are set out in this Scheme Specification for this Individual Scheme and Schedule 3 of the Agreement.

2.16 REGULATORY REQUIREMENTS

Care Quality Commission regulations will be followed for all NHS commissioned services.

2.17 INFORMATION SHARING AND COMMUNICATION

The Information/data sharing arrangements are set out in schedule 4 of the Agreement and each Partner shall bear their own costs in sharing information to the other Partner.

The Connecting Care Executive will have a cross sector communications and engagement workstream which will implement a communications and engagement plan. This will be approved by the Connecting care Executive.

2.18 DURATION

This Individual Scheme shall be for one year commencing on 1st April 2025 and shall expire automatically on 31st March 2026, unless it is extended or terminated earlier by mutual agreement of the Partners.

3. COMMUNITY SOLUTIONS

3.1 OVERVIEW OF INDIVIDUAL SERVICE

Name of Individual Scheme: Community Solutions

Pooled Fund: Yes. The Host Partner for the Pooled Fund is the ICB and the Pooled Fund Manager, being an officer of the Host Partner is Melanie Brown, Director of System Reform and Integration.

3.2 AIMS AND OUTCOMES

Focusing on wider determinants of health, social capital, community assets and supporting our citizens holistically. This includes a number of voluntary community sector (VCS) organisations including the work of Age UK Wakefield to help our community home from hospital when they are medically fit to be discharged. We recognise that health care is only one factor contributing to health and wellbeing – others include environment, poverty, education and employment. Improving population health requires collective action across different sectors to act on these wider determinants of health and this scheme is focused on these.

3.3 THE ARRANGEMENTS

Joint (Aligned) Commissioning arrangements and the establishment of a Pooled Fund

3.4 FUNCTIONS

No delegation of either the Council's Health Related Functions to the ICB or of the ICB's NHS Functions to the Council will be applied for the commissioning of this Individual Scheme.

3.5 SERVICES

Model of Care and Support

The model of care is focused on aligning funding to a variety of VCS sector initiatives to develop social capital. An example is Age UK Wakefield's "hospital to home" service is best described as a non-medical model for patients that are stable and fit to return to their place of residence from the urgent care departments. The key outcome of the service is to ensure that all patients are managed effectively in an integrated way and risks anticipated thereby reducing the risk of complications.

People may require transport and some basic 1:1 care, such as food and drink preparation, contacting family, ensuring house warm, food in the fridge etc. This is fast becoming an established pathway, covering 7 days a week with the numbers of referrals rising. Support once home can be short term or longer term (with signposting to other voluntary and statutory services via the hubs) if necessary.

The team also delivers Supported Discharge and work specifically on the Elderly care wards. This scheme also includes our district social prescribing offer –or social well-being service that improves the wellbeing of the population, to reduce social isolation, increase independence, and empower clients to self-manage their conditions. This includes elements of social wellbeing assessment, self-management, referral to lifestyle and specialist services and third sector support for small initiatives.

3.6 COMMISSIONING, CONTRACTING, ACCESS

Commissioning Arrangements

Lead commissioning and Joint (Aligned) commissioning arrangements will be used. For majority of this scheme the Council and the ICB will operate a Pooled Funds but not delegate the exercise of any functions to each other (but work to 'align' them). The Council and ICB as commissioning organisations shall each let their own contracts for services (as detailed below under the heading "Contracting Arrangements") and each shall pay providers directly and be reimbursed with monies from the Pooled Fund.

With exception of one area where the Council will be lead commissioner this is for VCS input into the Connecting Care Hubs for both Age UK and Carers Wakefield and District. The Council will act as the lead commissioner for this aspect of the scheme and ICB will pool funds with the Council to commission these services for the Connecting Care Hubs. The Council will draw down from the Pooled Fund to pay for the services provided by both Age UK and Carers Wakefield and District for the Connecting Care Hubs.

Contracting Arrangements

The following contracting arrangements are applicable for this Individual Scheme:

NHS West Yorkshire Integrated Care Board	Wakefield Council
Age UK (Hospital to Home)	Adults Social Care Community Services and Management Team (LA provide In house) Voluntary Sector grants as outlined in scheme

The Partners will be responsible for contracting with the Providers of services as outlined above.

Population

The Providers will deliver integrated NHS community health services to individuals registered with a General Practice within the ICB Wakefield District defined boundaries and in respect of social care services to the population who reside within the boundaries of the Wakefield District (i.e. who pay their Council Tax to Wakefield Council).

Service eligibility

The integrated care programme covers all patients and residents within the Wakefield District focusing on citizens with specific needs, and those who are frail and elderly.

- Individuals eligibility criteria for the service are:
- Individuals must be registered with a Wakefield District GP
- Individuals who are a resident of Wakefield District and those who are eligible for their needs to be met under the Care Act.
- Consideration will be given to providing access to reablement for people who have moderate support needs through care co-ordination, where this is likely to lead to a reduction in demand for social care services. This may include signposting people to other lower level commissioned preventative services within the voluntary and community sector and universal services
- Individuals must be over 18 years of age;

Exclusion Criteria

- Individuals who are not a Wakefield District resident will not receive any social care element of the service from the Council, this will be provided by the Council where the individual normally resides.

However, the Council will liaise with the relevant local authority for people who are registered with a Wakefield District GP to ensure that their social care needs can be appropriately considered.

- Anyone under 18 years of age

3.7 FINANCIAL CONTRIBUTIONS AND REVENUE FUNDING PAYMENTS BY THE ICB TO THE COUNCIL

Financial Contributions and Spend for Financial Year 2025/26

Financial Year 2025/26

The financial contributions and spend of the Council and ICB for the Financial Year 2025/26 to the Pooled Fund for this Individual Scheme 3 are set out in Parts 1 and 2 of Annex A of this Schedule 1.

Payment of Revenue Funding by the ICB to the Council for Financial Year 2025/26

The ICB shall pay to the Council the revenue funding for Individual Scheme 1 for the Financial Year 2025/26 as detailed in Part 3 of Annex A of this Schedule 1 monthly in arrears or at such other frequency agreed by the ICB and the Council.

3.8 FINANCIAL GOVERNANCE ARRANGEMENTS

Management of the Pooled Fund

The Host Partner will be responsible for the accounts and audit of the Pooled Fund arrangements and shall appoint an officer who will be the Pooled Fund Manager responsible for managing the Pooled Fund and submitting to the Partners monthly reports, and an annual return, about the income of, and expenditure from, the Pooled Fund and other information by which the Partners can monitor the effectiveness of the Pooled Fund arrangements for this Individual Scheme.

Management of Overspend

The Pooled Fund Manager shall notify the Partners and the Connecting Care Executive as soon as reasonably practicable of any projection of an overspend. Each Partner will have total responsibility for their own overspend which occurs in relation to the contracts (listed in the table under the heading "Contracting Arrangements" in paragraph 3.6 above) each enters into to deliver their own service schemes unless otherwise agreed by the Partners. For the avoidance of doubt, the Council shall be solely responsible for financing any overspend that occurs from the contracts it enters into for the delivery of services for this Individual Scheme and the ICB will be solely responsible for

financing any overspend that occurs from the contracts it enters into for the delivery of services for this Individual Scheme unless otherwise agreed by the Partners.

Management of Underspend

The Pooled Fund Manager shall notify the Partners and the Connecting Care Executive as soon as reasonably practicable of any projection of an underspend. Each Partner shall be entitled to retain any underspend which occurs from the contracts (listed in the table under the heading "Contracting Arrangements" in paragraph 3.6 above) each enters into to deliver their own service schemes unless otherwise agreed by the Partners. For the avoidance of doubt, the Council shall be entitled to retain any underspend that arises from the contracts it enters into for the delivery of services for this Individual Scheme and the ICB shall be entitled to retain any underspend that arises from the contracts it enters into for the delivery of services for this Individual Scheme unless otherwise agreed by the Partners.

Audit Arrangements

The Host Partner shall arrange for the audit of the accounts of the Pooled Fund. All internal and external auditors and all other persons authorised by the Partners will be given the right of access by them to any document, information or explanation they require from any employee, member of the Partner in order to carry out their duties. This right is not limited to financial information or accounting records and applies equally to premises or equipment used in connection with this Agreement. Access may be at any time without notice, provided there is good cause for access without notice.

Financial Management

Financial management of the Pooled Fund will be the responsibility of the Host Partner and the appointment of a Pooled Fund Manager to oversee the management of the Pooled Fund and produce monthly reports and annual return. This will include:

- financial accountability and governance for implementation of the Better care Fund;
- ongoing monitoring of performance;
- alignment with planning and budget processes, including the process for areas to review non-elective target which needs reviewing every quarter;

3.9 VAT

The Council and ICB as commissioning organisations shall each let their own contracts for services (as detailed above under the heading "Contracting Arrangements") and each shall pay providers directly and be reimbursed with monies from the Pooled Fund and the Council and ICB will be responsible for

applying their own VAT arrangements for payments made to their respective providers using monies from the Pooled Fund.

3.10 GOVERNANCE ARRANGEMENTS FOR THE PARTNERSHIP

The Connecting Care Executive (which is the Partnership Board) will be the body that reviews this Individual Scheme and the governance arrangements for the Partnership Board are set out in schedule 2 of the Agreement.

The Connecting Care Executive reports to the Health and Wellbeing Board. The Senior Responsible Officers (The Chief Officer of the ICB and the Service Director – Older People and Physical Disabilities of the Council) will report to the Health and Wellbeing Board in respect of this Individual Scheme.

3.11 NON FINANCIAL RESOURCES

Not applicable

3.12 ASSURANCE AND MONITORING

This will be implemented in three key ways;

- 1) By a Connecting Care Assurance Framework, which provides a suite of indicators under each outcome. These will give the Connecting Care Executive and the Health and Wellbeing Board a high level strategic picture of what is happening across the Wakefield District and will be reported quarterly. Public Health are co-ordinating the lead reporting this Assurance Framework to the Connecting Care Executive.
- 2) A set of key performance indicators, decided by the integrated care team and based on the patient pathway, which will monitor the operational elements of the integrated care teams. Outlined in schedule 5 of this agreement.
- 3) Our innovative patient engagement model which will carry out interviews with a representative sample of patients/service users on an on-going basis.

The main measures of health gain are:

Attendances and emergency admissions metrics;

- Length of stay metrics;
- Emergency re-admissions;
- Delayed transfers of care;
- Re-ablement provision;

- Permanent admissions to residential and nursing care homes; and
- Qualitative interviews with staff to explore their perceptions of changes in health gain.

3.13 LEAD OFFICERS

Partner	Name of Lead Officer	Address	Telephone Number	Email Address	Fax Number
Council	Angela Hemingway	Wakefield Council County Hall Bond Street Wakefield WF1 2QW	01924 303782	angelahemingway@wakefield.gov.uk	n/a
ICB	Melanie Brown	NHS West Yorkshire Integrated Care Board White Rose House West Parade Wakefield WF1 1LT	01924 317776	Melanie.brown18@nhs.net	n/a

3.14 INTERNAL APPROVALS

The ICB and Council have approved the Partnership Agreement (including this Individual Scheme).

3.15 RISK AND BENEFIT SHARE ARRANGEMENTS

The risk and benefit share arrangements are set out in this Scheme Specification for this Individual Scheme and Schedule 3 of the Agreement.

3.16 REGULATORY REQUIREMENTS

Care Quality Commission regulations will be followed for all NHS commissioned services.

3.17 INFORMATION SHARING AND COMMUNICATION

The Information/data sharing arrangements are set out in Schedule 4 of the Agreement and each Partner shall bear their own costs in sharing information to the other Partner.

The Connecting Care Executive will have a cross sector communications and engagement workstream which will implement a communications and engagement plan. This will be approved by the Connecting care Executive.

3.18 DURATION

This Individual Scheme shall be for one year commencing on 1st April 2025 and shall expire automatically on 31st March 2026, unless it is extended or terminated earlier by mutual agreement of the Partners.

4. MENTAL HEALTH

4.1 OVERVIEW OF INDIVIDUAL SERVICE

Name of Individual Scheme: Mental Health

Pooled Fund: Yes. The Host Partner for the Pooled Fund is the ICB and the Pooled Fund Manager, being an officer of the Host Partner is Melanie Brown, Director of System Reform and Integration.

4.2 AIMS AND OUTCOMES

Focusing on providing quality care to older people with complex care needs focussed on the mental health services and supporting people in the community. This scheme includes all out of hospital mental health services.

4.3 THE ARRANGEMENTS

Joint (Aligned) Commissioning arrangements and the establishment of a Pooled Fund

4.4 FUNCTIONS

No delegation of either the Council's Health Related Functions to the ICB or of the ICB's NHS Functions to the Council will be applied for the commissioning of this Individual Scheme.

4.5 RISK AND BENEFIT SHARE ARRANGEMENTS

The risk and benefit share arrangements are set out in this Scheme Specification for this Individual Scheme and Schedule 3 of the Agreement.

4.6 SERVICES

Model of Care and Support

Joint working between SWYFT and the Council enable a full health and social care assessment and interventions provided by both organisations for each and every older person identified with needs. The mental health services include Mental Health Commissioned placements, Community Mental Health Teams and Older Peoples Teams, Carer's needs are also addressed and the focus is always on recovery and independence.

For individuals and their carers living with dementia, a wealth of joined up services exist to support them both at diagnosis and post diagnostic stage including but not limited to; Connecting Care teams, practice nurses, GPs, community staff, befrienders and the voluntary sector.

4.6 COMMISSIONING, CONTRACTING, ACCESS

Commissioning Arrangements

Joint (Aligned) commissioning arrangements will be used. The Council and the ICB will operate a Pooled Fund but not delegate the exercise of any functions to each other (but work to 'align' them). The Council and ICB as commissioning organisations shall each let their own contracts for services (as detailed below under the heading "Contracting Arrangements") and each shall pay providers directly and be reimbursed with monies from the Pooled Fund.

Contracting Arrangements

The following contracting arrangements are applicable for this Individual Scheme:

NHS WEST YORKSHIRE ICB'S CONTRACTING ARRANGEMENTS , including but not limited to:

ADVITAM LTD

AIREDALE NHS FT

AMBULNZ COMMUNITY PARTNERS LTD

AMVALE MEDICAL TRANSPORT LTD

BARNSELY METROPOLITAN BC

BRADFORD DIST CARE NHS FT

CAMBIAN HEALTHCARE LTD

CARE IN MIND LTD

CHESH/WIRRAL PART NHSFT

CORNWALL PARTSHIP NHS FT

COV/WARWICK PART TRUST

CUMBRIA NORTHUMBERLAND TYNE AND WEAR NHS FOUNDATION TRUST

CYGNET BEHAVIOURAL HEALTH LTD

CYGNET HEALTHCARE LTD

DEAF4DEAF LTD

DEARNEVALE HEALTH CARE LTD

DISABILITIES TRUST

EAST LONDON NHS FOUNDATION TRUST

ELYSIUM HEALTHCARE LTD

FAIRBURN MEWS HEALTH CARE LTD

FAIRWINDS HEALTH CARE LTD

FORTIS CARE

GARY BRIDGEWATER

G-MAP SERVICES LTD

GREATER MANCHESTER MENTAL HEALTH NHS FOUNDATION TRUST

HATZFELD CARE LTD

HC ONE LTD

HEATHCOTES CARE LTD

HEATHCOTES LTD

HUMBER TEACHING NHS FOUNDATION TRUST

IDEAL CAREHOMES (NUMBER ONE) LTD

INCLUSION NORTH CIC

INMIND LTD

IVY COTTAGE ACKTON LTD

IVY DENE

JS CARE LTD

LANCASHIRE & SOUTH CUMBRIA NHS FOUNDATION TRUST

LANCASHIRE CARE NHS FOUNDATION TRUST

LANGLEY HOUSE TRUST

LEEDS & YORK PARTNERSHIP NHS FOUNDATION TRUST

LEICESTERSHIRE PARTNERSHIP NHS TRUST

MID YORKSHIRE HOSPITALS NHS TRUST

MIDLANDS PARTNERSHIP NHS FOUNDATION TRUST

MILLENNIUM CARE SERVICES LTD

NAVIGO

NHS GREATER HUDDERSFIELD ICB

NHS SOUTH WEST LINCOLNSHIRE ICB

NORTHUMBERLAND TYNE AND WEAR NHS FOUNDATION TRUST

ONE-OFF SUPPLIER

OXFORD HEALTH NHS FOUNDATION TRUST

OXLEAS NHS FOUNDATION TRUST

PARTNERSHIPS IN CARE LTD

PENNINE CARE NHS FOUNDATION TRUST

ROTHERHAM DONCASTER & SOUTH HUMBER MENTAL HEALTH NHS FOUNDATION TRUST

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

SANDAL RUGBY CLUB

SHEFFIELD HEALTH & SOCIAL CARE NHS FOUNDATION TRUST

SHORT GROUND LTD

SOMERSET PARTNERSHIP NHS FOUNDATION TRUST

SOUTH LONDON AND MAUDSLEY NHS FOUNDATION TRUST

SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST

SUN HEALTHCARE LTD

SUSSEX PARTNERSHIP NHS FOUNDATION TRUST

TEES ESK & WEAR VALLEYS NHS FOUNDATION TRUST

TRUST CARE LTD

TURNING POINT (SERVICES) LTD

UNIVERSITY OF BOLTON

VIVID RESOURCING LTD

WAKEFIELD COUNCIL

WDH LTD

WEST LONDON NHS TRUST

COUNCIL'S CONTRACTING ARRANGEMENTS:-

ADULTS SOCIAL CARE COMMUNITY SERVICES AND MANAGEMENT TEAM (COUNCIL TO PROVIDE IN-HOUSE)

Each Partner will be responsible for contracting with the Providers of services as outlined above.

Population

The Providers will deliver integrated NHS community health services to individuals registered with a General Practice within the ICB Wakefield District defined boundaries and in respect of social care services to the population who reside within the boundaries of the Wakefield District (i.e. who pay their Council Tax to Wakefield Council).

Service eligibility

The integrated care programme covers all patients and residents within the Wakefield District focusing on citizens with specific needs, and those who are frail and elderly.

- Individuals eligibility criteria for the service are:
- Individuals must be registered with a Wakefield District GP
- Individuals who are a resident of Wakefield District and those who are eligible for their needs to be met under the Care Act.
- Consideration will be given to providing access to reablement for people who have moderate support needs through care co-ordination, where this is likely to lead to a reduction in demand for social care services. This may include signposting people to other lower level commissioned preventative services within the voluntary and community sector and universal services
- Individuals must be over 18years of age;

Exclusion Criteria

- Individuals who are not a Wakefield District resident will not receive any social care element of the service from the Council, this will be provided by the Local Authority where the individual normally resides. However, the Council will liaise with the relevant local authority for people who are registered with a Wakefield District GP to ensure that their social care needs can be appropriately considered.
- Anyone under 18 years of age

4.7 FINANCIAL CONTRIBUTIONS AND REVENUE FUNDING PAYMENTS BY THE ICB TO THE COUNCIL

Financial Year 2025/26

The financial contributions and spend of the Council and ICB for the Financial Year 2025/26 to the Pooled Fund for this Individual Scheme 4 are set out in Parts 1 and 2 of Annex A of this Schedule 1.

Payment of Revenue Funding by the ICB to the Council for Financial Year 2025/26

The ICB shall pay to the Council the revenue funding for Individual Scheme 4 for the Financial Year 2025/26 as detailed in Part 3 of Annex A of this Schedule 1 monthly in arrears or at such other frequency agreed by the ICB and the Council.

4.8 FINANCIAL GOVERNANCE ARRANGEMENTS

Management of the Pooled Fund

The Host Partner will be responsible for the accounts and audit of the Pooled Fund arrangements and shall appoint an officer who will be the Pooled Fund Manager responsible for managing the Pooled Fund and submitting to the Partners monthly reports, and an annual return, about the income of, and expenditure from, the Pooled Fund and other information by which the Partners can monitor the effectiveness of the Pooled Fund arrangements for this Individual Scheme.

Management of Overspend

The Pooled Fund Manager shall notify the Partners and the Connecting Care Executive as soon as reasonably practicable of any projection of an overspend. Each Partner will have total responsibility for their own overspend which occurs in relation to the contracts (listed in the table under the heading "Contracting Arrangements" in paragraph 4.6 above) each enters into to deliver their own service schemes unless otherwise agreed by the Partners. For the avoidance of doubt, the Council shall be solely responsible for financing any overspend that occurs from the contracts it enters into for the delivery of services for this Individual Scheme and the ICB will be solely responsible for financing any overspend that occurs from the contracts it enters into for the delivery of services for this Individual Scheme unless otherwise agreed by the Partners.

Management of Underspend

The Pooled Fund Manager shall notify the Partners and the Connecting Care Executive as soon as reasonably practicable of any projection of an underspend. Each Partner shall be entitled to retain any underspend which occurs from the contracts (listed in the table under the heading "Contracting Arrangements" in paragraph 4.6 above) each enters into to deliver their own service schemes unless otherwise agreed by the Partners. For the avoidance of doubt, the Council shall be entitled to retain any underspend that arises from the contracts it enters into for the delivery of services for this Individual Scheme and the ICB shall be entitled to retain any underspend that arises from the contracts it enters into for the delivery of services for this Individual Scheme unless otherwise agreed by the Partners.

Audit Arrangements

The Host Partner shall arrange for the audit of the accounts of the Pooled Fund. All internal and external auditors and all other persons authorised by the Partners will be given the right of access by them to any document, information or explanation they require from any employee, member of the Partner in order to carry out their duties. This right is not limited to financial information or accounting records and applies equally to premises or equipment used in connection with this

Agreement. Access may be at any time without notice, provided there is good cause for access without notice.

Financial Management

Financial management of the Pooled Fund will be the responsibility of the Host Partner and the appointment of a Pooled Fund Manager to oversee the management of the Pooled Fund and produce monthly reports and annual return. This will include:

- financial accountability and governance for implementation of the Better Care Fund;
- ongoing monitoring of performance;
- alignment with planning and budget processes, including the process for areas to review non- elective target which needs reviewing every quarter;

4.9 VAT

The Council and ICB as commissioning organisations shall each let their own contracts for services (as detailed above under the heading "Contracting Arrangements") and each shall pay providers directly and be reimbursed with monies from the Pooled Fund and the Council and ICB will be responsible for applying their own VAT arrangements for payments made to their respective providers using monies from the Pooled Fund.

4.10 GOVERNANCE ARRANGEMENTS FOR THE PARTNERSHIP

The Connecting Care Executive (which is the Partnership Board) will be the body that reviews this Individual Scheme and the governance arrangements for the Partnership Board are set out in schedule 2 of the Agreement.

The Connecting Care Executive reports to the Health and Wellbeing Board. The Senior Responsible Officers (The Chief Officer of the ICB and the Service Director – Older People and Physical Disabilities of the Council) will report to the Health and Wellbeing Board in respect of this Individual Scheme.

4.11 NON FINANCIAL RESOURCES

Not applicable

4.12 ASSURANCE AND MONITORING

This will be implemented in four key ways;

- 1) By a Connecting Care Assurance Framework, which provides a suite of indicators under each outcome. These will give the Connecting Care Executive and the Health and Wellbeing Board a high level strategic picture of what is happening across the Wakefield District and will be reported

quarterly. Public Health are co-ordinating the lead reporting this Assurance Framework to the Connecting Care Executive.

- 2) An independent, longitudinal evaluation covering quantitative and qualitative data and including staff and patient perspectives. This evaluation is also embedding a cost-effectiveness study.
- 3) A set of key performance indicators, decided by the integrated care team and based on the patient pathway, which will monitor the operational elements of the integrated care teams. Outlined in schedule 5 of this agreement.
- 4) Our innovative patient engagement model which will carry out interviews with a representative sample of patients/service users on an on-going basis.

The main measures of health gain are:

- Length of stay metrics;
- Emergency re-admissions;
- Delayed transfers of care;
- Re-ablement provision;
- Permanent admissions to residential and nursing care homes; and
- Qualitative interviews with staff to explore their perceptions of changes in health gain.

4.13 LEAD OFFICERS

Partner	Name of Lead Officer	Address	Telephone Number	Email Address	Fax Number
Council	Angela Hemingway	Wakefield Council County Hall Bond Street Wakefield WF1 2QW	01924 303782	angelahemingway@wakefield.gov.uk	n/a
ICB	Melanie Brown	NHS West Yorkshire Integrated Care Board	01924 317776	Melanie.brown18@nhs.net	n/a

		White Rose House			
		West Parade Wakefield			
		WF1 1LT			

4.14 INTERNAL APPROVALS

The ICB and Council have approved the Partnership Agreement (including this Individual Scheme).

RISK AND BENEFIT SHARE ARRANGEMENTS

The risk and benefit share arrangements are set out in this Scheme Specification for this Individual Scheme and Schedule 3 of the Agreement.

4.16 REGULATORY REQUIREMENTS

Care Quality Commission regulations will be followed for all NHS commissioned services.

4.17 INFORMATION SHARING AND COMMUNICATION

The Information/data sharing arrangements are set out in Schedule 4 of the Agreement and each Partner shall bear their own costs in sharing information to the other Partner.

The Connecting Care Executive will have a cross sector communications and engagement workstream which will implement a communications and engagement plan. This will be approved by the Connecting care Executive.

4.18 DURATION

This Individual Scheme shall be for one year commencing on 1st April 2025 and shall expire automatically on 31st March 2026, unless it is extended or terminated by mutual agreement of the Partners.

5. INTEGRATED COMMUNITY EQUIPMENT SERVICE AND WHEELCHAIR SERVICE

5.1 OVERVIEW OF INDIVIDUAL SERVICE

Name of Individual Scheme: Integrated Community Equipment Service and Wheelchair Service

Context and Background: The model will deliver integrated service provision ensuring that community equipment is coordinated and distributed effectively, ensuring early supported discharge and potentially unnecessary admission to hospital. Supporting individuals to be in control of their care and independence for longer and their carers to care for longer. Central to this will be the principle of supporting people to self-care and manage their own conditions by providing them with the essential equipment to ensure they can be cared from home in the community.

Since 2nd December 2019 people who access wheelchair service, where postural and mobility needs impact their wider health and social care needs, and meet the eligibility criteria, have a legal right to Personal Wheelchair Budget (PWB). Additionally this covers people who are already registered with the wheelchair service, when they require a new wheelchair either through change in clinical needs or in the condition of the chair

Pooled Fund: Yes. The Host Partner for the Pooled Fund for the Integrated Community Equipment Service and Wheelchair service is the Council and the Pooled Fund Manager, being an officer of the Host Partner is Nichola Esmond, Service Director – Older People and Physical Disabilities.

5.2 AIMS AND OUTCOMES

Our overall aims for this integrated service for children, young people and older people and vulnerable adults are that:

- Care is co-ordinated and seamless
- Nobody is kept in hospital or residential care unnecessarily;
- People are supported and in control of their condition and live, enjoying independence for longer;
- Care is cost-effective and within available budgets;
- All staff understand the system and work in it effectively;

5.3 THE ARRANGEMENTS

Lead Commissioning arrangements with the Council acting as Lead Commissioner and the establishment of a Pooled Fund which the Council will be the Host Partner and nominate the Pooled Fund Manager.

5.4 FUNCTIONS

The ICB delegates to the Council and the Council agrees to exercise on the ICB's behalf the NHS Functions, in conjunction with the Health Related Functions for the purpose of commissioning and delivering the integrated community equipment and wheelchair service.

5.5 SERVICES

Integrated Community Equipment Service (ICES)

The service is available Monday to Friday between 8.30-17.00 hours. It operates from Unit 10, Trinity Business Park, Turner Way, Wakefield, WF2 8EF premises shared with TEC Wheelchair Services.

Referrals from Healthcare Professionals for equipment can be either made on-line or on a paper referral. The service supplies equipment to people and their carers living in the community who are assessed and meet eligibility guidelines for aids to daily living or require nursing at home. Equipment is provided as a free loan for as long as it is needed. The Service supplies the following:

- Aids to daily living:
- Toileting equipment, i.e. raised toilet seats and toilet surrounds
- Bathing equipment, i.e. bath lifts, shower chairs Kitchen equipment, i.e. trolleys and perching stools Lounge equipment, i.e. chair raisers
- Moving and handling equipment, i.e. hoists and slings
- Nursing:
- Pressure relief, i.e. Dynamic air mattresses and foam mattresses Fully profiling community beds
- Commodes
- Moving and handling equipment, i.e. slide sheets.
- Equipment is maintained as necessary whilst on loan to the client, this ensures that the service not only has a full service history but is fully compliant with all relevant legislation including but not limited to the lifting Operations and Lifting equipment Regulations 1998.

Once the service is notified that the equipment is no longer required it is collected, decontaminated and inspected prior to repackaging where appropriate or scrapping.

Additionally the service has several satellite stores throughout the district accessible to Healthcare Professionals.

The service provided encompasses all activities associated with the supply of equipment to patients/service users to include:

- Administration/processing referrals
- Procurement
- Warehousing and stock control
- Delivery and collection

- Fitting, installation and demonstration of equipment (where appropriate)
- Maintenance, cleaning and recycling of equipment Exclusion criteria
- The service is not commissioned to supply low level equipment e.g. tap turners, long handles shoe horns, etc.
- The service will not provide health equipment to patients registered with a GP outside of the Wakefield ICB area unless NHS responsible commissioner rules apply.
- The service does not provide equipment into private nursing homes

Out of hour emergency service is provided by Sidhel through single point of contact and they will only provide the following items in an emergency:

Bed

Foam Mattress

Siderails/Bumpers

Commode. Static/Glideabout

Hoist and Sling

Dynamic Mattress

Dynamic Cushion

Gel Cushion

Foam Cushion

Bed Extension

Mattress Infills

Suction Machines

Wheel Chair Service

The service is delivered in line with the ICB's service specification .

The service is available Monday to Friday between 8.30-17.00 hours. The service holds clinics at Unit, 10 Trinity Business Park, Turner Way, Wakefield, WF2 8EF premises shared with the Integrated Community Equipment Service. They also provide prison, home and hospital visits. The service receives referrals from Healthcare Professionals e.g. GP's, Hospital Consultants, Physiotherapists, etc.

for a wheelchair assessment. The overarching objectives expected of the service are to deliver the markers of good practice for a comprehensive service, namely:

- A person-centred service that works in partnership with patients and their Carers and makes their voice central to any design, innovation and service change
- To ensure that clients are assessed by an appropriate therapist and issued with an appropriate wheelchair, seating; postural and pressure care equipment to meet their and their carer's needs in a timely and accessible manner;
- To respond to the changing medical needs of wheelchair users with provision of different wheelchairs when required;
- To support GPs and other healthcare professionals by providing assessment for the provision of wheelchairs;
- To ensure that communications with referring healthcare professionals are established and maintained;
- To ensure that a telephone advice and guidance service is available to clients and healthcare professionals;
- To ensure that protocols for referral are regularly updated and communicated between all agencies;
- Contribution of wheelchair service to other health and social care priorities such as reduction of hospital admission rate, delayed discharge, reduction in care services etc.

The service provided encompasses all activities associated with a Wheelchair Service to include:

- Administration and clinic management
- Triage
- Clinical assessment and review process
- Procurement
- Stock control
- Arranging delivery and collection of equipment
- Demonstration and training with regard to new equipment on the market including wheelchairs e.g. Electric powered chairs
- Contract monitoring approved repairer contract
- Liaise with Yorkshire Ambulance Service as and when required.

The service currently holds a contract with Ross Care Leeds for an approved repair and maintenance service. The contract also requires Ross Care to hold up to 500 wheelchair service stock and to refurbish/recycle wheelchairs for re-issue and to provide an out of hours emergency service of the Wakefield Wheelchair Service.

Equipment is provided as a free loan for as long as it is needed. Equipment supplied is from the range of contracted suppliers, with preferred suppliers determined locally by the Service within the best value framework and is reviewed regularly by the service. The range of equipment on offer has been selected to balance the requirement to meet clinically assessed needs with effective use of resources. It is also designed to allow better product knowledge to be maintained.

The Service supplies the following for adults or children,

- Manual (non-powered) wheelchairs,
- Electrically powered wheelchairs suitable for indoor use only (EPICs),
- Electrically powered wheelchairs for indoor-outdoor use (EPIOCs),
- For children only, the Service also supplies specialist attendant pushed buggies
- Postural and Special Seating
- Pressure relieving cushions
- Wheelchair accessories are supplied where the Service has assessed and identified clinical need.

In order to maximise use of available resources and recycling; a wheelchair will be issued on loan to the user from the current stock wherever possible irrespective of its age. If no appropriate stock is available a new wheelchair will be purchased.

Although user/carer preference is taken into consideration, equipment is issued to meet clinical need. Alternatives may be available through the NHS Personal Wheelchair Scheme.

Exclusion criteria

- The service does not provide wheelchairs to residential or nursing homes for general portering and moving and handling use.
- They do not provide a wheelchair to an individual whose use will be less than three times per week every week and not determined by the reliance of relatives or carers occasional visits
- A wheelchair will not be issued in place of a static chair where the latter would be more appropriate to the User's clinically assessed need or assessment will be undertaken to clarify if any equipment is available on the market which will meet the required outcome.
- The Service does not supply three or four-wheeled scooters, electric buggies or powered wheelchairs for outdoor use only (Also known as EPOCs)
- The Service does not supply all weather clothing, rain covers or sunshades.
- A wheelchair will not be issued to specifically meet sporting requirements
- The Service does not supply wheelchairs for individuals as part of their rehabilitation programme; however assessment will take place when the patient has reached a plateau of

recovery and their discharge destination is known. This will be co-ordinated with the in-patient health care professional once the patient is well enough and an environmental assessment of their final destination can be completed.

Eligibility

Wakefield Wheelchair Service following an assessment and providing the client meets the criteria for provision; will loan wheelchairs, specialist seating, and specialist buggies for children, who have a long-term physical disability that affects their mobility and are therefore unable or virtually unable to walk. It takes into account the needs of carers as appropriate.

The Service is provided for patients registered with a General Practitioner (GP) within the services' catchment area, currently the Wakefield District.

Integrated Community Equipment Scheme

The service is for clients registered with a GP in the Wakefield District and /or reside in the Wakefield District boundaries and who are assessed by a healthcare Professional e.g. Community Occupational Therapist, District Nurse, etc., as requiring equipment.

5.6 COMMISSIONING, CONTRACTING, ACCESS

Commissioning Arrangements

Lead Commissioning arrangements will be used. The Council shall be responsible for lead commissioning of the Services on behalf of the Partners. These arrangements will be applicable for one year from 1st April 2025 to 31st March 2026.

Lead Provider of the Services and Contracting Arrangements

The Council is the Lead Provider for the provision of the Services and shall enter into a Service Level Agreement for the provision of the Services.

Population

The Lead Provider will deliver an integrated community equipment service to individuals registered with a Wakefield District GP defined boundaries and in respect of social care services to the population who reside within the boundaries of Wakefield District (i.e. who pay their Council Tax to Wakefield Council).

Service eligibility

The criteria is fully outlined in the specification for the service.

5.7 FINANCIAL CONTRIBUTIONS

Financial Contributions and Spend for Financial Year 2025/26

Financial Year 2025/26

The financial contributions and spend of the Council and ICB for the Financial Year 2025/26 to the Pooled Fund for this Individual Scheme 5 are set out in Parts 1 and 2 of Annex A of this Schedule 1 and Annex B of this Schedule 1.

Payment of Revenue Funding by the ICB to the Council for Financial Year 2025/26

The ICB shall pay to the Council the revenue funding for Individual Scheme 5 for the Financial Year 2025/26 as detailed in Part 3 of Annex A of this Schedule 1 and Annex B of this Schedule 1 monthly in arrears or at such other frequency agreed by the ICB and the Council.

5.8 FINANCIAL GOVERNANCE ARRANGEMENTS

Management of the Pooled Fund

The following arrangements shall apply to the management of the Pooled Fund for this Individual Scheme: There will be monthly financial reporting into the Connecting Care Executive from the Host Partner from April 2023. There will be quarterly performance reporting into the Connecting Care Executive from the Host Partner from April 2023.

Overspends and underspends will be reported to the Connecting Care Executive for a decision to how this will be dealt with across the system.

Year-end audit certification will also take place. The annual return shall be certified in accordance with the requirements of section 75(1)(d) of the Audit Commission Act 1998.

The Host Partner will be responsible for the accounts and audit of the Pooled Fund arrangements and shall appoint an officer the Pooled Fund Manager who will be responsible for managing the Pooled Fund and submitting to the Partners monthly reports, and an annual return, about the income of, and expenditure from, the Pooled Fund and other information by which the Partners can monitor the effectiveness of the Pooled Fund arrangements for this Individual Scheme.

The Pooled Fund Manager shall be responsible for the development and management for the Services on a day to day basis, and also shall:

- oversee and make payments from the Pooled Fund for the Services to either of the Partners or the Lead Provider or to third party service providers; and

- collect and provide to the Council, ICB, the Department of Health or any Government body or agency such information as shall be required to be provided in accordance with any guidance issued by the Better Care Fund Task Force to review monitor and evaluate use of the Pooled Fund and to support the Partners to secure Best Value and Clinical Governance.

Audit Arrangements

The Host Partner shall arrange for the audit of the accounts of the Pooled Fund. All internal and external auditors and all other persons authorised by the Partners will be given the right of access by them to any document, information or explanation they require from any employee, member of the Partner in order to carry out their duties. This right is not limited to financial information or accounting records and applies equally to premises or equipment used in connection with this Agreement. Access may be at any time without notice, provided there is good cause for access without notice.

Financial Management

The Council shall act as Host Partner for the purposes of the Regulations for the Pooled Fund. The Council and ICB will provide the financial administrative systems for the Pooled Fund.

Financial management of the Pooled Fund will be the responsibility of the Host Partner and the appointment of a Pooled Fund Manager to oversee the management of the Pool and produce monthly reports and annual return. This will include:

- financial accountability, governance and monitoring
- ongoing monitoring of performance of the scheme
- submit an annual return and all information required by the Council and ICB to monitor the Pooled Fund
- alignment for Financial Year 2023/24 with 2024/25 planning, Including the process for areas to review
- alignment for Financial Year 2023/24 with 2024/25 planning, Including the process for areas to review

The ICB and the Council agree that monies may not be transferred from one Pooled Fund to another Pooled Fund without the prior written consent of both Partners.

Expenditure can only be committed by persons authorised to do so, and invoices can only be authorised by individuals who are recognised as authorised signatories.

All invoices must be authorised prior to payment, in accordance with the Standing Financial Orders and Instructions of the Council.

5.9 VAT

The Host's VAT arrangements shall be applied to the Pooled Fund. The Council acts as agent for the ICB i.e. funds are paid to the Council and payments are made directly by the Council to providers. VAT is directly recoverable, maximising resources.

5.10 GOVERNANCE ARRANGEMENTS FOR THE PARTNERSHIP

The Connecting Care Executive (which is the Partnership Board) will be the body that reviews this Individual Scheme and the governance arrangements for the Partnership Board are set out in Schedule 2 of the Agreement.

The Connecting Care Executive reports to the Health and Wellbeing Board. The Senior Responsible Officers (The Chief Officer of the ICB and the Service Director – Older People and Physical Disabilities) will report to the Health and Wellbeing Board in respect of this Individual Scheme.

Clinical Supervision and Governance

The Partners agree that the Mid Yorkshire Hospital NHS Trust shall be commissioned by the Council to provide clinical supervision and governance to ensure that the commissioning of the Services and provision of the Services by the Lead Provider complies with relevant clinical governance requirements.

The Council's Pooled Fund Manager shall be responsible for ensuring that the commissioning of the Services and provision of the Services by the Lead Provider and the Pooled Fund fully complies with relevant clinical governance requirements.

A matrix of ICB strategies and policies and the operational policies and procedures will support Clinical Governance at a local level and the Pooled Fund Manager shall ensure compliance with these.

5.11 ASSURANCE AND MONITORING

There will be quarterly monitoring reporting into the Connecting Care Executive from the Host Partner from April 2023.

Wheelchair Service KPIs

- Average waiting time within the 18 week pathway- currently 9 weeks from referral to completion for standard wheelchair provision.
- Other outputs: referral activity, types of assessments, equipment issued, client demographics, discharges from service, number of completed episodes of care.
- Where assessment was complete and equipment was delivered in 18 weeks.
- Total number of clients currently registered with the service.

- The number of new clients referred to the service within the reporting period.
- The number of clients re-referred to the service within the reporting period.
- The number of new clients whose episodes of care was closed in the reporting period and is assessed in different categories of need.
- The number of re-referred clients whose episode of care was closed in the reporting period and is assessed in various categories of need.
- The current expenditure on wheelchair service annually.
- PWB data.

Integrated Community Equipment Scheme- KPIs

Orders received before 11.00am same day delivery (Critical 4 hours)

- Next day delivery (within 24 hours) – delivery next working day by 17:00 hours for orders received up to 17:00 hours.
- Standard delivery – delivery shall be completed by 17:00 hours on the 7th working day after receipt of the order.
- Specialist delivery – longer delivery timescale over and above the standard delivery and agreed with the Prescriber and User (usually for specialist or bespoke equipment).
- Dated delivery - For dated deliveries, the Prescriber shall specify the date that the delivery must be made (usually to support the Prescriber in training the User in the correct use of the equipment).

Other outputs: referral activity, numbers of referrals, numbers of items delivered/collected, recycle rates, equipment rental activity.

The Partners will agree the Performance Indicators for the provision of the Services. The Partners agree that they will provide information to each other and otherwise as necessary in the manner and frequency as set out in any agreed joint Performance Indicators.

General service standards and the annual Service and Financial Plan will be set in accordance with the applicable National Service Framework documents and legislation and guidance produced by the Department of Health and as may be agreed locally by the Partners.

The Partners shall monitor and review the effectiveness of this Individual Scheme against the annual Service and Financial Plan using a range of performance measures including the joint Performance Indicators, Targets and the Service Level Agreement. This shall include annual reports.

The Partners shall each year endeavour to agree the draft Service and Financial Plan and submit the draft to the Connecting care Executive for approval by no later than the 31st March in the Financial Year prior to the Financial Year to which the draft Service and Financial Plan relates.

5.12 LEAD OFFICERS

Partner	Name of Lead Officer	Address	Telephone Number	Email Address	Fax Number
Council	Angela Hemingway	Wakefield Council County Hall Bond Street Wakefield WF1 2QW	01924 303782	angelahemingway@wakefield.gov.uk	n/a
ICB	Melanie Brown	NHS West Yorkshire Integrated Care Board White Rose House West Parade Wakefield WF1 1LT	01924 317776	Melanie.brown18@nhs.net	n/a

5.13 INTERNAL APPROVALS

The ICB and Council have approved the Partnership Agreement (including this Individual Scheme).

5.14 RISK AND BENEFIT SHARE ARRANGEMENTS

The following principles shall be adopted by the Partners and shall be the basis upon which agreement shall be reached between the relevant Partners-for managing financial risk:

Where one Partner's statutory responsibility differs from another, and financial risk arises as a consequence, each Partner shall ensure their financial contribution payments into the Pooled Fund and any Non-Pooled Funds is sufficient to discharge their respective statutory obligations.

Where professional opinion can distinguish services that primarily meet a health or social care objective then such information may be used to determine a Partner's financial contribution and balance of risk. The Connecting Care Executive will have oversight of this decision through the agreed governance arrangements.

Management of Overspend

Whenever an Overspend is projected within the Pooled Fund the Council and ICB shall agree how to manage the Overspend in order to achieve financial balance and the Partners shall keep the position under review. The Partners shall act in good faith and in a reasonable manner in agreeing the management of the Overspend.

The Pooled Fund Manager shall notify the Council and ICB and the Connecting Care Executive immediately of any projection of an Overspend. The Partners shall then prepare a joint plan for the management of the Overspend, where possible, within the financial limits set out in the Source and Application of Funds Statement for the relevant Financial Year.

If at the end of each Financial Year of this Agreement or upon termination of this Individual Scheme there is an Overspend the Partners shall identify the reasons for the Overspend. The Partners may agree that financial resources in the next Financial Year shall be applied in meeting the Overspend. If this is not agreed the Overspend shall be apportioned between the Partners in proportion to each Partner's financial contributions to the Pooled Fund in that Financial Year except where agreed otherwise by the Partners and the Partners shall make such payments to each other to reflect apportionment. The proportion of contribution for Integrated Community Equipment Service (ICES) Scheme by the ICB is 60% of the ICES Scheme pooled budget and 40% for the Council for ICES Scheme. Any resources for the ICES Scheme overspend will be proportioned on the ICES Scheme contribution by both partners.

In the event that agreement cannot be reached in respect of the Overspend, the Partners shall follow the dispute resolution procedure as set out in clause 23. If agreement still cannot be reached, then the Partners may mutually agree to terminate this Individual Scheme.

Management of Underspend.

The Pooled Fund Manager shall notify the Partners and the Connecting Care Executive as soon as reasonably practicable of any projection of an underspend. Whenever an underspend is projected within the Pooled Fund and Partners may agree to the redeployment of that underspend or that money shall be retained as a contingency in the Pooled Fund where the underspending has occurred. In the event that agreement cannot be reached the underspend shall be retained as a contingency until the end of the relevant Financial Year.

Any underspend in relation to any Pooled Fund at the end of a Financial Year or upon termination shall be apportioned between the Partners in proportion to their contributions to the Pooled Fund in that Financial Year and the Partners shall make such payments as are necessary to reflect such apportionment.

The Partners may agree to carry forward any underspend in relation to Pooled Funds or Non-Pooled Funds provided that such carry forward will be in accordance with any relevant statutory or other legal requirement or guidance. If there is an underspend in the Wheelchair service then the Partners may agree, through the Connecting Care Executive, to use such underspend to offset in whole or in part any overspend by the Integrated Community Equipment Service.

5.15 REGULATORY REQUIREMENTS

All equipment purchased meets the requirements of the medical devices directive (MHRA).

5.16 INFORMATION SHARING AND COMMUNICATION

The information/data sharing arrangements are set out in Schedule 4 of the Agreement and each Partner shall bear their own costs in sharing information to the other Partner. The service provides regular monitoring updates (quarterly service overview) this also includes detailed activity for the service. This reporting will continue to the Connecting Care Executive.

The Connecting Care Executive will have a cross sector communications and engagement workstream which will implement a communications and engagement plan. This will be approved by the Connecting Care Executive.

Complaints

In the event of any complaints whatsoever regarding the Services such complaint shall be dealt with pursuant to the Council's complaints procedure.

Ombudsman Complaints

Either Partner shall take such action as is reasonably required from time to time by the other Partner to respond to any complaint referred to the Ombudsman in respect of the Partnership Arrangements.

5.17 DURATION

This Individual Scheme shall be for one year commencing on 1st April 2025 and shall expire automatically on 31st March 2026, unless it is extended or terminated by mutual agreement of the Partners.

6 DISCHARGE GRANT

6.1 . OVERVIEW OF INDIVIDUAL SERVICE

Name of Individual Scheme: Discharge Grant/D2A

Context and Background: This Individual Scheme is funded by the discharge grant provided by government separately to the Council and the ICB and the Council and ICB shall jointly agree the spending plans of the discharge grant to meet the aims and objectives set out in paragraph 6.2 below and to comply with all grant conditions (including use of discharge grant funding, reporting requirements, payment arrangements and financial management) and guidance which the government requires the Council and ICB to each comply with in relation to spending the discharge grant for this Individual Scheme.

Pooled Funds: Yes. The Host Partner for the Pooled Discharge Grant Fund (Pooled Fund) is the ICB and the Pooled Fund Manager, being an officer of the Host Partner is Melanie Brown, Director of System Reform and Integration.

6.2. AIMS AND OBJECTIVES

To build additional adult social care and community-based reablement capacity to reduce hospital discharge delays through delivering sustainable improvements to services for individuals which will support the principles of 'Discharge to Assess', to enable timely discharge from hospital with appropriate short-term support, where needed, pending assessment of long-term care needs.

6.3. THE ARRANGEMENTS

Joint (Aligned) Commissioning arrangements and the establishment of a Pooled Fund.

6.4. FUNCTIONS

No delegation of either the Council's Health Related Functions to the ICB or of the ICB's NHS Functions to the Council will be applied for the commissioning of this Individual Scheme.

6.5. SERVICES

The Council and the ICB will jointly agree the provision of services / service schemes that will be funded by the Pooled Fund and the spending plan for the provision of services / service schemes using the Pooled Fund.

6.6. COMMISSIONING, CONTRACTING, ACCESS

Commissioning Arrangements

Joint (Aligned) commissioning arrangements will be used. The Council and the ICB will operate a Pooled Fund but not delegate the exercise of any functions to each other (but work to 'align' them). The Council and ICB as commissioning organisations shall jointly agree the services / service schemes that each organisation shall deliver itself or let contracts for services to deliver and from the Pooled Fund.

Contracting Arrangements

The Council and ICB shall jointly agree the contracting arrangements that each organisation will be responsible for delivering in respect of this Individual Scheme.

Population

The services delivered under this Individual Scheme will only be provided to individuals registered with a General Practice within the ICB's Wakefield District defined boundary and in respect of social care services to the population who reside within the Wakefield District (i.e. who are liable to pay their Council Tax to the Council).

Service eligibility

The discharge grant programme covers all patients and residents within the Wakefield District focusing on citizens with specific needs, and those who are frail and elderly.

- Individuals eligibility criteria for the service are:
- Individuals must be registered with a Wakefield District GP
- Individuals who are a resident of Wakefield District and those who are eligible for their needs to be met under the Care Act.
- Consideration will be given to providing access to reablement for people who have moderate support needs through care co-ordination, where this is likely to lead to a reduction in demand for social care services. This may include signposting people to other lower level commissioned preventative services within the voluntary and community sector and universal services
- Individuals of all ages;

Exclusion Criteria

- Individuals who are not a Wakefield District resident will not receive any social care element of the service from the Council, this will be provided by the local authority where the individual normally resides. However, the Council will liaise with the relevant local authority for people who are registered with a Wakefield District GP to ensure that their social care needs can be appropriately considered.

6.7. FINANCIAL CONTRIBUTIONS AND REVENUE FUNDING PAYMENTS BY THE ICB TO THE COUNCIL

Financial Contributions and Spend for Financial Year 2025/26

Financial Year 2025/26

The financial contributions and spend of the Council and ICB for the Financial Year 2025/26 for this Individual Scheme are set out in Parts 1 and 2 of Annex A of this Schedule 1.

Payment of Revenue Funding by the ICB to the Council for Financial Year 2025/26

The ICB shall pay to the Council the revenue funding for Individual Scheme 6 for the Financial Year 2025/26 as detailed in Part 3 of Annex A of this Schedule 1 monthly in arrears or at such other frequency agreed by the ICB and the Council.

6.8 FINANCIAL GOVERNANCE ARRANGEMENTS

Management of the Pooled Fund

The following arrangements shall apply to the management of the Pooled Fund for this Individual Scheme:

Management of Overspend

The Pooled Fund Manager shall notify the Partners and the Connecting Care Executive as soon as reasonably practicable of any projection of an overspend. Each Partner will have total responsibility for their own overspend which occurs in relation to the contracts each Partner enters into to deliver services / service schemes or to services / service schemes which each Partner delivers itself, unless otherwise agreed by the Partners. For the avoidance of doubt, the Council shall be solely responsible for financing any overspend that occurs from the contracts it enters into for the delivery of services for this Individual Scheme and any services / service schemes it delivers itself and the ICB will be solely responsible for financing any overspend that occurs from the contracts it enters into for the

delivery of services for this Individual Scheme and any services / service schemes it delivers itself, unless otherwise agreed by the Partners.

Management of Underspend

The Pooled Fund Manager shall notify the Partners and the Connecting Care Executive as soon as reasonably practicable of any projection of an underspend. The Council and ICB shall recycle any underspend back into the Pooled Fund and then agree the re-allocation of that funding from the Pooled Fund to this Individual Scheme.

The Host Partner will be responsible for the accounts and audit of the Pooled Fund arrangements and shall appoint an officer who will be Pooled Fund Manager who will be responsible for managing the Pooled Fund and submitting to the Partners monthly reports, and an annual return, about the income of, and expenditure from, the Pooled Fund and other information by which the Partners can monitor the effectiveness of the Pooled Fund arrangements for this Individual Scheme.

Audit Arrangements

The Host Partner shall arrange for the audit of the accounts of the Pooled Fund. All internal and external auditors and all other persons authorised by the Partners will be given the right of access by them to any document, information or explanation they require from any employee, member of the Partner in order to carry out their duties. This right is not limited to financial information or accounting records and applies equally to premises or equipment used in connection with this Agreement. Access may be at any time without notice, provided there is good cause for access without notice.

Financial Management

Financial management of the Pooled Fund by the Pooled Fund Manager for this Individual Scheme will include:

- financial accountability and governance for implementation of the Better Care Fund;
- compliance with all grant conditions (including use of discharge grant funding, reporting requirements, payment arrangements and financial management) and guidance which the government requires the Council and ICB to each comply with in relation to spending the Pooled Fund for this Individual Scheme;
- ongoing monitoring of performance;
- alignment with planning and budget processes, including the process for areas to review non-elective target which needs reviewing every quarter;

6.9 VAT

The Council and ICB as commissioning organisations shall each let their own contracts for services (as detailed above under the heading "Contracting Arrangements") and each shall pay providers directly and be reimbursed with monies from the Pooled Fund and the Council and ICB will be responsible for applying their own VAT arrangements for payments made to their respective providers using monies from the Pooled Fund.

6.10 GOVERNANCE ARRANGEMENTS FOR THE PARTNERSHIP

The Connecting Care Executive (which is the Partnership Board) will be the body that reviews this Individual Scheme and the governance arrangements for the Partnership Board are set out Schedule 2 of the Agreement.

The Connecting Care Executive reports to the Health and Wellbeing Board. The Senior Responsible Officers (The Chief Officer of the ICB and the Service Director – Older People and Physical Disabilities of the Council) will report to the Health and Wellbeing Board in respect of this Individual Scheme.

6.11 ASSURANCE AND MONITORING

The Council and ICB shall ensure that all assurance and monitoring requirements (including use of discharge grant funding, reporting requirements, payment arrangements and financial management and guidance) which the government requires the Council and ICB to each comply with in relation to spending the Pooled Fund for this Individual Scheme are met.

6.12 LEAD OFFICERS

Partner	Name of Lead Officer	Address	Telephone Number	Email Address	Fax Number
Council	Angela Hemingway	Wakefield Council County Hall Bond Street Wakefield WF1 2QW	01924 303782	angelahemingway@wakefield.gov.uk	n/a

ICB	Melanie Brown	NHS West Yorkshire Integrated Care Board White Rose House West Parade Wakefield WF1 1LT	01924 317776	Melanie.brown18@nhs.net	n/a

6.13 INTERNAL APPROVALS

The ICB and Council have approved the Partnership Agreement (including this Individual Scheme).

6.14 RISK AND BENEFIT SHARE ARRANGEMENTS

The risk and benefit share arrangements for this Individual Scheme are set out in this Scheme Specification for this Individual Scheme and in Schedule 3 of the Agreement.

6.15 REGULATORY REQUIREMENTS

Care Quality Commission regulations should be followed for all NHS commissioned services.

6.16 INFORMATION SHARING AND COMMUNICATION

The information/data sharing arrangements are set out in schedule 4 of the Agreement and each Partner shall bear their own costs in sharing information to the other Partner.

The Connecting Care Executive will have a cross sector communications and engagement workstream which will implement a communications and engagement plan. This will be approved by the Connecting Care Executive.

6.17 DURATION

This Individual Scheme shall be for one year commencing on 1st April 2025 and shall expire automatically on 31st March 2026, unless it is extended or terminated earlier by mutual agreement of the Partners.

Annex A of Schedule 1 - 2025/26

Annex A of Schedule 1 2025/2026

Part 1		Commissioning Intentions						
		Scheme 1	Scheme 2	Scheme 3	Scheme 4	Scheme 5	Scheme 6	TOTAL
BCF Category	Funding Source	Enhanced Care and Supprt (Proactive Care) £'000	Prevention and self Care £'000	Community Solutions £'000	Mental Health £'000	ICES & Wheelchair Service £'000	Discharge £'000	£'000
Assistive Technologies and Equipment	Health Minimum							-
Care Act Implementation Related Duties	Health Minimum							-
Community based schemes	Health Minimum	16,346						16,346
Residential Placements	Health Minimum				7,473			7,473
Personalised support- Extra Care in house	Health Minimum							-
Personalised Care at Home	Health Minimum							-
Enablers for Integration	Health Minimum							-
Integrated care planning and navigation	Health Minimum							-
Bed Based Intermediate Care Services	Health Additional						1,364	1,364
Carers Services	Health Additional							-
Home Care or Domiciliary Care	Health Additional						60	60
Community based schemes	Health Additional	14,174					684	14,858
Home-based intermediate care services	Health Additional							-
Workforce recruitment and retention	Health Additional							-
Integrated care planning and navigation	Health Additional				1,239			1,239
								-
Health Commissioned Services		30,520	-	-	8,712	-	2,108	41,340
Assistive Technologies and Equipment	Health Minimum		641			3,311		3,952
Assistive Technologies and Equipment	LA Additional					990	412	1,402
Assistive Technologies and Equipment	Health Additional						333	333
Adaptations team & equipment	Health Minimum		1,119					1,119
Bed Based Intermediate Care Services	Health Additional							-
Bed Based Intermediate Care Services	LA Additional						2,752	2,752
Care Act Implementation Related Duties	Health Minimum	2,613						2,613
Carers Services	Health Minimum							-
Community based schemes	LA Additional			965			40	1,005
Community based schemes	Health Minimum			1,169				1,169
Community based schemes	Health Additional							-
DFG related schemes	DFG - LA minimum		5,386					5,386
DFG related schemes	Health Minimum							-
Enablers for integration	Health Minimum	907		488				1,395
Enablers for integration	IBCF - LA minimum	17,422						17,422
Enablers for integration	Health Additional							-
Home-based intermediate care services	Health Additional						621	621
Home-based intermediate care services	LA Additional						-	-
Home care or domiciliary care	Health Minimum							-
Home care or domiciliary care	LA Additional						432	432

Housing related schemes	LA Additional			273				273
Integrated care planning and navigation	Health Minimum							-
Integrated care planning and navigation	Health Additional							-
Personalised budgeting and commissioning	LA Additional			163				163
Personalised support- Extra Care in house	Health Minimum	850						850
Personalised care at home	Health Minimum	2,173						2,173
Prevention/Early intervention	LA Additional							-
Residential placements	Health Minimum	2,302			3,255			5,557
Residential placements	Health Additional							-
Residential placements	LA Additional						-	-
Workforce recruitment and retention	Health Additional					355		355
Workforce recruitment and retention	LA Additional					435		435
D2A LA	LA Additional							-
D2a Health	Health Additional							-
LA Commissioned Services		26,267	7,146	3,058	3,255	4,301	5,380	49,407
Total Commissioning		56,787	7,146	3,058	11,967	4,301	7,488	90,747

Part 2		Sources of Funding						
		Scheme 1	Scheme 2	Scheme 3	Scheme 4	Scheme 5	Scheme 6	TOTAL
		Enhanced Care and Supprt (Proactive Care) £'000	Prevention and self Care £'000	Community Solutions £'000	Mental Health £'000	ICES & Wheelchair Service £'000	Discharge £'000	£'000
Health minimum funding allocation	Health Minimum	25,191	1,760	1,657	10,728	3,311	-	42,647
Health additional funding contributions	Health Additional	14,174	-	-	1,239	-	3,417	18,830
	Health Funding Sources	39,365	1,760	1,657	11,967	3,311	3,417	61,477
LA minimum funding allocation	LA Minimum	-	-	-	-	-	-	-
LA additional funding contributions	LA Additional	17,422	5,386	1,401	-	990	4,071	29,270
	LA Funding Sources	17,422	5,386	1,401	-	990	4,071	29,270
	Total Funding Sources	56,787	7,146	3,058	11,967	4,301	7,488	90,747

Part 3								
		Scheme 1	Scheme 2	Scheme 3	Scheme 4	Scheme 5	Scheme 6	TOTAL
		Enhanced Care and Supprt (Proactive Care) £'000	Prevention and self Care £'000	Community Solutions £'000	Mental Health £'000	ICES & Wheelchair Service £'000	Discharge £'000	£'000
Commissioning Intentions	LA	26,267	7,146	3,058	3,255	4,301	5,380	49,407

Sources of Funding	LA	17,422	5,386	1,401	-	990	4,071	29,270
	Funds flow to match payments to sources (inflowto the LA)	8,845	1,760	1,657	3,255	3,311	1,309	20,137
Commissioning Intentions	Health	30,520	-	-	8,712	-	2,108	41,340
Sources of Funding	Health	39,365	1,760	1,657	11,967	3,311	3,417	61,477
	Funds flow to match payments to sources (outflow from the Health)	(8,845)	(1,760)	(1,657)	(3,255)	(3,311)	(1,309)	(20,137)

Annex B for 2025/26

		Total £'000
Contribution by the ICB to the LA for the premises for WCS & WES under the Memorandum of Understanding		
Annual Contribution		118
Sources of Funding	LA	43
	Health	75
		<u>118</u>
Total Funds flow to match payments to sources (outflow from the Health)		(20,212)



**CONNECTING CARE EXECUTIVE AS THE PARTNERSHIP BOARD
(CHILDREN AND ADULTS)**

**WAKEFIELD COUNCIL
NHS WEST YORKSHIRE INTEGRATED CARE BOARD
TERMS OF REFERENCE**

1. Introduction

The purpose of the Connecting Care Executive is to be the Partnership Board responsible for review of performance and oversight of the Better Care Fund and to deliver the ambition of the Health and Wellbeing Board to achieve more effective integration between the commissioning of children's, adults', public health and NHS services.

The Connecting Care Executive needs to also undertake the statutory functions outlined in the Care Act 2014 and managing the implementation of the Better Care Fund Plan and associated Section 75 Better Care Fund Partnership Agreement.

Constitution

The Connecting Care Executive will be a stand alone Partnership Board reporting to Wakefield Council (Council) and the NHS West Yorkshire Integrated Care Board (ICB) (together the Partners).

2. Membership

2.1 The membership of the Connecting Care Executive will be as follows:

2.1.1 the Council:

- Corporate Director, Adults and Health
- Corporate Director, Children and Young People
- Group Finance Manager, Adults and Health
- Group Finance Manager, Children and Young People
- Service Director Older, People & Physical Disabilities
- Service Director, Mental Health and Learning Disabilities

- Director of Public Health

or a deputy to be notified in writing to the Chair in advance of any meeting;

2.1.2 the ICB:

- Director System Reform and Integration /Deputy Place Accountable Officer for Wakefield
- Operational Director of Finance (Wakefield Place)
- Chair of Wakefield Professional Leadership Group
- ICB Governing Body Clinical lead for Children and Young People
- Chief of Service Delivery and Quality

or a deputy to be notified in writing to the Chair in advance of any meeting;

2.1.3 The Chair of Healthwatch Wakefield (or a deputy to be notified in writing to the Chair in advance of any meeting) shall be a non-voting observer.

2.2 **Appointments**

Appointment to the Connecting Care Executive will be agreed by the Council and ICB.

2.3 **Chair**

The Chair of the Connecting Care Executive will be the the Corporate Director, Adults and Health of the Council and the Deputy Chair will be Chief Officer of the ICB. If the Chair is absent then the Deputy Chair will preside. If both the Chair and Deputy Chair are absent such member as the members present choose will preside. The member presiding at the meeting will exercise any power or duty of the Chair.

3 **Arrangements for the Conduct of Business**

3.1 **Quorum**

The quorum for meetings of the Connecting Care Executive shall be a minimum of two members from the Council and a minimum of two members from the ICB.

3.2 **Frequency of Meetings**

Meetings will be held bi-monthly.

3.3 **Frequency of Attendance by Members**

Members are required to attend at least 75% of the meetings held in any calendar year.

3.4 **Declaration of Interests**

The Partners shall ensure that those officers with decision-making responsibilities in the Connecting Care Executive will comply with the relevant provisions of their respective organisation's Code of Conduct policies for managing conflicts of interest to the extent relevant. In addition to each Partner's own Code of Conduct Policy the following principles for the management of conflicts of interest will also apply to members of the Connecting Care Executive:

The Partners as commissioners and providers will be jointly developing new models of integration, careful consideration will need to be given to potential conflicts of interest.

Members of the Connecting Care Executive are expected to conduct themselves in an appropriate manner and must refrain from actions that are likely to create any real or perceived conflict of interest, save those that are inherent in the institutional interests of the organisations that members represent.

Conflicts of interest may arise where a member of the Connecting Care Executive has:

- An institutional or financial/pecuniary interest in a specific service change that is being considered; and/or
- A close personal or professional connection with any individuals that may be directly affected by proposed service changes.

If any member of the Connecting Care Executive has an interest, pecuniary or otherwise, in any matter and is present at the meeting at which the matter is under consideration, they must disclose, to the Chair of the Connecting Care Executive, the nature of the interest at the meeting. This member will declare that interest as early as possible and shall not participate in the discussions and decision on that matter. The Chair will have the power to request that the member withdraw until the Connecting Care Executive has considered and made a decision on that matter.

Information obtained during the business of the Connecting Care Executive must only be used for the purpose it is intended. Particular sensitivity should be applied when considering financial, activity and performance data associated with individual services and institutions. The main purpose of sharing such information will be to inform new service models and such information should not be used for other purposes (e.g. performance management, securing competitive advantage in procurement).

Members of the Connecting Care Executive are expected to protect and maintain as confidential any privileged or sensitive information divulged during the work of the Connecting Care Executive. Where items are deemed to be privileged or particularly sensitive in nature, these should be identified and agreed by the Chair. Such items should not be disclosed until such time as it has been agreed that this information can be released.

All declarations of interest will be minuted.

3.5 **Urgent matters arising between meetings**

Any urgent matters arising between meetings will be dealt with by the Chair's action after agreement between the Chair and Deputy Chair or their representatives.

3.6 **Secretariat Support**

Secretariat support for the Connecting Care Executive will be provided by both the Council and ICB.

Minutes of all decisions shall be kept and copied to the members within seven (7) days of every meeting.

4. **Authority**

The Connecting Care Executive is authorised within the limits of the delegated authority given to either Partner and exercised by its members (which is received through their respective organisation's own scheme of delegation).

The Care Act 2014 (Part 4, section 121, (3)) sets out the legislative framework that the resources identified as part of the Better Care Fund are required to be placed into pooled budgets under section 75 joint governance arrangements between the ICB and the Council. The Connecting Care Executive shall have oversight and responsibility for the statutory arrangements for the Better Care Fund.

Voting

Both the ICB and the Council will have three votes per organisation, in relation to decisions. The following officers of the ICB and the Council through their delegated authority from their respective organisation's own scheme of delegation will have voting powers in the Connecting Care Executive:

the Council
Director of Public Health
Corporate Director, Adults and Health
Corporate Director, Children and Young People
the ICB
Chief Officer
Chief Finance Officer
Director of Commissioning for Integrated Care

5. **Role of the Connecting Care Executive**

5.1 **Role**

The role of the Connecting Care Executive across Adult and Children and Young People arenas is:

- a. To promote the agenda for integrating care, both in terms of sharing commissioning resource but also in terms of delivering a far more joined up service for people living in the Wakefield District
- b. To have a forum where both the Council and the ICB can make commissioning decisions collectively on areas of joint activity
- c. To ensure individual organisational commissioning decisions which could have implications or consequences for broader partners are shared through this forum in a transparent manner
- d. Whilst there will be a 'host' partner organisation for the management of the Better Care pooled fund, it is intended that each partner organisation will follow their own organisational policies and procedures for responsibility of expenditure, commissioning and procurement policies. This is outlined in the flowchart in the attached appendix 1.
- e. Have oversight and assurance that commissioning strategy and commissioning delivery plans drive forward the strategic intentions of the Health and Wellbeing Board in relation to Wakefield's published Joint Strategic Needs Assessment.
- f. To have responsibility for the development and implementation of joint commissioning strategies in line with the Joint Strategic Needs Analysis, Joint Health and Wellbeing Strategy as approved by the Health and Wellbeing Board, Children's Partnership arrangements and the Better Care Fund arrangements.
- g. Oversee all joint commissioning arrangements within agreed budgets. Ensure the Connecting Care Executive are sighted throughout the commissioning cycle on any joint commissioning activity (from understanding the need to reviewing the commission that has been procured)
- h. To ensure the quality, improvement, innovation and productivity (QIPP) challenges are managed effectively through the joint commissioning process
- i. The Connecting Care Executive will oversee joint decommissioning of services and develop a prioritisation methodology to ensure as a District we invest in services most likely to improve outcomes.
- j. Collectively the Connecting Care Executive needs to be able to be responsive to resolving commissioning issues that need addressing, regardless of their threshold value.
- k. The Connecting Care Executive needs to make decisions about the position it will adopt in relation to any joint commissioning activity and consider the approach of joint procurement arrangements and and market management issues collectively.
- l. To oversee partnership agreements under Health Act flexibilities
- m. To monitor the formal Better Care Fund pooled budget arrangements and any other appropriate informal aligned budgets
- n. To take a strategic approach to commissioning for transformation
- o. To build effective partnerships to promote collaborative commissioning to achieve better outcomes with other local partners, including third sector and independent sector

- p. To undertake the statutory requirements outlined in the Care Act 2014.
- q. To undertake the role of Partnership Board for the Better Care Fund and carry out the following in connection with the Better Care Fund:
- to agree the strategic planning and direction on the Individual Schemes;
 - to receive the financial and activity information;
 - to oversee, review and performance manage the planning as well as the practical and financial implementation of the Better Care Fund;
 - to review the operation of this Agreement and Schedules and agree such variations from time to time as it thinks fit;
 - to promote a creative and innovative approach to health and wellbeing using the freedoms afforded by the pooled funds of the Better Care Fund

6. Relationships and Reporting

6.1 Reporting arrangements from sub-committees/groups

Existing commissioning and operational and transformational boards/groups between the ICB and the Council will report into the Connecting Care Executive as outlined in Appendix 1.

6.2 Reporting Arrangements

The Connecting Care Executive will ensure the progress on the work programme and minutes that record commissioning decisions are provided to and published by the Wakefield District Health and Wellbeing Board and the ICB's governing body.

6.3 Sub groups for Connecting Care Executive

The structure highlighted in Appendix 2 outlines the groups that will continue to exist and report into the Connecting Care Executive these include for example the existing transformation programmes on Urgent Care, Planned Care, Mental Health and Children and Young People's partnership Transformation Boards. Some workstreams of enablers will be developed to go across both adults and children and young people arena, these will include ICT, communications and engagement, Estates and contracting and commissioning models for integrated care.

7. Monitoring of Compliance

The Chair and Deputy Chair will monitor compliance with these terms of reference.

8. Connecting Care Executive Decision making

Decisions of the Connecting Care Executive shall be made unanimously. Where unanimity is not reached then the item in question will in the first instance be referred to the next meeting of the Connecting Care Executive. If no unanimity is reached on the second occasion it is discussed then the matter shall be dealt with

in accordance with the dispute resolution procedure set out in the Section 75 Better Care Fund Partnership Agreement.

9. **Monitoring Information and Reports**

The following reporting arrangements will be monitored by the Connecting Care Executive:

- Connecting Care Adults Assurance Framework will be reported by Public Health quarterly
- Children and Young People's Performance Framework will be reported quarterly
- All areas of joint commissioning activity or pooled budget activity across Adults and Children's arena will be reported to the Connecting Care Executive monthly
- Better Care Fund Pooled Fund Manager shall supply to the Connecting Care Executive on a Monthly basis the financial and activity information as required under the Agreement.
- NHS England has published templates for the Better Care Fund assurance and monitoring. These will be available as both quarterly reports and as an annual report and will be shared at the Connecting Care Executive before formal sign off at the Health and Well-being Board. These requirements are to ensure the ability to monitor the effectiveness of the pooled fund arrangements and provide assurance to NHS England as to the appropriate use of the Better Care Fund. The assurance templates cover reporting on: income and expenditure, payment for performance, supporting metrics, and the national conditions. This template is available in the Better Care Fund: Guidance for the operationalisation of the BCF in 2021-22.
- NHS England require submission of the monitoring reports at 5 points in the year, these dates have not been confirmed for 2016/2017. The host partner shall submit reports in accordance with the required timescales as specified by NHS England.

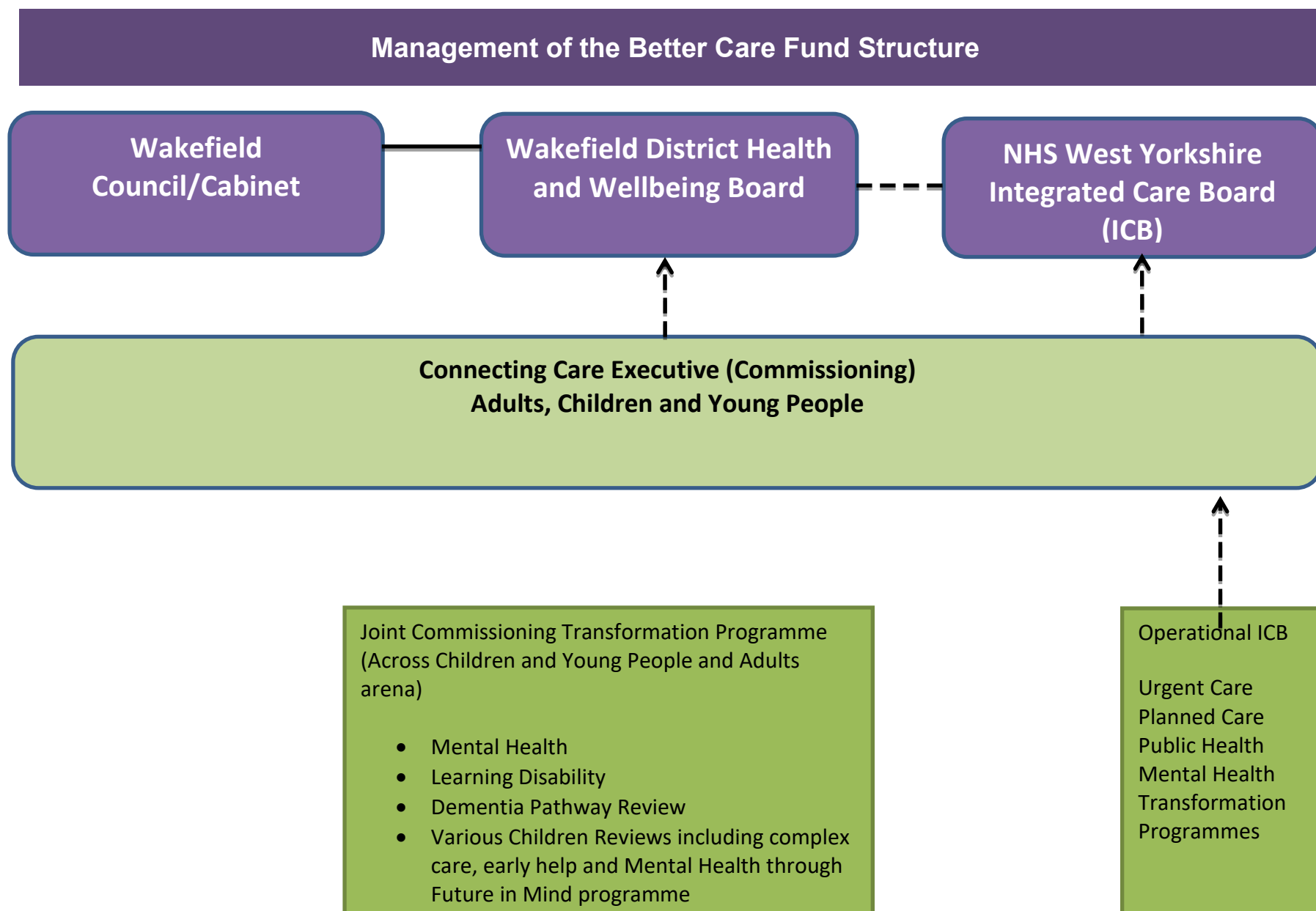
10. **Review of Terms of Reference**

These terms of reference will be reviewed annually or earlier in the light of national/local policy changes..

Appendix 1



Governance.pdf





SCHEDULE 3 RISK SHARE AND OVERSPEND

1. PAYMENT FOR PERFORMANCE ELEMENT OF BETTER CARE FUND

No longer applicable to the Better Care Fund 2025-26.

2. POOLED FUND MANAGEMENT

The relevant Host Partner of the Pooled Fund for each Individual Scheme is required to manage the Pooled Fund through its Pooled Fund Manager in accordance with the duties and responsibilities set out in clause 8 of the Agreement.

The additional Pooled Fund management provisions that apply to each of the 6 (six) Individual Schemes as follows:

Individual Scheme 1 - Enhanced Care and Support (Proactive Care)

Refer to paragraph 1.8 of the Scheme Specification for the additional pooled fund management provisions that apply to this Individual Scheme.

Individual Scheme 2 - Connecting Care – Whole Population Prevention

Refer to paragraph 2.8 of the Scheme Specification for the additional pooled fund management provisions that apply to this Individual Scheme.

Individual Scheme 3 - Connecting Care – Community Solutions

Refer to paragraph 3.8 of the Scheme Specification for the additional pooled fund management provisions that apply to this Individual Scheme.

Individual Scheme 4 - Connecting Care – Mental Health

Refer to paragraph 4.8 of the Scheme Specification for the additional pooled fund management provisions that apply to this Individual Scheme.

Individual Scheme 5 - Connecting Care – ICES and Wheelchair Services

Refer to paragraph 5.8 of the Scheme Specification for the additional pooled fund management provisions that apply to this Individual Scheme.

Individual Scheme 6 – Discharge Grant

Refer to paragraph 6.8 of the Scheme Specification for the additional pooled fund management provisions that apply to this Individual Scheme.

3. OVERSPEND

Overspend for Individual Schemes 1, 2, 3, 4 and 6 shall be as follows:

3.1 Individual Schemes 1, 2, 3, 4 and 6

3.1.1 The provisions that apply to Overspend for Individual Schemes 1, 2, 3, 4 and 6 are set out in paragraphs 1.8, 2.8, 3.8, 4.8 and 6.8, (Financial Governance Arrangements) of the Scheme Specification under the sub-heading “Management of Overspend”.

3.2 Individual Scheme 5 - Integrated Community Equipment Service and the Wheelchair Service

The provisions that apply to Overspend for Individual Scheme 5 are set out in paragraph 5.14 (Risk and Benefit Share Arrangements) of the Scheme Specification for Individual Scheme 5 under the sub-heading “Management of Overspend”.



SCHEDULE 4– INFORMATION GOVERNANCE PROTOCOL

The Council and ICB are signatories to the Interagency Information Sharing Protocol Final Version 8 which was signed by the Council on 22nd April 2014 and the ICB (formerly NHS Wakefield CCG) on 22nd May 2014. The Council and ICB have agreed that the Interagency Information Sharing Protocol Final Version 8 shall be used as the Information Governance Protocol for sharing information under this Agreement.



SCHEDULE 5 – PERFORMANCE ARRANGEMENTS

BACKGROUND

There are different delegated roles and responsibilities for the management of the BCF these include:

- The Health and Wellbeing Board: will set the strategic direction and have overall authority for the alignment of activities with the performance fund;
- Connecting Care Executive: strategic management of risk for BCF and resolution of any issues, with overall management of the work streams and BCF plan; and
- Finance work stream: design size of the BCF fund and development of any proposed risk sharing arrangements, The BCF quarterly performance reports and monthly finance reports are presented to the Connecting Care Executive and escalated to the HWB where necessary.

Through the development of the Business Rules Wakefield has had detailed conversations about the commitment to system behaviours and management of risk and these rules act as a strong lever to manage the system and any issues that may arise. Any remedial actions will be actioned through the Connecting Care Executive and escalated to the Health and Wellbeing Board if required.

In recognition of the readiness for change and the scale of change required an Integration programme has been established to help provide focus, rigour and ensure that outcomes are achieved and benefits realised.

Good programme management is essential to the delivery of the programme of work and a programme director has been appointed as a joint role across the ICB and Local Authority and a Programme Management Office has been set up to manage the programme and outputs.

A number of work streams have been agreed to support the delivery of the vision for integration. These are:

- Finance and Business: understanding the Wakefield public pound, development of the business rules, development of section 75 Better Care Fund, commercial strategy, contracting and business intelligence to support system changes.
- Workforce and OD: agreeing the new workforce commissioning model, support the culture change and behaviours, helping to embed the business rules.
- Research and Evaluation: developing and reviewing the evidence-base, overseeing the evaluation process, supporting best practice and learning, system wide metric development and monitoring.
- Communications and Engagement: development of communications and engagement plan, development of key messages, on-going stakeholder management.
- Information Technology: development of district approach and plans to technology and digital solutions supporting information sharing, collaboration and improved communication.

Further detail on governance arrangements can be seen within Schedule 2

BETTER CARE FUND 2025 TO 2026 PERFORMANCE ARRANGEMENTS

The quarterly template for the Better Care Fund assurance and monitoring shall comply with the National Guidance. The quarterly reports will be shared at the Connecting Care Executive before formal sign off at the Health and Well-being Board and submittal to NHS England. These requirements are to ensure the ability to monitor the effectiveness of the pooled fund arrangements and provide assurance to NHS England as to the appropriate use of the Better Care Fund.

The Partners agree that whichever Partner shall act as Host Partner for the Pooled Fund for an Individual Scheme and the Host Partner's Pooled Fund Manager is required under clauses 8.2.7 and 8.2.8 of the Agreement to prepare and submit quarterly reports via the Connecting Care BCF Programme Manager to the Connecting Care Executive and the Health and Wellbeing Board. The Connecting Care BCF Programme Manager shall use the required BCF Quarterly Report Template.



SCHEDULE 6 – BETTER CARE FUND PLAN

The Better Care Fund Plan for the Wakefield District for the financial year 2025/26 for the purposes of Schedule 6 of this Agreement will be the Better Care Fund Plan which was submitted by the Council and ICB and which was approved by NHS England on 30th May 2025.

SCHEDULE 7 – POLICY FOR THE MANAGEMENT OF CONFLICTS OF INTEREST

The Partners shall ensure that those officers with decision-making responsibilities in the Connecting Care Executive in relation to this Agreement for the Better Care Fund will comply with the relevant provisions of their respective organisation's Code of Conduct policies for managing conflicts of interest to the extent relevant.

In addition to each Partner's own Code of Conduct Policy the following principles for the management of conflicts of interest will also apply to members of the Connecting Care Executive:

1. As commissioners and providers will be jointly developing new models of integration, careful consideration will need to be given to potential conflicts of interest.
2. Members of the Connecting Care Executive are expected to conduct themselves in an appropriate manner. They must refrain from actions that are likely to create any real or perceived conflict of interest, save those that are inherent in the institutional interests of the organisations that members represent.
3. Conflicts of interest may arise where a member of the Connecting Care Executive has:
 - An institutional or financial interest in a specific service change that is being considered; and
 - A close personal or professional connection with any individuals that may be directly affected by proposed service changes.
4. A member of the Connecting Care Executive that has a material interest in an item being considered must disclose, to the Chair of the Connecting Care Executive, the nature of the interest at the meeting.
5. Information obtained during the business of the Connecting Care Executive must only be used for the purpose it is intended. Particular sensitivity should be applied when considering financial, activity and performance data associated with individual services and institutions. The main purpose of sharing such information will be to inform new service models and such information should not be used for other purposes (e.g. performance management, securing competitive advantage in procurement).
6. Members are expected to protect and maintain as confidential any privileged or sensitive information divulged during the work of the Connecting Care Executive. Where items are deemed to be privileged or particularly sensitive in nature, these should be identified and agreed by the Chair. Such items should not be disclosed until such time as it has been agreed that this information can be released.

ITEM 18

Meeting name:	Wakefield District Health and Care Partnership Committee
Agenda item number:	18
Meeting date:	9 September 2025
Report title:	Risk Register (Cycle 2 2025/26)
Report presented by:	Asma Sacha, WY ICB – Risk Manager
Report approved by:	Sue Baxter, WY ICB - Head of Partnership Governance
Report prepared by:	Asma Sacha, WY ICB – Risk Manager

Purpose and Action:			
Assurance ☒	Decision ☐ (approve/recommend/ support/ratify)	Action ☒ (review/consider/com- ment/discuss/escalate)	Information ☐
Previous considerations:			
Wakefield place management meeting 16 July 2025 Wakefield Integrated Assurance Committee 22 July 2025			
Executive summary and points for discussion:			
This report provides details of all risks on the Wakefield Place Risk Register in Cycle 2, 2025/26. The total number of place risks for consideration, the numbers of risks which are marked for closure, new, increasing or decreasing in score are set out in the report, along with the numbers of Critical and Serious Risks. The paper includes the Cycle 2 review of the Board Assurance Framework (BAF) for all five places which is attached at Appendix 3. 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 District Health and Care Partnership Committee is asked to review the risks and: RECEIVE and NOTE the High-Scoring Risk Report as a true reflection of the risk position in the ICB in Wakefield. CONSIDER whether it is assured in respect of the effective management of the risks and the controls and assurances in place.			

RECEIVE and NOTE the Board Assurance Framework for Cycle 2 2025/26
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 and an update of the Board Assurance Framework review. The various ICB Risk Registers support and underpin the BAF, and relevant links will be drawn between risks on each going forward.
Appendices:
Appendix 1: Wakefield Place Risk Register, Cycle 2 2025/26 Appendix 2: Wakefield Place Risks on a Page Report, Cycle 2 2025/26 Appendix 3: West Yorkshire ICB Board Assurance Framework, Cycle 2 2025/26
Acronyms and abbreviations explained:
- 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. Purpose of this report

- 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.

2. Context and Background information

- 2.1 The WY 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 24 June 2025 which details the risk management process including the risk scoring matrix.
- 2.3 During each risk cycle, risk leads across the ICB review the risks on each place risk register. This supports the identification of place risks scoring 15+ and common risks on the registers. The detailed review and mapping of the risks also enables the flagging of potential anomalies in scoring or wording between different places, supporting the discussions that ensure the continued evolution of the risk register.
- 2.4 All corporate risks, place risks scoring 15 and above and common risks will be presented to the relevant WY ICB committee and to the WY ICB Board on the following dates:
 - West Yorkshire ICB Finance, Investment and Performance Committee – 2 September 2025 (AM)
 - West Yorkshire ICB Quality Committee – 2 September 2025 (PM)
 - West Yorkshire ICB Board – 23 September 2025

- 2.5 The Cycle 1, 2025/26 [Corporate Risk Register](#), the common risk mapping across the five places and the Cycle 1 [Board Assurance Framework](#) was presented to West Yorkshire Integrated Care Board on 24 June 2025.

3. Key Points

- 3.1 This report set out the key changes to the risk profile of the Wakefield place risks during risk cycle 2 2025/26 which commenced on 25 June 2025 and will end after the WY ICB Board meeting on 23 September 2025.
- 3.2 The extract of the Risk Register (Appendix 1) provides further detail of all risks including the key controls and assurances for each risk. The 'Risk on a Page' report (Appendix 2) provides a summary of the key changes since the last review cycle.

There are 20 risks on the Wakefield place risk register:

- Six high scoring risks (15+ in risk score)
- One new risk
- One risk has decreased in risk score

3.3 High Level Risks

There are six open high level risks (15+) in Cycle 1, 2025/26:

Risk	Sub-Committee Alignment	Cycle 2 2025/26	Update for Cycle 2 2025/26
2439 - 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.	Wakefield Integrated Assurance Committee	20 (I4xL5)	Static – 3 cycles There is still a significant backlog of invoices which is discussed at a bi-weekly meeting with a key focus on reducing the backlog, although there has been a reduction. The team are currently clearing the backlog for Q3 and Q4 for 2024/25. The risk score will be reviewed in Cycle 3, 2025/26.

Risk	Sub-Committee Alignment	Cycle 2 2025/26	Update for Cycle 2 2025/26
2553 - There is a risk that initial health assessments for children in care, will not be completed within the statutory time frames. This is due to limited medical resource capacity, increased demand and the complexity of Place-based commissioning arrangements. This could result in health needs assessments of Children in Care being delayed and the health needs of these vulnerable children not being met, which could impact upon long term outcomes.	Wakefield Integrated Assurance Committee	16 (I4xL4)	New risk A new risk has been added to places (Wakefield, Leeds, Bradford District and Craven and Kirklees) in relation to initial health assessments for children in care not being completed within statutory time frame. The lead health commissioner is working with the CIC health provider to resolve the current position, and a recovery plan is being agreed.
2513 - 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.	Wakefield Integrated Assurance Committee	16 (I4xL4)	Static – 1 cycle A review timescale has been added to the risk actions to mitigate this risk. The Task and Finish Group are working on a business continuity plan in the event of a sudden closure of the building, which will be completed by early Q3, 2025/26. ICB influence remains restricted as the lease agreement is between NHS property services and the landlord.
2481 - 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	Wakefield Integrated Assurance Committee	16 (I4xL4)	Static – 2 cycles Options workshop and scoring for April 2025 completed with final recommendation to be progressed. No change to risk score for Cycle 2. The Task and Finish Group continue to meet.

Risk	Sub-Committee Alignment	Cycle 2 2025/26	Update for Cycle 2 2025/26
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).			
2397 - 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	Wakefield Integrated Assurance Committee	16 (I4xL4)	Static – 4 cycles The risk remains high and significant underlying deficit still remains. Risk score to remain the same.

Risk	Sub-Committee Alignment	Cycle 2 2025/26	Update for Cycle 2 2025/26
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.			
2329 - 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.	Wakefield Integrated Assurance Committee	16 (I4xL4)	Static – 6 cycles WY ICB decision on minimum wait times for some ICS activity and strong governance for new investment decisions. Risk still remains high.

3.4 New Risk

One new risk has been added to the risk register during Cycle 2, which is under risk ID 2553 in section 3.3 (above).

3.5 Change in Risk Score

One risk has reduced in risk score during cycle 2 2025/26:

Risk ID	Risk score Cycle 1	Risk score Cycle 2	Sub-Committee	Risk Description	Reason for change
2501	16 (I4xL4)	12 (I4xL3)	Wakefield Integrated Assurance Committee	There is a risk of poor outcomes, safety and experience for patients in the district due to overcrowding in the emergency departments (ED's) and ward areas at Mid Yorkshire Teaching Trust 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 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.	Risk score reduced from 16 to 12. Risk score reduced following positive assurance provided at Rapid Quality Review meeting in June 2025 which evidenced improvements in urgent and emergency care performance and quality measures.

4. Emerging risks

4.1 The following risks are being developed on the WY ICB corporate risk register in relation to the WY ICB organisational change:

- Risk to being able to deliver statutory functions in respect of quality and safety including safeguarding
- Financial risk due to lack of funding for staff redundancy costs and exit packages

- Risk of prolonged distraction, disruption and people starting to disengage impacting on the ICB's core activities
- Risk of increased turnover of staff and wellbeing concerns for staff due to the organisational change programme and the development of the ICB operating model.
- The risk on industrial action will also be reviewed due to recent strike action by resident doctors (previously referred to as Junior Doctors) and the possibility of strike action by nursing colleagues.
- A new risk will be reviewed and developed capturing the challenges of out of area bed usage by South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) and the impact on patient flow and pressures on the wider system.

5 Board Assurance Framework (BAF) update for Cycle 2 2025/26

- 5.1 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.
- 5.2 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**.
- 5.3 The Board Assurance Framework reviewed in Cycle 2 2025/26 is attached at Appendix 3 and the review for Cycle 2 is highlighted using blue font.
- 5.4 The table below shows key changes which has been made to the BAF following review by Wakefield senior managers during Cycle 2, 2025/26;

BAF risk	Cycle 4, 2024/25	Cycle 2 2025/26	Reason for change
3.1 There is a risk that we do not invest resources in a way which prioritises community, primary & prevention programmes and so doesn't maximise value for money.	9	12	The risk score has increased from 9 to 12 (which is in line with the overall WY ICB position). A greater understanding is required of service join-up within Place in order to invest more wisely and a requirement for more robust return on investment modelling within place.

BAF risk	Cycle 4, 2024/25	Cycle 2 2025/26	Reason for change
3.3 There is a risk that ICB capacity and infrastructure is not sufficient nor targeted effectively towards key priorities.	12	12	The risk score remains the same but it is important to note that Wakefield place are working with other places and the strategic commissioning functions between June and September 2025 to mobilise a new operating model to go live in April 2026.

6 Next Steps

- 6.1 The risks will be carried forward to the next risk review cycle which will commence after the WY ICB Board meeting on 23 September 2025.
- 6.2 Subsequent to that meeting, any closed risks will be archived and open risks carried forward to the next risk review cycle.

7 Recommendations

The Wakefield District Health and Care Partnership Committee is asked to review the Wakefield place risks and:

- **RECEIVE** and **NOTE** the High-Scoring Risk Report as a true reflection of the risk position in the ICB in Wakefield.
- **CONSIDER** whether it is assured in respect of the effective management of the risks and the controls and assurances in place.
- **RECEIVE** and **NOTE** the Board Assurance Framework for Cycle 2 2025/26

	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	27/04/2024	Wakefield Integrated Assurance Committee	Healthy standard of living for all	20	(4x4.5)	4	(2x4.2)	Jenny Davies	Ian Cornell	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/processing 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 recosting 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 - 3 Archive(s)
	2553	31/07/2025	Wakefield Integrated Assurance Committee	Improve healthcare outcomes for residents	10	(4x4.4)	6	(3x4.2)	Sarah Booth	Penny Mcsorley	There is a risk that initial health assessments for children in care, will not be completed within the statutory time frames. This is due to limited medical resource capacity, increased demand and the complexity of Place based commissioning arrangements. This could result in health needs assessments of Children in Care being delayed and the health needs of these vulnerable children not being met, which could impact upon long term outcomes.	1. Risk also reviewed on WY risk corporate risk register 2. Standing Operating Procedures (SOP's) across West Yorkshire to be standardised (2025/26) 3. Risk escalated to children's commissioners at Place where appropriate. 4. Risk communicated to Place based Corporate Planning Boards. 5. Demand and capacity assessment to be undertaken across WY to look at improving resources (2025/26). 6. There is an increased reliance on other services to inform of health issues and signpost accordingly.	1. Review of the commissioning arrangements (review ongoing - 2025) 2. Long term staff absence and recruitment issues. 3. Combined Designated nurse role for Safeguarding and Children looked after does not provide the strategic oversight required. 4. Extent of influence over commissioning and provision of sufficient medical capacity.	1. Designated Nurse working with Named Nurse and Doctor to monitor performance and escalate issues. 2. The West Yorkshire CIC Group is: • Looking at a standardised approach to reduce unwarranted variation • Connecting with relevant Regional and National Groups • Seeking to influence and ensure that robust processes and procedures are in place. • Review Performance Monitoring is undertaken at each place on a monthly basis and overall performance is shared at the WY CIC group for oversight. • Ensure regular review of the WY ICB corporate risk at the bi-monthly WY CIC group meeting. • Ensure regular reporting into place provider safeguarding Committees, Corporate Planning Boards and WY ICB Safeguarding Oversight and Assurance Partnership for oversight. 3. Written Statement of Action in response to SEND inspection and improvements to date.	1. WY Safeguarding Oversight and Assurance Partnership	1. Health Data and LA data are not consistent to demonstrate an accurate picture of the issues.	New - Open
	2513	02/04/2025	Wakefield Integrated Assurance Committee	Improve healthcare outcomes for residents	10	(4x4.4)	12	(3x4.3)	Jon Parnaby	Ruth Urwin	There is a risk of potential issues at the property (Kings Street walk-in centre) related to statutory compliance issues. NHS property services (NHSF) have made several requests of the landlord for relevant documentation and certificates. NHS 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, during the current contract extension period (lease expires October 2026) Completion Q3 2025/26 2. Local Care Direct (LCD) to ensure a business continuity plan is in place in the event of sudden building closure, completion early Q3, 2025/26 - LCD have a BCP in the event of an immediate closure modelled upon satellite provision delivered through their Primary Care Centre and partner sites across Wakefield 3. NHSF mitigation in place. Ongoing as estate options continually changing NHS Property Services are developing mitigations in the occurrence of any immediate closure of the current estate. This includes working with LCD in the further development of their satellite provision model as well as continual monitoring of current suitable health estates	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 at Quarterly meetings with NHSF 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	Static - 1 Archive(s)
	2481	14/01/2025	Wakefield Integrated Assurance Committee	Improve healthcare outcomes for residents	10	(4x4.4)	12	(3x4.4)	Jon Parnaby	Ruth Urwin	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 vacating 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 system such as increased attendance at A&E or GP practices, increase in demand for out of hours, 111 or Dewsbury walk in centre (MYTT).	1. A walk-in centre task and finish group was established in Sept 2024 which continues to meet to develop options during the current contract extension period (lease expires October 2026). 2. Oversight by the unplanned care alliance at each monthly with receipt of monthly Task & Finish highlight reports 3. To implement a strong communication strategy and engage local stakeholders and community groups. Q3 2025/26 pending preferred option development - Ongoing during the option development phase and any implementation of change 4. To conduct an early impact assessment Q3 2025/26 pending preferred option development focussing on vulnerable groups and if alternatives are sought (mobile clinics) that they are designed to mitigate inequality and are accessible including Quality Impact Assessment. Will be conducted on the short list options post October 2025 5. To test robust data migration protocols with thorough testing and back-up systems, including a pilot programme with the IT experts. Part of any migration to preferred option in Q2 2026/27 - Ongoing through the options development period 6. Environmental Impact Assessment, alongside EIA as point 4 above - Will be conducted on the short list options post October 2025 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. Options workshop and scoring for April 2025 completed with final recommendation to be progressed. Risk scoring included	See above	1. ICB influence is restricted as lease agreement is between NHS property services and the landlord	Static - 2 Archive(s)
	2397	11/12/2023	Wakefield Integrated Assurance Committee	Healthy standard of living for all	10	(4x4.4)	6	(3x4.2)	Jenny Davies	Ian Cornell	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 WYICS - 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 NHSF non-recurrent funding that has been delegated WYICS to be split between Acute Trusts to reduce borrowing requirements. Awaiting WYICS 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 NHSF 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 NHSF in February 2024 7. High degree of scrutiny of savings targets from WY executive 8. A review of plans by NHSF with a view to resubmitting on 2 May 2024 9. TDC overseeing efficiency savings on a monthly basis 10. Paper to TDC around investments and disinvestment for July meeting	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 WYICS assurance process where Place financial position is assessed 2. Additional WYICS assurance meetings 3. WYICS 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. NHSF review of plans at WY level 5. Underlying position understood and detail planning model constructed with known gaps.	1. Longer term recovery plan and Wakefield place financial strategy for sustainability	Static - 4 Archive(s)
	2329	13/06/2023	Wakefield Integrated Assurance Committee	Healthy standard of living for all	10	(4x4.4)	6	(2x4.3)	Jenny Davies	Ian Cornell	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, A&D 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 exercises. 8. Financial Plan for 24/25 submitted to NHSF 18 March. Continue to work on final plan. 9. Planning assumptions and risks articulated as part of submission and at Partnership Committee. 10. Paper to TDC around investments and disinvestment for July meeting	1. Joint efficiency schemes - Trust and ICB needs developing. 2. All business cases should consider how schemes are funded and show a RCR. 3. Actions to achieve balance / recovery plan still to be identified 4. Benchmarking work starting to compare expenditure across places in WYICS.	1. New committee / meeting structure for Wakefield ICB & Place monthly reporting to management team meeting on finance and CIPP. 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 - 6 Archive(s)
	2507	01/04/2025	Wakefield Integrated Assurance Committee	Improve healthcare outcomes for residents	12	(4x4.3)	6	(2x4.3)	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 accurate 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 ADAS 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 at 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 2. ADAS 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. 6. MCA Specialist Practitioner / Lead in place to ensure clinical team are clear on roles and responsibilities in the CHC process to support necessary C&P applications. 7. Good relationship with Local Council in C&P processes, including where joint responsibility in place. 8. 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. ADAS 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.	Static - 1 Archive(s)
	2501	31/03/2025	Wakefield Integrated Assurance Committee	Prevention of ill health	12	(4x4.3)	9	(3x4.3)	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 department (ED) and ward area at M&F Hospital Teaching Trust 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 lack of accurate 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. 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. Subsequent meeting held in June 2025. 4. ICB working with MYTT and system colleagues around effective discharge and flow from the hospitals. 5. Focused work in MYTT in three areas - pre admission/front door, inpatient flow (supported by the new structured management quality system - Improving Together); and discharge. 6. Emergency Care Improvement Support Team (ECIST) visit in May identified three areas for further work. A 6 month programme of work with ECIST will cover development of site management; development of acute medicine model; and review of inpatient bed model against demand	1. Possible work around discharge and flow out of the hospital with system partners. 2. Intermediate care workstream established as component of neighbourhood health plan	1. Regular quality monitoring walkabouts to ensure TES guidelines are adhered to and patients are being kept safe 2. Use of the NQBR rapid quality review process as required. 3. ICB attendance at MYTT quality committee, which receives updates from the division of medicine and acute care and on C&P action related to access and flow 4. Workstreams identified through the unplanned care alliance improve pre-hospital /avoidable ED attendances, improving ambulance times), in-hospital 4-hour wait times, ED avoidance, reducing length of stay, and post-hospital (safe and effective discharge, access to care)	1. RQR process provided good level of assurance and presented clear plans to improve flow 2. Improvement work commenced in Q1, and the performance for the above indicators has improved significantly in urgent and emergency care performance including improved ambulance handover times, and 4 hour A&E waiting times, and a decrease in waits longer than 12 hours) and quality measures (reduction in deteriorating patient, falls and hospital acquired pressure ulcer patient safety events as a result of TES care and long waits) 3. A greater community team involvement and alternative care pathways to avoid unnecessary ED attendance is being considered. 4. In hospitals, improvements are being made to emergency department processes, ambulance handover times, and patient flow through initiatives like SDEC expansion and the "Improving Together" model. 5. Post-discharge efforts include piloting integrated discharge planning with social workers, co-locating teams at DGH, evaluating intermediate care and home-first funding, and expanding the Optica system to support seamless care across services. 6. Patient Safety Walkabout to Pinderfields Hospital in June 2025 highlighted improvements in discharge processes through a multidisciplinary team (MDT) approach, effective utilisation of the Discharge Lounge, and a pilot on Ward 43 involving social workers to enable quicker access to post-hospital care.	1. ICB visit arranged for October to see first hand the impact of the quality improvement work - will include assurance on preparations for the forthcoming winter period.	Decreasing
	2495	26/03/2025	Wakefield Integrated Assurance Committee	Improve healthcare outcomes for residents	12	(3x4.4)	9	(3x4.3)	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.	1. Unannounced Resident Safety Walkabouts (RSW) undertaken to care home providers. 2. 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 ICS. 3. Regular Enhanced Quality Surveillance Group with relevant teams, partners and regulators. 4. Regular partner/provider meetings held with care homes under enhanced quality surveillance and monitoring 5. Integrated Quality team between ICB and Council - undertake regular engagement visits to care homes 6. Contract monitoring by CHC and Council contracting teams 7. Safe and Wellbeing checks in place for residents when concerns raised 8. Proactive supported visits to care homes by integrated quality, infection prevention and control, and medicines optimisation teams - building relationships with providers 9. Safeguarding adults systems and processes including social care direct triage, safeguarding referrals and investigations by care coordinators 10. Quality Intelligence Notifications (QINs) submitted by professionals reviewed and discussed at Safeguarding Adults Board Quality Intelligence Group 11. Upheld care home rates for 2025/26 to support the market, staffing and quality outcomes	1. Limited information about some care homes 2. Reduced number of CQC assessments/inspections due to CQC's internal reorganisations 3. Capacity across teams to offer proactive quality improvement support to all care homes across the district	1. Reports from Resident Safety Walkabouts 2. Quality Assurance Framework for Adult Social Care 3. Enhanced Quality Surveillance Group 4. Safeguarding Adults Board Quality Intelligence Group 5. Quarterly Adult Social Care Surveillance report presented to Integrated Assurance Committee 6. CQC assessment/inspection reports for individual care homes	1. Improvement in CQC ratings across Wakefield district (one nursing/dementia care home rated inadequate June 2025) 2. Quality Assurance Framework for Adult Social Care approved at Integrated Assurance Committee (January 2025) 3. Deep Dive presentation to Integrated Assurance Committee - June 2025	1. Reduced number of CQC assessments/inspections due to CQC's internal reorganisations 2. Capacity within integrated quality team to regularly visit all care homes across the district	Static - 1 Archive(s)

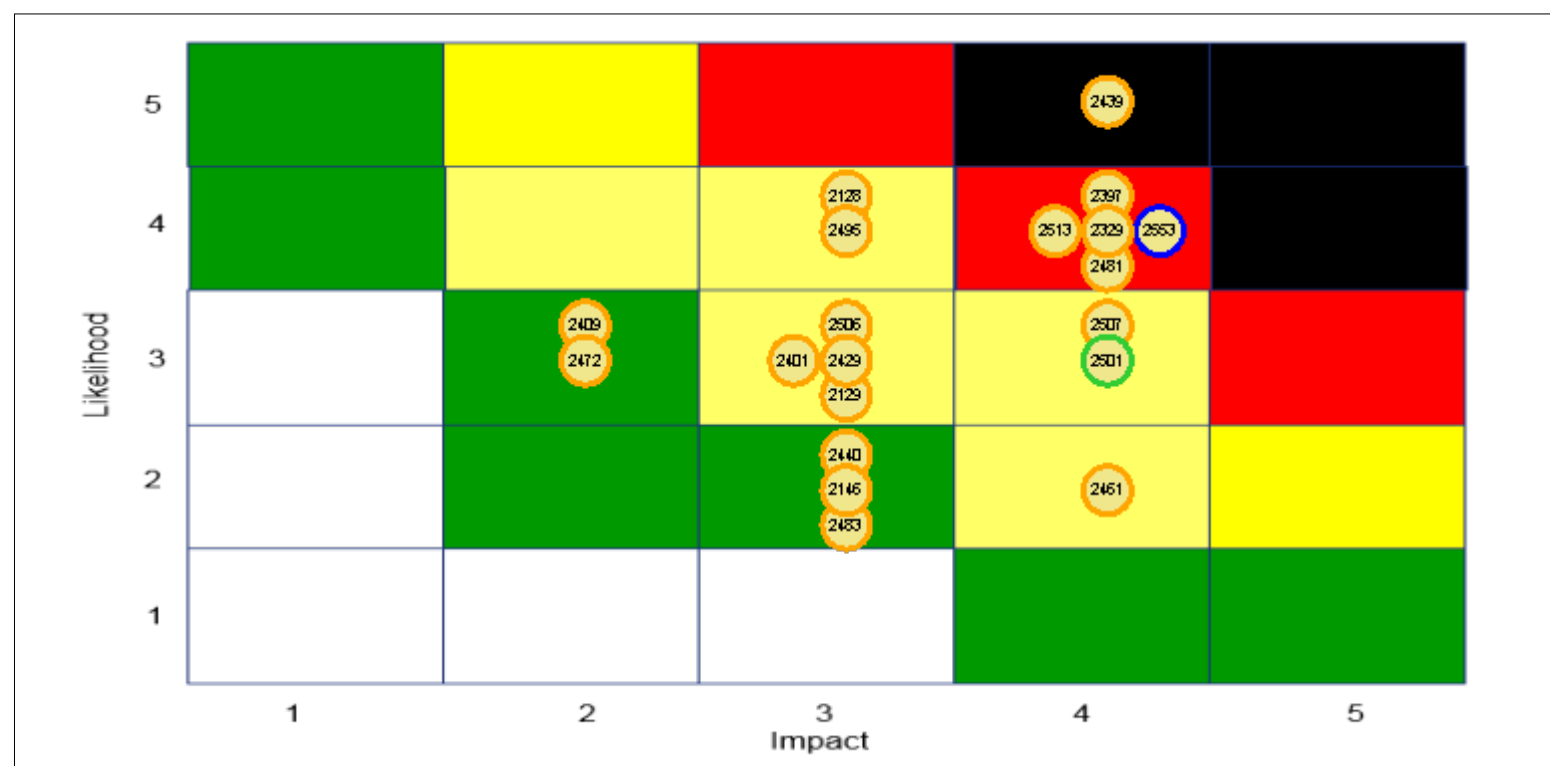
2128	04/10/2022	Wakefield Integrated Assurance Committee	Giving every child the best start in life	12 (B34.4)	12 (B34.4)	Joanne Rooney	Jenny Lingrell	There is a risk of reputational harm due to the long waiting times for children and young people accessing neurodevelopmental assessment and the unavailability 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. Update July 2025 MHTT have undertaken a review of the System1 modules and recording of data to ensure an accurate picture of referrals and where the child is on the pathway, this should enable more accurate forecasting of trajectories but also greater assurance for families and improved communication. 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 MGA is now complete; recruitment of paediatricians is progressing subject to final interview. Vacancies 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 PAs to be offered in next Job Planning cycle. 0.5 PA identified. MSA Recruitment: 87 SALT and OT – Start dates confirmed for early January 2025 R6 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 B6 Psychologist – recruited internal candidate transitioning from B6 in next month in post early 2025 B4 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 it's 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 Kier 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 plan 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&P Monthly monitoring of the the service through data reports and the Multi-agency Neurodiversity Strategy Group (regular agenda and minutes) Overnight by the Children's Alliance. Reporting the SHD Strategic Board Reporting and to the MH Provider Alliance Integrated Assurance Committee (bi-monthly) a discussion took place October 2024 at IAC WY ICB MSLDA forum developing a all age ND strategy and approach- agreed at SOAG November 2024. Kier Shikler 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. Trjectories 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&P waiting for diagnosis access support Futurestep project also provides support for young people who may be experiencing neurodiverse symptoms for 16-25year olds	C&P dashboard to be developed being discussed by Lead Children's Alliance and MYTT BI staff and divisional team	Static - 3 Archive(s)
2506	01/04/2025	Wakefield Integrated Assurance Committee	Improve healthcare outcomes for residents	9 (B34.3)	6 (D24.3)	Judith Wild	Penny Mccorley	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 4. Funding agreed for agency post for Wakefield and wider ICB CHC team to address the backlog of reviews	1. Sickness absence due to work related conditions 2. Inability naturally 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 clinical 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 wellbeing/ well being issues	1. Increased number of applicants for clinical posts due to reduction of AACC activity continues to be a consistently 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	Static - 1 Archive(s)
2429	16/04/2024	Wakefield Integrated Assurance Committee	Improve healthcare outcomes for residents	9 (B34.3)	4 (D24.2)	Jon Farnaby	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 5. Regular updates to overnight forums including Transformation and Delivery Collaborative 6. IAC deep dive November 2024 IAC meeting 7. IAC recommends a MYTT quality meeting which took place 9th December 2024 8. NMR reduction agreed as one of the 3 priorities T&P groups of the Unplanned Care Alliance	1. Greater understanding of impact by partners	1. Minutes of meetings of GCC at MYTT 2. Minutes of unplanned care alliance 3. Minutes of System Discharge Forum 4. Minutes of TDC 5. IAC deep dive report November 2024 6. Briefing from Doni Kirklees and Wakefield Places following 9th December 2024 MYTT quality meeting at the T&P 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 - 5 Archive(s)
2401	18/01/2024	Wakefield Integrated Assurance Committee	Giving every child the best start in life	9 (B34.3)	4 (D24.2)	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 organisation 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 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 - 2 Archive(s)
2129	04/10/2022	Wakefield Integrated Assurance Committee	Healthy standard of living for all	9 (B34.3)	6 (B34.2)	James Brownejohn	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 specialties 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 FPU 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. 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 specialists 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 specialties is very challenging with low uptake 2. Not all patients accepting choice of provider 3. Lack of options for alternative providers in challenged specialties 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 in responding to these priority areas and oversees a monthly update	1. Mainly two specialties contributing to the waiting time issues (Gynaecology and Ophthalmology) both have full overarching actions plans in place. Ophthalmology is a national issue with a shortage of consultant grrats. 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 52 week trajectory status, Referral Demand & productivity, Cancer Performance, 6 Usage with most risk specialties invited to share recovery plans	Some specialties with excessive waits have no alternative capacity options across WYAAT. Some Specialists have patients waiting above 52 weeks. This will be overseen by MYTT division and reported to NHSE.	Static - 2 Archive(s)
2461	10/10/2024	Wakefield Integrated Assurance Committee	Support broader social and economic development	8 (B44.2)	4 (D24.2)	Jenny Davies	Ian Cornell	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 the others. Local intelligences 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 DoPs etc. Finance report to WDH&CP also reports on the LA financial position.	None identified	Minutes from WDH&CP demonstrate discussion on financial position. Regular meeting of Wakefield Place DoPs taking place.	YBC	None identified	Static - 3 Archive(s)
2483	15/01/2025	Wakefield Integrated Assurance Committee	Improve healthcare outcomes for residents	6 (B34.2)	4 (D24.2)	Luke O'Neill	Michele Enzo	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: It has been agreed to uplift funding allocations to all Hospices by 0.6% to mirror NHS statutory organisations. Additional funding has been prioritised and allocated through WY modelling on the basis of starting point contribution. Wakefield Hospice received an additional £2344 and Potwell received £2232. This additional funding takes Wakefield Place to 67%, a strategy is being developed with the hospices to achieve 100% over the next 3 years. 2. Collaboration: Engagement with Place providers and hospices in taking place to explore priorities and develop strategy 3. Cost saving measures: Explore efficiency strategies, such as streamlining operations to reduce overhead costs. This is being explored but believed to be limited. 4. Fundraising campaigns: Support Hospices and local authorities where possible with targeted campaigns to increase donations and secure new funding streams	1. Limited flexibility in further funding provision or reallocation at present 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	1. Financial audits: Work with finance teams to monitor and understand the impact of the tax increase on hospice finances and assess the effectiveness of mitigation measures 2. Hospice performance reviews: Quarterly reviews of service provision 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 Transforming and Delivery Collaborative: Regular reporting to the group 7. West Yorkshire Palliative End of Life Care Steering Group: Regular reporting to the group 8. Wakefield (End of Life) EOL Board workshops to agree priorities and develop 3-5 year strategy in partnership with MYTT, hospices and VCSE organisations	Positive outcome in terms of additional allocation.	None identified at this stage.	Static - 1 Archive(s)
2472	27/12/2024	Wakefield Integrated Assurance Committee	Tackle inequalities in access, experience, outcome	5 (B24.3)	4 (D24.2)	Charlotte Witter	Michele Enzo	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 SWWPT 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 SWWPT 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 accommodate 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, NHS funding cannot be used. The business case is being re-visited to discuss if a pilot project can be set up across Calderdale, Kirklees and Wakefield. WY ICB ND Strategy has been identified as a gap. WY ICB MSLDA forum developing an all age ND strategy and approach- agreed at SOAG November 2024. Kier Shikler leading updates to SOAG in WY ICB.	This risk is being managed and reported on through the LD and ND Alliance. The WY ACP may provide an opportunity for access to assessments for this cohort. WY ICB MSLDA forum developing an all age ND strategy and approach- agreed at SOAG November 2024. Kier Shikler leading updates to SOAG in WY ICB.	Patients in this category are receiving MDT support for ongoing behavioural interventions. SWWPT adult psychiatry supports medication prescribed by CAMHS as patients with an existing diagnosis move into adult services.	It's not yet known what the WY ACP providers might be able to offer in terms of ADHD assessments for people with a LD.	Static - 2 Archive(s)
2440	28/06/2024	Wakefield Integrated Assurance Committee	Tackle inequalities in access, experience, outcome	5 (B34.2)	4 (D24.2)	Sarah Booth	Penny Mccorley	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 12 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 CQN 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	Static - 1 Archive(s)
2409	20/02/2024	Wakefield Integrated Assurance Committee	Improve healthcare outcomes for residents	6 (B24.3)	2 (D24.2)	Jon Farnaby	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	1. Performance reviewed at Wakefield Integrated Assurance Committee (as part of Performance Report) 2. Quality Team have oversight of any learning from 12 hour branches 3. Oversight at the Unplanned Care Alliance 4. Continued priority of the Unplanned Care Alliance into 2025/26 and a further priority of the UEC Plan published 6th June 2025.	1. 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.	Static - 6 Archive(s)
2146	04/10/2022	Wakefield Integrated Assurance Committee	Healthy standard of living for all	5 (B34.2)	4 (D24.2)	Charlotte Witter	Michele Enzo	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 2025 so that the ADHD huge gap can continue. 2. For West Yorkshire ICB the Any Qualified Provider (ACP) contract is being renewed. Private providers will be able to sign up to this with set tariffs and standards of quality criteria met. 3. Discussion being held at a West Yorkshire level about creating a referral hub that will triage all referrals, signpost individuals to support and ensure that only clinically appropriate referrals go for full assessment.	Identified as a gap across WY ICB - WY ICB wide ND strategy and consistent commissioning approach for all age ND. Agreed actions: WY ICB MSLDA forum developing an all age ND strategy and approach- agreed at SOAG November 2024. Kier Shikler leading updates to SOAG in WY ICB.	Agreed actions: WY ICB MSLDA forum developing an all age ND strategy and approach- agreed at SOAG November 2024. Kier Shikler 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 2025 agreed. SWWPT 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 - 7 Archive(s)

Wakefield place, Risk on a Page Report Cycle 2, 2025/26

Total Place Risks	20 Risks
All risks aligned to Wakefield Integrated Assurance Committee	

Movement of Risks		Risk Score Increasing	0
New	1	Risk Score Decreasing	1
Marked for Closure	0	Risk Score Static	18

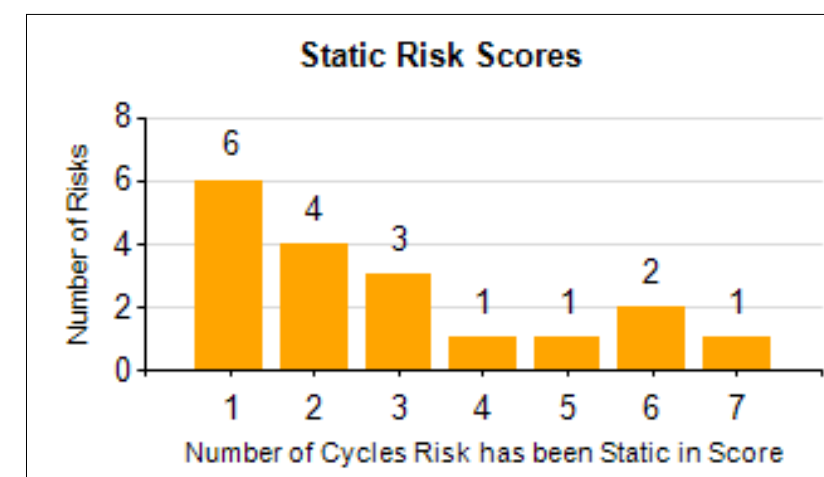
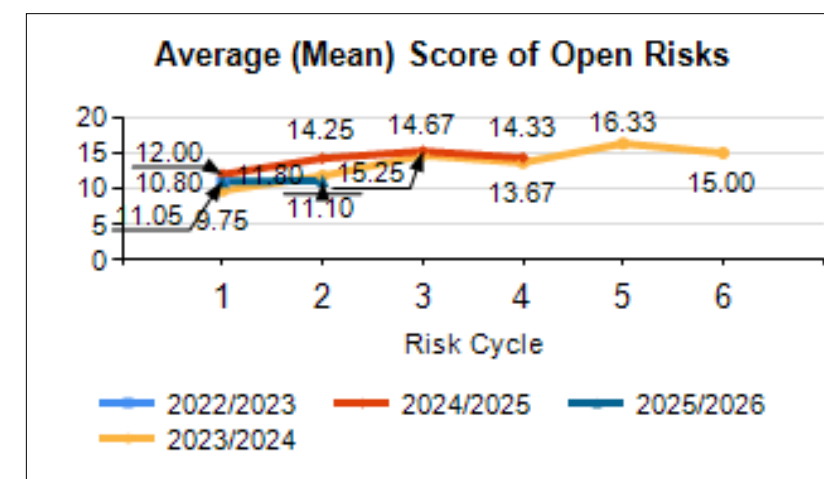
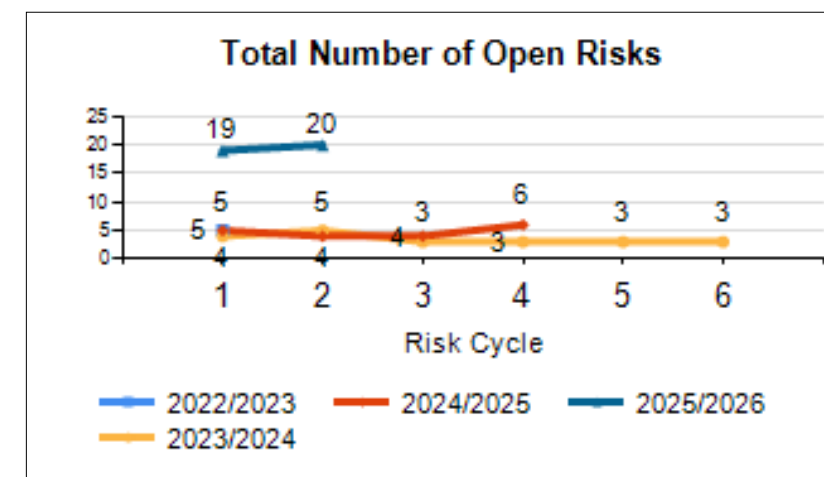
Risk Overview (Wakefield place)



Key
Wakefield Integrated Assurance Committee



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



The following information is taken from the WYICB's *Risk Management Policy and Framework (v1.0)* to provide guidance to those completing the Board Assurance Framework (BAF) on behalf of the ICB and place partnerships. The full document can be accessed here:

https://www.wypartnership.co.uk/application/files/7017/5395/3821/Risk_Management_Framework_v4.0.pdf

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

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

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

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

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

Controls describe the available systems and processes (*the specific things we are doing*) which help to minimise and/or manage the risk.

Assurance is the (*source*) information used to ascertain whether the controls are effective.

Mitigating actions describe what else we are doing to control the risk and/or provide additional assurance.

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

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

Definitions of impact:

Risk impact	Insignificant	Minor	Moderate	Major	Catastrophic
	1	2	3	4	5
Purpose					
Achievement of the ICB mission	A decision affecting contracts finance, collaborations, quality or governance has no impact on the ICB mission.	A decision affecting contracts finance, collaborations, quality or governance does not support the ICB mission.	A decision affecting contracts finance, collaborations, quality or governance delays the achievement of the ICB mission.	A decision affecting contracts finance, collaborations, quality or governance impedes or significantly delays the achievement of the ICB mission.	A decision affecting contracts finance, collaborations, quality or governance majorly impedes and/or delays the achievement of the ICB mission.
Health outcomes and life expectancy	Marginal reduction to health outcomes and life expectancy	Minor reduction to health outcomes and life expectancy	Moderate reduction in health outcomes and life expectancy	Significant reduction in health outcomes and life expectancy	Major reduction to health outcomes and life expectancy

Health outcomes and life expectancy	outcomes and/or life expectancy for >5% of a given population.	outcomes and/or life expectancy for >15% of a given population.	outcomes and/or life expectancy for >30% of a given population.	outcomes and/or life expectancy for > 50% of a given population.	Major reduction in health outcomes and/or life expectancy for >75% of a given population.
Health inequalities	Marginal increase in the health inequality gap in up to all six of most deprived Local Care/Community Partnerships (PCNs)	Minor increase in the health inequality gap in up to all of the six most deprived Local Care/Community Partnerships (PCNs) and / or a minor increase in the number of deprived Local Care/Community Partnerships (PCNs)	Moderate increase in the health inequality gap in up to all of the six most deprived Local Care/Community Partnerships (PCNs) and / or a moderate increase in the number of deprived Local Care/Community Partnerships (PCNs)	Significant increase in the health inequality gap in up to all of the six most deprived Local Care/Community Partnerships (PCNs) and / or a significant increase in the number of deprived Local Care/Community Partnerships (PCNs)	Major increase in the health inequality gap in up to all of the six most deprived Local Care/Community Partnerships (PCNs) and / or a major increase in the number of deprived Local Care/Community Partnerships (PCNs)
Service quality and performance (includes patient experience, safety and clinical effectiveness)	Informal complaint	Formal complaint	Investigation by Health Service Ombudsman	Multiple complaints	Litigation certain
		Local resolution	Minor out-of-court settlement	Judicial review Litigation expected Civil action – no defence	Criminal prosecution
	Negligible effect on quality of clinical care	Noticeable effect on quality of care Single failure to meet internal standards Minor implications for patient safety if unresolved	Significant effect on quality of care / significantly reduced effectiveness Repeated failure to meet internal standards Major patient safety implications of findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved.	Totally unacceptable level or quality of treatment / service Gross failure of patient safety if findings not acted on Gross failure to meet national standards
	Commissioned local or national targets not achievable – single episode	Commissioned local or national targets not achievable – 1-3 episodes	Repeated failure to meet commissioned local or national targets > 3 episodes	Commissioned national targets not achieved resulting in involvement of external bodies / regulator	Commissioned national targets not achieved resulting in special measures
Financial efficiency	Small loss	Loss of 0.1–0.25 per cent of budget	Loss of 0.25–0.5 per cent of budget	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget	Non-delivery of key objective/ Loss of >1 per cent of budget
Capability					
Compliance (includes H&S and other legal or governance factors such as procurement, information governance etc.)	Negligible injury or ill health requiring no absence from work. Negligible damage to equipment or property. No or minimal impact or breach of guidance / statutory duty.	Minor injury or ill health requiring up to 2 days absence from work. Minor damage to equipment or property. Breach of statutory legislation Reduced performance rating if unresolved	Moderate injury or illness resulting in the submission of a RIDDOR report. Moderate damage to equipment or property. Single breach in statutory duty Challenging external recommendations / improvement notice	Single fatality. HSE improvement notice received. Major damage to property Enforcement action Multiple breaches in statutory duty Improvement notices Low performance rating Critical report	Multiple fatalities HSE or police investigation resulting in imprisonment of Chief Executive or other implicated staff Multiple breaches in statutory duty Prosecution Complete system s change required Zero performance rating Severely critical report

Descriptors for risk likelihood:

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

Overall risk matrix scoring (= impact x likelihood):

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

West Yorkshire Integrated Care Board - Board Assurance Framework - Summary						Version: 11	Date: Sept 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

[illegible]

WYICB - Board Assurance Framework - ICB and places						Version: 11	22 April 2025
Mission 1	Failure to manage strategic risk could result in a failure to REDUCE INEQUALITIES					Lead director(s) / board lead	Ian Holmes
Strategic risk 1.1	There is a risk that our local priorities to narrow inequalities are not delivered due to the impact of wider economic social and political factors.					Lead committee / board	ICB Board (linked to place committees)
ICB risk appetite	ICB risk scores					Rationale for current ICB score	
	Target (ICB)			Current (ICB)			Inequalities have widened in recent years due to broader social and economic factors. Our health and care partnership will make a positive contribution on these issues, there are a range of factors outside of our control that are likely to make narrowing inequalities more challenging.
BOLD	Likelihood	4	16	Likelihood	5	20	
	Impact	4		Impact	4		
Key controls (What helps us mitigate the risk?)						Mitigating actions (What more are we/should we be doing at ICB level?)	
1	ICS Five Year Strategy, including the 10 Big Ambitions, focusing on health inequalities and wider economic, social and political factors.					(1) Development of granularity of data to have full insight across different inequalities and impact across different populations. This is aimed for completion by the end of 2025/26.	
2	Health Inequalities Steering Group oversees spend of funding on specific initiatives to address inequalities.						
3	An MOU with WYCA setting out shared priorities, working and governance arrangements.						
4	Team working across health inequalities, with an in-house ICB team together with shared posts with WYCA.						
Sources of assurance (Where is the evidence that the controls work?)						Links to ICB risk register (Reference numbers/brief description)	
1	Integrated Care Partnership Board - agenda items, discussions, evidenced by minutes					2120 - reduction/loss of VCSE services; 2437 - GP collective action; 2402 - access GP services; 2267 - maternity services; 2106 - Cancer health inequalities;	
2	ICB Board - four deep dives into health inequalities during 2024/25 - agenda and minutes						
3	ICB Board - six monthly performance dashboard metrics against 10 Big Ambitions - agenda and minutes						
4	System Oversight and Assurance Group - rolling programme of metrics reported - agenda and minutes						
5	WYCA / ICB Quarterly Leadership Team meeting to oversee MOU						
6	Internal Audit review of Health Inequalities Partnering Arrangements - Significant Assurance (June 2024)					Positive Assurance - see separate log	
Bradford District and Craven (BD&C) Place lead: Therese Patten						Nominated lead for this risk: Sohail Abbas (26.06.25)	
ICB risk appetite	Place risk scores					Rationale for current place score	
	Target (BD&C)			Current (BD&C)			We agree with WYICB assessment and score the same for the BDC HCP with the following rationale: Inequalities occur due to health and wider determinants. We are working closely with health and social partners within BDC HCP. There are a range of factors where we have more limited control with regards to narrowing inequalities, e.g. around poverty, housing, skills. With the financial deficit in the ICB there is a risk of losing funding streams aimed at reducing health inequalities for example Core20Plus5.
BOLD	Likelihood	4	16	Likelihood	4	20	
	Impact	4		Impact	5		
Key controls (What helps us mitigate the risk?)						Mitigating actions(What more are we/should we be doing at place by when?)	
1	BDC HCP (place) Population Health Management structure implemented and Business Intelligence team aligned to transformation priorities, enablers, Community Partnerships / Primary Care Networks					1. Health and Wellbeing Board Strategy - work is ongoing to finalise the district plan for 2025/2035 with a clear focus on improving economic activity and reducing wider inequalities. 2. EDI work and anti-racism strategy development in Bradford District and Craven (2025 ongoing). 3. The economic accelerator programme has started from April 2025, work ongoing (2025/26) 4. Core20Plus5 intial evaluation is complete, we are now working on the economic evaluation of the programme (2025/26) 5. BDC Health and Care Strategy is in development and underpinned by the work of Population Health Management and reducing inequalities teams on assessing our population health and care needs (2025/26) 6. Bradford District Council growth plans (including city of culture 2025) are in development and will have an impact on the overall healthcare of our population.	
2	Wellbeing Board (Bradford District) and Health and Wellbeing Board (North Yorkshire)						
3	Health and Wellbeing Board Strategy						
4	Reducing Inequalities in Communities (RIC) work plan for the Reducing Inequalities Alliance sets out work on local priorities to address wider determinants; local Core20PLUS5 implementation group; Reducing Inequalities Alliance (cross partnership membership).						
5	The alliance has a work plan to deliver the Core20PLUS5 programme locally (with hyper local commissioning at community partnership level, and for CYP interventions to reduce inequalities).						
6	We are ensuring that our work to reduce inequalities runs as a golden thread through all that we do in the Act as One partnership and have published our Call to Action to reduce inequalities locally (and launched the Inequalities campaign and events with our workforce)						
7	The Core20Plus5 and health inequalities premium dashboards are established						
8	We are supporting West Yorkshire Health Equity fellowship scheme and mentoring local fellows across a range of work areas. Our Reducing Inequalities in Communities programme has 20 different projects covering health, wider determinants of health and community settings and we have extended many of these initiatives and embedded into business as usual where appropriate.						
Sources of assurance (Where is the evidence that the controls work?)						Links to Place Risk Register	
1	Reducing inequalities alliance - regular meetings - Papers and Mins					2317, 2386, 2477, 2418, 2221	
2	Health and Wellbeing Board - Papers and Mins						
3	The Core20Plus5 and health inequalities premium dashboards						
4	Outcomes focused performance report for HCP Board capturing health inequalities						
Calderdale Place lead: Robin Tuddenham						Nominated lead for this risk: Neil Smurthwaite (17.07.2025)	
ICB risk appetite	Place risk scores					Rationale for current place score	
	Target (Calderdale)			Current (Calderdale)			As WYICB outlines above. The CCPB focuses regularly on health inequalities. Presentation due in September 2025 Committee on latest intelligence and how we will using linked data sets to provide greater insight into the Integrated Neighbourhood Health work.
BOLD	Likelihood	4	16	Likelihood	5	20	
	Impact	4		Impact	4		
Key controls (What helps us mitigate the risk?)						Mitigating actions (What more are we/should we be doing at place?)	
1	We have a shared set of priorities set by Calderdale Health and Wellbeing Board - local plan feeds into ICB / ICP 5-year strategy forward plan					1. Calderdale council run a cost of living programme (2022 - ongoing) 2. Public have produced population data packes for each PCN and Integrated Neighbourhood health team.	
2	Reducing inequalities is a key ambition of the partnership						
3	Council Director of Public Health is lead for health inequalities work across Calderdale						
Sources of assurance (Where is the evidence that the controls work?)						Links to Place Risk Register;	
1	Progress against the ICB metrics on inequalities is reviewed regular by HWBB and CCPB					2224, 2476, 2149, 1998, 1493, 62, 2469, 2484,	
2	Local JSNA						
3	Council Director of Public Health- attends Partnership Board						
Kirklees Place lead: Vicky Dutchburn						Nominated lead for this risk: Steve Brennan (27.06.2025)	
ICB risk appetite	Place risk scores					Rationale for current place score	
	Target (Kirklees)			Current (Kirklees)			Recognise that addressing inequalities will take time and there are factors beyond our

BOLD	Likelihood	4	16	Likelihood	5	20	control, however the partners are committed to addressing this through the work that they do.
	Impact	4		Impact	4		
Key controls (What helps us mitigate the risk?)							Mitigating actions
1 Kirklees Health and Wellbeing strategy							1. Progressing on the work of the inclusive community framework (one of top tier partnership strategy) Power of one, power of many, working other for equity and fairness linked to the inclusive communities framework (2025/26) 2. The Kirklees ICB committee committed to continue with their work and actions were agreed as part of this work (November 2025) 3. Focus on addressing inequalities is key to how we deliver the Kirklees Healthy Working Life programme (for example the VCSE sector has a prominent role in helping to deliver this) 2025/26
2 Health and Wellbeing Plan							
3 Kirklees Economic, Environment and Inclusive Communities Strategies.							
Sources of assurance (Where is the evidence that the controls work?)							Links to place risk register: 2475, 2240, 2445
1 Regular reports to Health and Wellbeing Board							
2 Regular reports to Partnership Forum / ICB committee/ and other place governance							
3 Project reports							
Leeds Place lead: Tim Ryley							Nominated lead for this risk: Nick Earl 27.06.25
ICB risk appetite	Place risk scores						Rationale for current place score
	Target (Leeds)			Current (Leeds)			Inequalities continue to widen in Leeds due to wider social and economic factors. LHCP has a strong and continued focus to address these disparities through our operating framework. Risk score remains the same.
BOLD	Likelihood	4	16	Likelihood	5	20	
	Impact	4		Impact	4		
Key controls (What helps us mitigate the risk?)							Mitigating actions (What more are we/should we be doing at place?)
1 Partnership Leadership Team and Health and Wellbeing Board meetings in Leeds - allow influence of wider							1. Continued participation and support for Leeds City Council's Marmot City ambition 2. Leveraging ICB's role at place as a (small) anchor institution, and influence over other (larger) anchor institutions (NB this may not take place during vacancy freeze/restructure)
2 The Delivery and Inequalities Sub-Committee - highlighting impact of wider factors							
3 Marmot City Programme - provides joint working mechanism to address wider determinants							
4 Ongoing contracting with the third sector - provide additional resource flow into local economy and areas of need							
							Links to place risk register: 2415, 2354, 2301, 2018
Sources of assurance (Where is the evidence that the controls work?)							
1 Minutes from PLT / HWB meetings, particularly sessions with a wider strategic focus							
2 Minutes from Delivery and Inequalities Sub-Committee							
3 Programme reports from the Marmot city programme							
4 Financial accounts recording proportion of spend in this area							
Wakefield Place lead: Mel Brown							Nominated lead for this risk: Ruth Unwin, Amrit Reyat (14.07.25)
ICB risk appetite	Place risk scores						Rationale for current place score
	Target (Wakefield)			Current (Wakefield)			Local position reflects the WYICB position. Current likelihood is high due to significant pressures in the system.
BOLD	Likelihood	4	16	Likelihood	5	20	
	Impact	4		Impact	4		
Key controls (What helps us mitigate the risk?)							Mitigating actions (What more are we/should we be doing at place?)
1 Healthy Standard of Living for All is one of the four priorities in the Health and Wellbeing Strategy							1. A further community of practice event has been planned for November 2025 2. The work to develop the place response to reducing economic inactivity is currently taking shape (2025/26) 3. Wakefield is working with funding from Health Determinants Research Collaborative (HDRC) to establish research capacity around health inequalities (2025/26) 4. The development of our integrated neighbourhood health model (2025/26)
2 Economic Strategy is in place led by the local authority. Elements that impact on health inequalities are reported to Health and Wellbeing Board							
3 Joint post working across health and the Local Authority addressing inequalities is in place							
4 Joint Steering Group established							
5 We are now established as a enabler programme in our transformation and delivery collaborative							
6 Community of Practice event being took place in May 2025							
7 Some of our uncommitted core spend for 2025/26 will be focusing on COPD							
8 The economic accelerator programme is now established.							
9 Development of a district plan							
Sources of assurance (Where is the evidence that the controls work?)							
1 Regular reports such as Bi-monthly public health profiles addressing inequalities are presented to the Health and Wellbeing Board and to the Wakefield District Health and Care Partnership							
2 Wakefield Joint Strategic Needs Assessment							Link to Place Risk Register
4 Report to WDHCP Committee in November 2024 on the evaluation and principles of allocation of resource for CORE20PLUS							2481

WYICB - Board Assurance Framework - ICB and places							Version 11	Date: 12 June 2025
Mission 1	Failure to manage strategic risk could result in a failure to REDUCE INEQUALITIES						Lead director(s) / board lead	Ian Holmes / Jonathan Webb
Strategic risk 1.2	There is a risk that operational pressures and priorities impact our ability to target resources effectively towards improving outcomes and reducing inequalities for children and adults.						Lead committee / board	Finance, Investment and Performance Committee
ICB risk appetite	ICB risk scores						Rationale for current ICB score	
	Target (ICB)			Current (ICB)			Significant financial and operational pressure continues to impact on our ability to deliver wider ambitions. The organisational change process and capacity will impact on the operational pressure.	
OPEN	Likelihood	3	9	Likelihood	4	16		
	Impact	3		Impact	4			
Key controls (What helps us mitigate the risk?)							Mitigating actions (What more are we/should we be doing at ICB level?)	
1	Clear, agreed plans that deploys £10.75m Health Inequalities funding across all Core 20PLUS5 priorities - specific workstream headed by Improving Population Health (IPH) Board with remit to recommend allocation of specific funding across the ICS						1. EQIA process on any proposed service change and commissioning policy change (2025/26).	
2	The first 3 ambitions in our Strategic Plan relate to inequalities. Plans for these are set out in the Joint Forward Plan which provides the foundation to prioritisation by the ICB Board. The Plan has a refreshed set of metrics to ensure that a difference can be made and measured.							
3	Measurement of inequalities relating to key operational priorities - such as elective recovery and ambulance waiting times.							
4	Board approved WY ICS Finance Strategy confirms importance of health inequalities as key element of how deploy resources.							
5	Committee overview of commissioning policies and quality impact by the Transformation Committee and Quality Committee respectively.							
6	Inclusion Health Unit, whose focus is on the sustainability of inclusion health services, supporting the system to improve the health of population groups.							
Sources of assurance (Where is the evidence that the controls work?)							Links to ICB risk register (Reference numbers/brief description)	
1	Partnership Board focus on 10 big ambitions						Risk 2309 - demand for CYP mental health services; 2451 - Delays in gender identity specialist services; 2400 - delays in health assessments of CiC; 2479 - children's hospice care; Positive Assurance: see log	
2	ICB Board - performance dashboard and deep dives into health inequalities							
3	SOAG updates against 10 big ambitions							
4	ICB Annual Report summarises work on improving outcomes and reducing inequalities							
5	Internal Audit 'Health Inequalities Partnership Working' review - Significant Assurance - June 2024							
Bradford District and Craven (BD&C) Place lead: Therese Patten							Nominated lead for this risk: Sohail Abbas (26.06.25)	
ICB risk appetite	Place risk scores						Rationale for current place score	
	Target (BD&C)			Current (BD&C)			There are higher levels of inequality in BDC as compared to other places. The organisational changes and wider environments makes it difficult to reduce inequalities. The risk score remains the same for this cycle.	
OPEN	Likelihood	3	9	Likelihood	3	12		
	Impact	3		Impact	4			
Key controls (What helps us mitigate the risk?)							Mitigating actions (What more are we/should we be doing at place?)	
1	QEIA assessments in routine use						1. Work is ongoing on population needs assessment and using population health management principles to identify population cohorts for targetting interventions (2025/26) 2. We are in the process of developing our health and care strategies in place together with our partners which will meet our ambitions around improving outcome and reducing inequalities. This work is being led by the Director of partnership and place (2025/26) 3. Alongside the strategy development we are developing our intent around neighbourhood health and have events in the diary both with practices but also as part of our Listen In engagement schedule across our communities to ensure we are developing services in partnership (2025/26) 4. QEIA assessments in routine use (process being refined and reviewed 2025) to ensure that the impact of proposed decisions does not move resource away from critical areas of health inequality (2025/26) 5. Economic evaluation of our health inequalities programme is undergoing which will help us deliver financial case for reducing inequalities (2025/26)	
2	Prioritising action plans to address the main causes of death, inequalities and poor health across BDC HCP (place) within the new Closing the Gap programme. Leadership group has been set up for implementing Core20PLUS5 for the ICS and BDC HCP (place). Targeting reduction of health inequalities by working closely with PCNs and Community Partnerships (and with Local Authority Area teams)							
3	Closing the gap programme has segmented the population and examines trends on health needs against expenditure, and high impact evidence based interventions to reduce inequalities and address pressure points locally.							
4	Inequalities toolkits have been used by our 13 Community Partnerships to guide commissioning (with guidance and separate intelligence packs itemising outliers). Primary care practice priorities have been aligned to Core20 priorities via the health inequality practice premium.							
5	Priority boards maintain a key focus on inequalities through their programmes of work							
6	Developing a System approach to reducing inequalities via improved collaboration between Inequalities, EDI, Research and Prevention programmes (included board readiness toolkit & development sessions to embed work to reduce inequalities through the governance structure).							
Sources of assurance (Where is the evidence that the controls work?)							Links to Place Risk Register	
1	BDC Partnership Board and Exec receive full papers and briefings on progress within the Priorities and Enablers alongside system based committees which provide oversight and assurance on our outcomes.							
2	Inequalities are embedded into our transformation work with Population Health Management (PHM) data identifying key areas of focus for priority. Priority Boards providing ownership of transforming services across all place based partners							
3	Outcomes focused performance report for HCP Board capturing health inequalities							
							2386, 2227, 2039, 2221	
Calderdale Place lead: Robin Tuddenham							Nominated lead for this risk: Neil Smurthwaite (17.07.2025)	
ICB risk appetite	Place risk scores						Rationale for current place score	
	Target (Calderdale)			Current (Calderdale)			Risk score reflects operational performance on NHS targets. There are pressures in the system but it's not impacting on our ability to deliver Core 20+5. There is a significant risk on future finances and the overall change programme announced in March 25 could result in inequalities being impacted. Score will be continually monitored. Reviewed target score and reduced this from 9 to 6, due to a OPEN risk appetite.	
OPEN	Likelihood	2	6	Likelihood	3	9		
	Impact	3		Impact	3			
Key controls (What helps us mitigate the risk?)							Mitigating actions (What more are we/should we be doing at place?)	
1	Clear plan for place share of £12m led by DPH, reports to HWBB.						1. The data model is being developed to help analyse the use of urgent care to help address and ensure that out-of-hospital services do not create health inequalities - Population health tool is being developed - local drop in sessions will take place with discussion at Board level in 2025-26. 2. Financial pressures continue to be monitored and savings identified recurrently to ensure underlying position does not deteriorate. 3. Change programme and new ICB operating model will impact on this risk and will be monitored.	
2	Tackling inequalities is a core requirement of all papers to comment upon, particularly contract awards / service improvement.							
3	Measurement of health inequalities for elective recovery has been key component for CHFT and its delivery of its waiting lists.							
Sources of assurance (Where is the evidence that the controls work?)							Links to Place Risk Register: 2224, 1338, 2476, 2149, 1998, 1493, 62, 2092	
1	Regular report to HWBB (as above) and CCPB.							
2	Joint Forward Plan will include health inequalities.							
3	Transformation delivery plan signed off by Board on 5 September 2024, one of the key ambitions in reduction in health inequalities							
Kirklees Place lead: Vicky Dutchburn							Nominated lead for this risk: Vickv Dutchburn (25.06.2025)	

ICB risk appetite		Place risk scores				Rationale for current place score	
		Target (Kirklees)		Current (Kirklees)			
OPEN	Likelihood	2	6	Likelihood	3	12	Outcomes Framework, indicators and proxy indicators, establish network, align core 20 plus 5 , strengthen reporting through PMO and align approaches to VCSE investment and Inclusive communities framework. The elective performances is included in the bi-monthly performance committee. There have been deep dive reports and discussions with our health and care partnership board specifically on child and adult mental health and neurodiversity assessment, there is an action plan. The core 20+5 schemes have been reviewed and built in as business as usual as an outcome of that review. The rigour of internal processes with regards to prioritisation and reviews of all contracts which are due to expire March 2026 - the governance timeline complete until the end of October 2025.
	Impact	3		Impact	4		
Key controls <i>(What helps us mitigate the risk?)</i>						Mitigating actions <i>(What more are we/should we be doing at place?)</i>	
1	Health and Wellbeing Strategy						1. Agreed that Kirklees place will develop an action plan on children and young people's neurodiversity to sign off by April 2025 - action plan has been completed and submitted as part of the SEND review - June 2025. 2. Expecting final SEND report end of August 2025 and implementing review actions from Q3, 2025/26 3. Establishment of transformation dashboard as per annual review recommendation (Q2, 2025/26)
2	Health and Wellbeing Plan						
3	Outcomes Framework						
4	Deep dive reports on high risk areas e.g. child & adult mental health, neurodiversity assessments.						
5	Completed review of the children and young people's mental health model (Kirklees Keeping In Mind) implementation commenced April 2025.						
Sources of assurance <i>(Where is the evidence that the controls work?)</i>						Links to place risk register:	
1	Regular reporting into Health and Wellbeing Board						2240
2	Regular reporting into place governance such as the Kirklees Quality Committee						
3	PMO reports on projects						
4	Reports and action plans to Transformation Committee						
Leeds				Place lead:	Tim Ryley		Nominated lead for <u>this</u> risk: Nick Earl 27.06.2025
ICB risk appetite		Place risk scores				Rationale for current place score	
		Target (Leeds)		Current (Leeds)			
OPEN	Likelihood	3	9	Likelihood	4	16	Current reduction in ICB resources and associated restructure will be presenting notable challenges to driving work in this area (alongside existing operational pressures - particularly during Winter). Reviewed target risk score in light of a open risk appetite (willing to take reasonable risks and is tolerant to some uncertainty), agreed to reduce the target risk score from 12 to 9.
	Impact	3		Impact	4		
Key controls <i>(What helps us mitigate the risk?)</i>						Mitigating actions <i>(What more are we/should we be doing at place?)</i>	
1	Local strategy with a focus on health inequalities (Healthy Leeds Plan), with key data cut by IMD and other relevant HI metrics.						1. Partnership focus in 25/26 on programme benefits quantification should support greater assessment of potential HI impact 2. Review approach to incentives in line with strategic commissioning role towards the end of this financial year 3. Provide both challenge and support to emerging HealthCare Inequalities Oversight Group, which has a partnership focus across providers
2	Local governance structures with a focus on inequalities - Delivery and Inequalities sub-committee, Health Inequalities Oversight Group and specific sessions at Partnership Leadership Team						
3	Leeds financial planning process includes mechanisms to minimise impact on inequalities as well as QEIA assessments in routine use (and published)						
4	All delivery plans have a clear focus on addressing inequalities within existing resources.						
5	Inequalities / Core20+5 / transformation funding as part of general practice incentive scheme (GPOP)						
Sources of assurance <i>(Where is the evidence that the controls work?)</i>						Links to place risk register:	
1	HLP document and access to PowerBI reporting						2354, 2301, 2480
2	Minutes and terms of reference for Delivery Sub-Committee, HIOG and PLT						
3	Online QEIA resource						
4	Business reporting to Leeds Director Team						
5	GPOP scheme documents						
Wakefield				Place lead:	Mel Brown		Nominated lead for this risk: Ruth Unwin, Amrit Reyat (14.07.25)
ICB risk appetite		Place risk scores				Rationale for current place score	
		Target (Wakefield)		Current (Wakefield)			
OPEN	Likelihood	3	9	Likelihood	4	16	Reflects the Integrated Care Board position. Local places have limited powers to reduce likelihood.
	Impact	3		Impact	4		
Key controls <i>(What helps us mitigate the risk?)</i>						Mitigating actions <i>(What more are we/should we be doing at place?)</i>	
1	Allocation of CORE20plus5 monies						1. Working with the data team to do more deeper evaluation of our CORE20plus funded programmes (2025/26) 2. Working through the investment panel process to secure funding (2025/26)
2	Healthy Sustainable Communities Oversight Group established for CORE20plus5 and reports through the governance structure						
3	Place Outcomes Framework currently in development						
4	Tackling inequalities is a priority of the Health and Wellbeing Board and associated work programmes						
5	Established CORE20plus5 strategic group which oversees the evaluation of funded programmes. Developed a evaluation framework which will support targeted interventions						
Sources of assurance <i>(Where is the evidence that the controls work?)</i>						Link to Place Risk Register	
1	Health and Wellbeing Board Outcomes Framework - reports to the Health & Wellbeing Board - annually						2128
2	Performance Report to Integrated Assurance Committee - bi-monthly						
3	Performance Report to Wakefield District Health and Care Partnership - quarterly						

WYICB - Board Assurance Framework - ICB and places							Version: 11		22 April 2025			
Mission 1		Failure to manage strategic risk could result in a failure to REDUCE INEQUALITIES					Lead director(s) / board lead		Ian Holmes			
Strategic risk 1.3 (previously 1.4)		There is a risk that we fail to join up services in our communities which means that we do not improve outcomes and reduce health inequalities.					Lead committee / board		ICB Board <i>(linked to place committees)</i>			
ICB risk appetite		ICB risk scores					Rationale for current ICB score					
		Target (ICB)			Current (ICB)		Integrated care in communities is fundamental to our strategy for improving outcomes and tackling inequalities and a priority for all places. We have made good progress in some areas, but progress has been variable and there is still significant work to be done.					
OPEN		Likelihood	2	8	Likelihood	3	12					
		Impact	4		Impact	4						
Key controls <i>(What helps us mitigate the risk?)</i>							Mitigating actions <i>(What more are we/should we be doing at ICB level?)</i>					
1		ICS and HWB strategies, together with the Joint Forward Plan set out a clear and aligned vision and plans for integrating services in communities, in line with the Fuller recommendations and the medium term strategy.					1. Place Partnership Review (led by Anthony Kealy) will support further development of Place model including provider collaboratives and integration in Places. The ICB's response to the running cost reduction will need to consider the findings of this review in the context of significantly reduced capacity. 2. National focus on integrated neighbourhood health as part of the new Government's objectives will create greater focus. This will influence ICB planning for 2025/26. The ICB has identified integrated neighbourhood health as a key priority lead by Places.					
2		ICB medium term financial plan supports a differential investment towards primary and community care.										
3		Working with stakeholders through the Power of Communities programme on 4 key priority areas for specific focus over the next 5 years to ensure reduction in inequalities and to add value and maximise impact including: Acute & Specialist Provision; Community & Neighbourhoods; Access, inclusion and working with diverse communities and workforce.										
4		Quality Committee and ICB Board receive Integrated Performance Dashboard which reflects progress made towards integrating services and neighbourhoods.										
5		Development of a Blueprint for delivering neighbourhood-based care, driven by integration, to deliver outcomes important to people and tackle inequalities. This is being overseen by the Transformation Committee.										
Sources of assurance <i>(Where is the evidence that the controls work?)</i>							Links to ICB risk register (Reference numbers/brief description)					
1		Published ICS health and wellbeing strategy and Joint Forward Plan					2120 - risk of a widening of health inequalities and poorer health outcomes due to the reduction or loss of VCSE services and aggregated impact of disinvestment in the VCSE					
2		Delivery of the Fuller Board work plan (minutes and actions)										
3		Metrics within the Integrated Performance Dashboard, discussion evidenced through minutes of Quality Committee and ICB Board										
4		Internal Audit review - Primary Medical Services Commissioning (significant assurance)					See the separate Positive Assurance Log					
Bradford District and Craven (BD&C)			Place lead:		Therese Patten		Nominated lead for <u>this</u> risk: Sohail Abbas (26.06.25)					
ICB risk appetite		Place risk scores					Rationale for current place score					
		Target (BD&C)			Current (BD&C)		Key priority with significant work required across our PCNs, CPs and localities. Challenges are capacity to deliver and maturity of multi-sector provider collaboration. We are prioritising based on areas PHM data is highlighting.					
OPEN		Likelihood	2	8	Likelihood	3	12					
		Impact	4		Impact	4						
Key controls <i>(What helps us mitigate the risk?)</i>							Mitigating actions <i>(What more are we/should we be doing at place?)</i>					
1		Development of our Primary Care Networks and Community Partnerships (CPs) that together support integrated neighbourhood health service models - and which can be flexible to the specific needs of local communities across BDC.					1. Continuing to expand use population health management data and analysis to drive our commissioning intentions and decisions on service transformation and provision - and empower service change at the neighbourhood level (2025/26) 2. Reducing Inequalities Alliance are working with our Community Partnerships (CPs) in relation to on-going roll out of Core20+5 initiatives. CPs are grouped by LA wards, have linked PCNs and also have strong input from the VCSE, to further facilitate opportunities for neighbourhood co-production on integrating care and tackling inequalities (2025/26) 3. BDC health and care strategy and national 10 Year Plan will inform continued evolution of local integrated neighbourhood health models (2025/26) 4. Long term conditions and multi-morbidity needs assessment and development of a holistic model of care, with focus on those at high/rising risk and high intensity users of health services (2025/26) 5. Work underway to develop our integrated neighbourhood team model (2025/26)					
2		Reduce Inequalities Alliance (RIA) built around 4 themes: to set the strategic vision; support best practice; build leadership capacity; and facilitate and share learning. This is also enabling embedding of Core20Plus5 approaches at the neighbourhood level.										
3		Strategic commissioning intent and development of our health and care strategy is underway.										
Sources of assurance <i>(Where is the evidence that the controls work?)</i>							Links to Place Risk Register					
1		Place priorities for system transformation, including integrated neighbourhood health services development, report to Partnership Leadership Executive and to the BDC HCP Partnership Board					2221, 2486					
2		Reducing Inequalities Alliance reporting to Exec and BDC HCP Partnership Board										
3		Development of our health and care strategy; co-production with Bradford LA on the district plan (delivery oversight by the Health and Wellbeing Board); ongoing work with NY LA via our localities										
Calderdale			Place lead:		Robin Tuddenham		Nominated lead for <u>this</u> risk: Neil Smurthwaite (17.07.2025)					
ICB risk appetite		Place risk scores					Rationale for current place score					
		Target (Calderdale)			Current (Calderdale)		Integrated care in communities is fundamental to our strategy for improving outcomes and tackling inequalities and a priority for Calderdale.					
OPEN		Likelihood	2	8	Likelihood	3	12					
		Impact	4		Impact	4						
Key controls <i>(What helps us mitigate the risk?)</i>							Mitigating actions <i>(What more are we/should we be doing at place?)</i>					
1		Calderdale Cares Community Programme Board is in place for integrating services and community.					1. Looking to utilise data over coming year to ensure efficiency and effectiveness of services to ensure out of hospital care reduces inequalities, there is a programme of work ongoing (Quality group) 2025/26 2 Place Partnership Review (led by Anthony Kealy) and ICB letter March 25 regarding Provider Collaboration will support further development of Place model including provider collaboratives and integration in Places. The ICB's response to the running cost reduction will need to consider the findings of this review in the context of significantly reduced capacity. 3. National focus on integrated neighbourhood health as part of the new Government's 10 year plan create greater focus. This will influence ICB planning for 2025/26 and beyond. The ICB has identified integrated neighbourhood health as a key priority lead by Places. 4. Consideration made for national programme for Integrated Neighbourhood Health, however due to uncertain times first phase application not proceeded with. Further strengthening of data and resource needed for future waves <u>Links to Place risk register:</u> 2476, 2163, 1493, 62, 1977, 2469, 2484, 2092					
2		Tranformation deliver plan has integrated neighbourhood team as key objective for the partnership board										
3		Calderdale Community Collaborative Programme board in placed led by PCN Directors.										
4		Senior leadership meeting in July 2024, discussion on integrated neighbourhood teams										
5		There are variety of governor forums and enabler groups that bring partners across the health and care partnership together to address issues relating to issues in a joined up way										
Sources of assurance <i>(Where is the evidence that the controls work?)</i>												
1		A year end report will be presented to the partnership board on the tranformation delivery plan for which integrated neighbourhood is the key priority										
2		Joint Forward Plan being developed.										
3		Calderdale Community Collaborative Programme board in place led by PCN Directors. Terms of Reference and mins.										
Kirklees			Place lead:		Vicky Dutchburn		Nominated lead for <u>this</u> risk: Catherine Wormstone (30.06.2025)					
ICB risk appetite		Place risk scores					Rationale for current place score					
		Target (Kirklees)			Current (Kirklees)		While a strategy is in place, there is a need to focus on the delivery of transformation and improvements across all nine integrated neighbourhood teams and to ensure adequate capacity is freed up by system partners. Risk score remains the same.					
OPEN		Likelihood	2	8	Likelihood	3	12					
		Impact	4		Impact	4						
Key controls <i>(What helps us mitigate the risk?)</i>							Mitigating actions <i>(What more are we/should we be doing at place?)</i>					
1		Core20+5 is being lead by the Public Health team on behalf of the Partnership					1. Programme plan in place to fully implement integrated neighbourhood teams and improve integrated neighbourhood health in line with 2025/26 planning guidance					

2	Addressing inequalities is and will continue to be written into the scope and terms of reference for all place based work areas, to ensure that the focus on inequalities is a common theme to all our work	improve integrated neighbourhood health in line with 2025/26 planning guidance
3	INT data packs developed and data sharing agreements in place	2. Business case developed for accessing West Yorkshire SDF funds (non-recurrent) to assist with accelerating pace of implementation
4	A number of services including VCSE already aligned around communities	3. Identified accelerator site to commence first INT on 2 July 2025, system partners are ready to facilitate engagement and support for accelerator site.
Sources of assurance <i>(Where is the evidence that the controls work?)</i>		4. Regular fortnightly call in place with SROs for 6 core components of integrated neighbourhood health
1	Published Health and Wellbeing Strategy	5. Workshop held on 27 June 2025 to co-design OD support for system leaders and integrated neighbourhood teams. Next steps will be to share draft programme with stakeholders (2025/26)
2	The local Health and Care Plan follows directly on from the Health and Wellbeing Strategy	6.Planned refresh of the objective within the health and care plan (2025/26)
3	Extensive engagement (lead by Healthwatch) with local people to inform strategy and plans to ensure they meet the needs of the local population	7. Neighbourhood level data being extracted from primary care and supported by linked data sets to facilitate a population health management approach. Next steps to share with accelerator site and other INTs (2025/26)
4	ICB Committee meetings - notes	Links to place risk register 2475
5	Delivery collaborative - notes	
6	PCN meetings - notes	
7	Data available at PCN level is already driving the delivery plans of PCNs working in partnership with statutory and VCSE partners in each footprint to support change and integration on the ground.	
8	WY INH Board in place	
Leeds Place lead: Tim Ryley		Nominated lead for this risk: Helen Lewis (23.06.25)
ICB risk appetite	Place risk scores	
	Target (Leeds)	Current (Leeds)
OPEN	Likelihood	2 8
	Impact	4
Key controls <i>(What helps us mitigate the risk?)</i>		Mitigating actions <i>(What more are we/should we be doing at place?)</i>
1	Strong LCPs and PCNs.	1. Developing (integrated neighbourhood clinics are in place and considering further developments) (2025/26)
2	All relevant data displayed by IMD and other key variables linked to inequalities.	2. LCH and GP confederation looking at neighbourhood integration opportunities as part of the system neighbourhood health model (2025/26)
3	Population and care delivery board structures in place, with increasing access to data that enables analysis of issues at very local levels, add neighbourhood health is one of the partnership leadership priorities and programme is reviewed regularly and overseen by partnership leadership team	3. LCH and Leeds City Council rolling out their active recovery offer to improve integration (2025/26)
Sources of assurance <i>(Where is the evidence that the controls work?)</i>		4. Community mental health programme engaging all relevant partners to improve service integration and focus on those people most at risk (new contract with VCSE 2025/26)
1	Access to Leeds data model/power BI platforms, and RAIDR to review data sets.	Positive Assurance
2	Notes of LCP/PCN meetings.	
3	All LHCP programmes pay due attention to joining up services, demonstrated via minutes.	Data available at PCN level is already driving the delivery plans of PCNs working in partnership with statutory and VCSE partners in each footprint to support change and integration on the ground.
		Link to place Risk Register
		2415
Wakefield Place lead: Mel Brown		Nominated lead for this risk: Ruth Unwin, Amrit Reyat (14.07.25)
ICB risk appetite	Place risk scores	
	Target (Wakefield)	Current (Wakefield)
OPEN	Likelihood	2 8
	Impact	4
Key controls <i>(What helps us mitigate the risk?)</i>		Mitigating actions <i>(What more are we/should we be doing at place?)</i>
1	Wakefield Transformation and Delivery Collaborative established supported by a network of Provider Alliances with responsibility for joining up services and addressing inequalities	1. The development of a neighbourhood model enables a targeted and more planned approach to care (2025/26)
2	Core Senior Leadership team established across Wakefield place with distributed leadership responsibilities	2. The reducing healthcare inequalities steering group is connected into the VCSE collaborative which is taking forward the development of the VCSE strategy for the district (2025/26)
3	Action plan to address the gaps following the publication of the Fuller report	3. The work to develop the place response to reducing economic inactivity is currently taking shape (2025/26)
4	This work is connected to the work to develop a neighbourhood model	
Sources of assurance <i>(Where is the evidence that the controls work?)</i>		Positive Assurance
1	Transformation and Delivery Collaborative Chair's report to Wakefield District Health and Care Partnership highlights key discussions - bi monthly	An update report was provided to the health and wellbeing board on the 30 January 2025 regarding the development of the VCSE strategy.
2	Provider Alliance deep dive regarding progress against priorities reported to Transformation and Delivery Collaborative - monthly	Links to Place Risk Register
3	Medical Director for Integrated Community Services attends Fuller Board	2397, 2429

WYICB - Board Assurance Framework - ICB and places							Version: 11		Date: 8 April 2025	
Mission 2		Failure to manage the strategic risk could result in a failure to MANAGE UNWARRANTED VARIATION IN CARE					Lead director(s) / board lead		Kate Sims	
Strategic risk 2.1		There is a risk that our inability to collectively recruit and retain staff across health and care impacts on the quality and safety of services.					Lead committee / board		Transformation Committee	
ICB risk appetite		ICB risk scores					Rationale for current ICB score			
		Target (ICB)			Current (ICB)			Workforce recruitment and retention remains a challenge across the system. The current workforce reduction programmes within both the ICB and provider Trusts will impact on the ability to attract and retain staff across the workforce. In addition, the system awaits further detail in relation to any potential growth as part of the NHS long term workforce plan and Adult Social Care workforce strategy. Risk score- increased impact from 3 to 4 for this quarter - increased from 12 to 16.		
OPEN	Likelihood	4	8	Likelihood	4	16				
	Impact	2		Impact	4					
Key controls <i>(What helps us mitigate the risk?)</i>							Mitigating actions <i>(What more are we/should we be doing at ICB level?)</i>			
1		WY People Board (multi-sector) oversight of priority programmes, The ICB EMT organisational change programme board - a system wide overview of the responses to the workforce challenges under the West Yorkshire People Plan					(1) WY People Strategy is being refreshed during 2025.			
2		WY Mental Health and Well Being Hub - a system wide offer to all staff across the WY partnership to ensure that access to Mental Health Wellbeing is available to all - with regular reporting into People Board					(2) The ICB received detail from each NHS provider of their current workforce planning and control mechanisms. These will be used to help monitor each Trusts workforce position against its operating planning submission (2025/26)			
3		WY Strategic Workforce Transformation Forum established (system wide) to have strategic overview to ensure readiness against long term workforce plan and adult social care workforce strategy					(3) Workforce Strategy and Planning Team - primary agenda is aligned with Strategic Workforce Transformation Forum, and as this develops they will provide a level of workforce transformation capacity.			
4		Workforce Place Leads and place-based plans (for further details, see Place BAF below)					(4) One of the agreed terms of reference for the Strategic Workforce Transformation Forum centres on influencing regionally and nationally. The Forum has now agreed its core 4 priorities with delivery groups established to respond to each - 2025/26			
5		Creating Global partnerships for the supply of International recruits into challenged areas - to ensure ethical and sustainable international recruitment, education pathway and to offer system support. Dedicated global team working directly with NHS England.					(5) The ICB has commenced a review of its operating model (Apr 2025) in response to the further targetted reduction of 50% of costs. There will be a large scale organisational change programme to deliver the required response to this announcement.			
6		Active leadership on workforce part of annual operating plan cycle, with ongoing assurance through Finance Investment and Performance Committee, Transformation Committee and ICB Board.					(6) NHS providers across West Yorkshire are also required to review their growth in corporate service costs since 2019/2020 and reduce these by 50%. This is in addition to the workforce reductions indicated within the operating planning submission.			
Sources of assurance <i>(Where is the evidence that the controls work?)</i>							Links to ICB risk register <i>(Reference numbers/brief description)</i>			
1		Transformation Committee; Strategic Workforce Forum; People Board - agenda, papers and minutes					2296 - YAS workforce; 2108 - cancer workforce; 2324 - ICB workforce; 2402 - general practice workforce; 2512 - ICB workforce			
2		Place leads meet with local NHS providers to ensure progress is monitored across WY against the operating planning submission. WY People Team actively attend Place workforce committees. Director of People is a member of Yorkshire and Humber Workforce Steering Group for adult social care.								
3		NHS sickness absence and turnover is reported to ICB Board via Integrated Performance Report.								
2		Active data flow across wider People agenda, which is presented to the People Board and Strategic Workforce Transformation Forum.								
3		(NHS specific) Staff Survey annual results					See the separate Positive Assurance Log			
Bradford District and Craven (BD&C)		Place lead:		Therese Patten			Nominated lead for <u>this</u> risk:		Andrew Milner 27.06.2025	
ICB risk appetite		Place risk scores					Rationale for current place score			
		Target (BD&C)			Current (BD&C)			The workforce challenges remain across both health and social care within the public and independent sector. Additionally, there are similar challenges within the voluntary, community and social enterprise sector where issues around living wage and competition from larger employers is cited as a particular challenge. Within health, retention remains a significant challenge. Current financial and organisational circumstances mean recruitment across healthcare organisations is extremely limited. Risk score increased from 12 to 16. Discussed target score as the appetite is currently cautious, agreed to increase the target risk score from 6 to 8 due to limited tolerance.		
CAUTIOUS	Likelihood	4	8	Likelihood	4	16				
	Impact	2		Impact	4					
Key controls <i>(What helps us mitigate the risk?)</i>							Mitigating actions <i>(What more are we/should we be doing at place?)</i>			
1		BDC HCP System Finance and Performance Committee (System FPC) – led by an independent NED chair who champions the agenda at the BDC Partnership Board. Broad based senior participation including care sector and primary care. Quarterly review of the detailed workforce dashboard with a view to identifying workforce risks and issues.					1 We have made progress in supporting the social care workforce with initiatives to help retain staff. As a part of the health and work accelerator programme multiple interventions including the provision of mental health and physiotherapy support are being commissioned to support the social care workforce. This builds upon learning from successful employee assistance programmes operating within our NHS provider organisations. We are building on this by working with the Bradford Care Association. 2. Delivery of the workforce priority programme at place with emphasis on building recruitment pipelines for health and social care staff specifically through the development of a consolidated entry level recruitment programme run via Skills House within Bradford Metropolitan District Council (Ongoing 2025/26) 3. Working across the system within partners including Higher Education Institutions to develop a pipeline for registered health and care roles (Ongoing 2025/26)			
2		BDC HCP People Plan has been refined to ensure alignment with the priorities of partner organisations and the partnership more broadly. As a part of this, particular focus has been placed upon capacity and ability to deliver.								
3		'People' is one of five strategic priorities for BDC HCP which means that additional focus and resource applied to delivery of the People Plan. Reported on at Partnership Leadership Executive and Partnership Board. With CEO lead Foluke Ajayi in place.								
Sources of assurance <i>(Where is the evidence that the controls work?)</i>							Links to Place Risk Register			
1		Triple A report from SFPC to Partnership Board					2386, 2227, 2477, 2434, 2422, 2420, 2418, 2417, 2215, 2421,			
2		Highlight reports from the People Programme through a Programme Board								
3										
Calderdale		Place lead:		Robin Tuddenham			Nominated lead for <u>this</u> risk:		Neil Smurthwaite (17.07.2025)	
ICB risk appetite		Place risk scores					Rationale for current place score			
		Target (Calderdale)			Current (Calderdale)			The workforce challenges remain across social care both within the public and independent sector, together with the voluntary, community and social enterprise sector, with challenges of living wage and competition from larger employers cited as a particular challenge. Within health, retention of staff is seen as a priority alongside recruitment.		
CAUTIOUS	Likelihood	4	8	Likelihood	4	12				
	Impact	2		Impact	3					
Key controls <i>(What helps us mitigate the risk?)</i>							Mitigating actions <i>(What more are we/should we be doing at place?)</i>			
1		West Yorkshire plans reflected at place.					1. Provider workforce plans led by Acute and Primary Care leads 2025/26 2. Local group looks at recruitment and development 2025/26			
2		Operating model is in place								
Sources of assurance <i>(Where is the evidence that the controls work?)</i>							Links to Place Risk Register:			
1		Update to the partnership board					2224, 1338, 2149, 1493, 62, 1977, 2092			
Kirklees		Place lead:		Vicky Dutchburn			Nominated lead for <u>this</u> risk: Steve Brennan (25.06.2025)			
ICB risk appetite		Place risk scores					Rationale for current place score			
		Target (Kirklees)			Current (Kirklees)			Whilst workforce data shows that generally the workforce is increasing at a modest rate, it is not		
	Likelihood			Likelihood						
	Impact			Impact						

CAUTIONS	Likelihood	4	8	Likelihood	4	16	in line with growth targets and therefore workforce challenges still remain across all sectors of Health and Social Care. The workforce controls around the 2025/26 planning round makes this challenging. Some of the challenges are structural [such as rates of pay within social care and potential changes for international staff particularly in the independent care sector and recent NI changes] and therefore are difficult to address in the short term. Current ongoing changes to where the responsibility for strategic workforce planning sits within the NHS make this more challenging. The workforce challenges with Kirklees are in line with those across West Yorkshire as a whole, and therefore our risk scores are in line with those for the wider West Yorkshire ICB. Risk score increased from 12 to 16 in line with WY ICB.
	Impact	2		Impact	4		
Key controls (What helps us mitigate the risk?)							Mitigating actions (What more are we/should we be doing at place?)
1	Kirklees actively engaged in West Yorkshire arrangements.						1 We have made progress in supporting the social care workforce with initiatives to help recruit staff. We are building on this by working with the Kirklees and Calderdale Care Association, for example, to support staff wellbeing within care homes roadshow which took place in May 2025. Compassionate cultures conference took place in June 2025, supporting staff with health and wellbeing. However, this is an area where we continue on supporting staff health and wellbeing. 2 We want to develop approaches to building training capacity in non-acute settings, but this will take time. Working as part of the WY placement expansion work with a focus on placements in care home settings (2025/26) 3 We also want to build more on the opportunities created by working with the University of Huddersfield, particularly around the new Health Innovation Campus, Health and Wellbeing Academy, and Leadership Development. Recently established a partnership board to oversee this work (2025/26) for example the development of new Radiography course.
2	Workforce arrangements well established within Kirklees for working with health and care providers and sectors including the VCSE and social care. We have an agreed integrated workforce approach with Calderdale which focuses on 3 pillars (1. Looking after our people, 2. Recruiting and retaining our people, and 3. Developing our people together). We have a system Senior Responsible Officer in place and a joint Workforce Steering Group which is supported by a Working Group for each of the 3 pillars.						
3	Placement work on pharmacy is now complete, the placement arrangements and systems will continue 2025/26						
Sources of assurance (Where is the evidence that the controls work?)							Link to place risk register: 2498
1	Evidence on the impact of projects and initiatives is monitored within the appropriate Working Group for each of the pillars.						
2	Each of the 3 Working Groups reports into our Joint Workforce Steering Group to present evidence of impact of their projects and initiatives.						
3	Regular updates on the Joint Workforce Programme are reported into the Kirklees Partnership Forum, which is part of our overall place governance arrangements. Updates are also presented to other governance forums when required such as the Kirklees Transformation sub-committee.						
Leeds Place lead: Tim Rley Nominated lead for this risk: Kate O'Connell (02/07/2025)							
ICB risk appetite	Place risk scores						Rationale for current place score
	Target (Leeds)			Current (Leeds)			
CAUTIONS	Likelihood	3	9	Likelihood	4	12	The current risk score reflects the scale of unfilled vacancies across the vast majority of employers in the context of a tight labour market. Although targeted activity has reduced some vacancies, the financial pressures have created recruitment controls and so notable risk remains. There has been a shift in focus from recruitment to retention. Current pressures on services and the cost of living increase creates significant risk of retention, particularly for the lowest paid staff, many of whom are in the third sector. Existing mitigations are unlikely to resolve the scale and nature of these challenges in the short term.
	Impact	3		Impact	3		
Key controls (What helps us mitigate the risk?)							Mitigating actions (What more are we/should we be doing at place?)
1	The Leeds One Workforce Strategy has been refreshed, continuing to providing a cohesive, prioritised approach for the city's health and care partners and a clearly defined programme of work.						1. Continue to identify and secure diverse funding which supports collaborative recruitment and retention. The Leeds Health and Care Academy leads this on behalf of the city and income is assessed annually. The last review took place on April 2025. The next review will take place in April 2026. 2. Continue to increase and diversify student placement opportunities and experience, and support transition from education to employment. This is a priority strategic project in the Leeds One Workforce Programme due for review in November 2025. 3. Health and growth accelerator programme providing additional support to retain staff in work (2025/26)
2	Leeds City Resourcing Group (LCRG) guide and monitor the collective impact of workforce recruitment and retention activity across Leeds Health and Care Partnership.						
3	Leeds H&W Community of Practice (CoP) collaborates on city-wide funding and services for H&SC staff.						
Sources of assurance (Where is the evidence that the controls work?)							Link to place risk register: None.
1	Minutes from Leeds One Workforce Strategic Board (LOWSB), LCRG and Leeds H&W CoP						
2	Academy Steering Group quarterly reports						
3	Leeds One Workforce City Risk profile						
Wakefield Place lead: Mel Brown Nominated lead for this risk: Dominic Blaydon/ Philip Marshall 01.07.25							
ICB risk appetite	Place risk scores						Rationale for current place score
	Target (Wakefield)			Current (Wakefield)			
CAUTIONS	Likelihood	4	8	Likelihood	4	12	The current likelihood and impact scores recognise the work underway as part of the implementation and delivery of The Wakefield People Plan. The Plan consists of 6 Pillars, all aligned to supporting staff health and wellbeing, retention and recruitment included in Pillar 1 'Looking after our People' and Pillar 5 'Growing and Developing Our Workforce. These programmes will support partnership and collaborative initiatives. It also includes commitment to the Memorandum of Understanding (MoU) and Operational Template to support the deployment of staff between organisations. This MoU will mitigate any future impact of operational and process challenges with recruitment and retention of staff at an organisational level. Currently there is a significant risk to the workforce as a result of the 50% reduction in ICB funding however, in Wakefield we are to some extent protected from this because of the way the PMO is currently funded. There is still residual risks to the social care workforce associated with a lack of the national strategy and funding arrangements.
	Impact	2		Impact	3		
Key controls (What helps us mitigate the risk?)							Mitigating actions (What more are we/should we be doing at place?)
1	Wakefield People Alliance oversight of priority programmes - a system wide overview of the responses to the workforce challenges under the Wakefield People Plan						The Wakefield People Alliance's Pillar 5 Programme adopts a comprehensive approach to tackling workforce risks through strategic recruitment initiatives. These initiatives mitigate workforce risks associated with recruitment and retention of staff across the health and care system. Initiatives include: (timescale - 2025/26) 1. Hyperlocal Recruitment Programme, which focuses on attracting talent from within the local community. By partnering with local organisations and offering tailored recruitment opportunities, this programme supports the development of a diverse workforce that is connected to local communities. 2. School Engagement Programme, which fosters early career awareness by engaging students and raising the profile of the full range of careers available in our sector. This initiative not only encourages the pursuit of healthcare careers but also strengthens the pipeline of future professionals. 3. The Student Placement Framework further enhances workforce sustainability by providing students with hands-on experience within the Wakefield health and care sectors, helping to
2	Mental Health and Well Being Hub - a system wide offer to all staff across the West Yorkshire partnership to ensure that access to Mental Health Wellbeing is available to all.						
3	The Wakefield People Plan has 6 Pillars within it, each with two Pillar Leads, supported by a Programme Manager to plan, lead the delivery of each Programme						
4	Wakefield Workforce Project Management Office established across the Wakefield system						
Sources of assurance (Where is the evidence that the controls work?)							
1	Access and analysis of workforce sector data to inform the development of a Workforce Plan dashboard to be reported through to Integrated Assurance Committee.						
2	Wakefield has been supported via system-wide funding/workstreams including staff training and support, coaching and mentoring, money buddies, physical health checks.						

	Positive Assurance The current Programme within the Wakefield People Plan focuses on the following priorities: - Community Career Events co-designed by the Community delivered by all health and social care providers across Place and hosted in Community Anchors. Hyper local recruitment in place with job interviews on the day and roles offered to community members. This is an evolving programme which will be delivered across all localities. - System approach to the pooling of the apprenticeship levy and developing resources specifically for young people to increase the number of apprenticeships in the system and grow our own from the future generation - Working with the social care independent sector to support their key challenges identified and co-design solutions, which include system offers on training, well-being and local recruitment. - Strong place-based governance arrangements are in place to support the delivery of the programmes, including a well-developed People Alliance, dedicated System Workforce Programme Management Office and Wakefield Health and District Partnership People Hub. - Recently launched economic accelerator programme that supports people in the current workforce who are at risk of becoming economically inactive. Commissioned a range of services to support this cohort.	bridge the gap between academic learning and real-world application. The Wakefield People Alliance addresses retention through its Pillars 1-3 Programmes. Initiatives include: (timescale - 2025/26) 1. The Wakefield Health and Care Learning Portal supports continuous development by offering accessible training and development resources for current staff, promoting career growth within the sector. 2. The Compassionate Leadership Programme cultivates empathetic leadership to create supportive working environments, while The Leading Wakefield Together training builds collaborative leadership skills across the workforce. 3. Coaching and Mentoring Hubs provide personalised support to staff, helping them navigate career challenges and fostering long-term engagement. Continues for 2025/26.
		Links to Place Risk Register
		2129

WYICB - Board Assurance Framework - ICB and places							Version: 11	Date: 19 March 2025
Mission 2	Failure to manage the strategic risk could result in a failure to MANAGE UNWARRANTED VARIATION IN CARE						Lead director(s) / board lead	James Thomas
Strategic risk 2.2	There is a risk that as a system we fail to innovate, learn lessons and share good practice that allows us to respond to service pressures resulting in widening variations across our footprint.						Lead committee / board	Quality Committee
ICB risk appetite	ICB risk scores						Rationale for current ICB score	
	Target (ICB)			Current (ICB)			More formal assurance is needed through Transformation Committee and Partnership Board. Significant work has taken place over the last 12 months. Digital is a risk in terms of separation with the new leadership arrangements however this is being focused on, this will continue in 2025/26. Uncertainty around the implications of current changes with ICBs and the impact on the WY ICB research function, risk scores may change by the end of Cycle 1 2025/26.	
	Likelihood	2	6	Likelihood	2	8		
OPEN	Impact	3		Impact	4			
Key controls (What helps us mitigate the risk?)							Mitigating actions (What more are we/should we be doing at ICB level?)	
1 Clear governance around Quality with NHSE, providers and places working collaboratively to share learning and report via System Quality Group and ICB Quality Committee							1. Develop assurance mechanisms to Transformation Committee and Partnership Board.	
2 Research via Applied Research Collaborative (ARC)							2. Annual review to bring additional rigour with lens on innovation.	
3 West Yorkshire Innovation Leadership Collaborative – joint chaired by Medical Director with Health Innovation Network Clinical lead								
4 West Yorkshire Health and Care Partnership Research Leadership Working Group (RLWG), chaired by Medical Director								
5 HIVE network brings together research and innovation networks								
6 Collaboration with Digital								
Sources of assurance (Where is the evidence that the controls work?)							Links to ICB risk register (Reference numbers/brief description)	
1 Agenda and minutes of meetings listed as controls							WY Corporate Risk Register - reference - 2108	
2 SOAG oversight of innovation and research networks								
3 Clinical and Care Professional Forum							See the separate Positive Assurance Log	
Bradford District and Craven (BD&C)			Place lead:	Therese Patten			Nominated lead for this risk:	Phillipa Hubbard (30.06.2025)
ICB risk appetite	Place risk scores						Rationale for current place score	
	Target (BD&C)			Current (BD&C)			Recognise the requirement to implement the BDC HCP strategy and 'inverting the power to act' at locality level - this is ongoing through Healthy Communities and Living Well Programmes. Risk score increased from 6 to 9 due to work needing to be undertaken with regards to digital upgrade for systems and software. Business case approved but not implemented to date. Primary care impact is on new approach to shared care protocols/ agreement still to be signed off.	
	Likelihood	2	4	Likelihood	3	9		
OPEN	Impact	2		Impact	3			
Key controls (What helps us mitigate the risk?)							Mitigating actions (What more are we/should we be doing at place?)	
1	Committee structure in place including BDC HCP System Quality Committee which oversees the process of mutual assurance of quality of care delivered by local providers, which identifies issues, and supports improvement. In addition we have Priority and Enabler Programme Boards that provide ownership to transforming services across all place based partners. The system quality insight and assurance group meets monthly to triangulate themes, intelligence and learning which then reports into the System and Quality Committee. The SQC reports quarterly into place partnership board and WY Quality Committee and Quality Group.						1.The Quality Team input into BDC priorities and transformation programmes and patient safety/ quality is taken into account when responding to financial pressures (Work ongoing 2024/25-2026) 2. Development of the dashboard to include patient outcomes to be used as a source of assurance operational is ongoing (2024/25 - 2026) 3. Work is progressing on the BDC clinical strategy to support and streamlining of clinical pathways which supports the work of the place based clinical forum. (September 2025) Governance system structures and alignment to support the wider collaborative have been revised including workstreams for integrated neighbourhood health.	
2	The Innovation Hub working alongside the development of improves as one portal and accompanying process identifies proven best practice and supports local teams to adopt and adapt across the BDC HCP							
3	Model of Distributive leadership in place in Bd&C with HCP for Chief Nurse which provides opportunities to provide assurance and oversight, share best practice, learning and improvement opportunities between partner organisations							
4	Prioritisation framework and WY ICB wide QEIA process has been implemented alongside strategic principles that have been produced by the BDC System Strategy working group to try and narrow the gap						Links to Bradford place risk register: 2419	
5	Quality requirements are represented with all providers and monitored through the contract management process							
Sources of assurance (Where is the evidence that the controls work?)								
1	Assurance through Internal Audit of our transformation programmes and via ongoing reporting and challenge through individual Programme Boards, Partnership Board, Clinical Forum and SQC/SQG and ICB governance structures - through AAA updates from assurance and governance committees (combined F&PC SQC and meet monthly) and priority and enabler programmes.							
2	Redeveloped model/way of working for the Place (Bd&C) System Quality Committee (SQC) including the provision of governance and assurance and sharing of best practice through the work of sub-groups and the reporting structure. Terms of Reference and Minutes.							
3	The Innovation Hub networked to all other parts of our BDC governance structure, including whole system enabling strategy groups for population health management, workforce, digital, estates, and communication & engagement. Supported by shared system committees for Finance and Performance, Quality and Safety, and our Clinical Forum. The Hub maintains strong links with Bradford Institute of Health Research (BIHR), Yorkshire & Humber AHSN, Yorkshire and Humber Improvement Academy (IA) and the University of Bradford (UoB). Terms of Reference and Meeting Minutes.							
4	Recommendations on investment / dis-investment take into account EQIAs/QEIAs, output from the prioritisation tool and demonstrate strategic fit.Equity, Quality Impact Assessment (EQIA) / Quality, Equality Impact Assessment (QEIA) embedded.							
Calderdale			Place lead:	Robin Tuddenham			Nominated lead for this risk:	Neil Smurthwaite (17.07.2025)
ICB risk appetite	Place risk scores						Rationale for current place score	
	Target (Calderdale)			Current (Calderdale)			Governance arrangements are continually reviewed locally. Development time dedicated at Partnership Board to discuss key issues as a system. Clear weakness in WY data/analytics for system overview. No significant resource locally to compare with other resource. Recognise work ongoing to produce consistent WY data.	
	Likelihood	2	4	Likelihood	2	6		
OPEN	Impact	2		Impact	3			
Key controls (What helps us mitigate the risk?)							Mitigating actions (What more are we/should we be doing at place?)	
1 Place-based Quality Group established to ensure we continue to share lessons and good practice.							1. Calderdale lead on a number of WY elective recovery programmes, ensuring greater consistency in single contracts, to help avoid variation. Consistent Independent Sector waiting times recently agreed across WY.	
2 Clinical and Professional Forum currently being reviewed with a aim to link the output of the forum to our transformation priorities and financial position								
3 Primary Care Strategy Group meets quarterly and reports to the partnership board.								

4 Urgent care model has been developed that will help UECB and Community programmes joined up impactful initiatives.										
Sources of assurance <i>(Where is the evidence that the controls work?)</i>							Links to Place risk register:			
1 Regular reporting to Calderdale Care Partnership Board.							1338, 2476, 2163, 2149, 1493, 62, 1977, 2092			
Kirklees Place lead: Vicky Dutchburn							Nominated lead for <u>this</u> risk: Vicky Dutchburn (25.06.2025)			
ICB risk appetite		Place risk scores					Rationale for current place score			
		Target (Kirklees)			Current (Kirklees)		Kirklees place reflects the current WYICB wide score.			
OPEN		Likelihood	2	4	Likelihood	2	8			
		Impact	2		Impact	4				
Key controls <i>(What helps us mitigate the risk?)</i>							Mitigating actions <i>(What more are we/should we be doing at place?)</i>			
1 Kirklees ICB Transformation Sub-Committee, supported by the Kirklees Delivery Collaborative as mechanism to enable shared learning across providers							1. Increase visibility and understanding of the West Yorkshire Innovation Leadership Collaborative and the interface between this network and place (Review 2025/26)			
2 Working across places and with WY programmes to share learning and experience, identify variation, and opportunities for improvement							2. Establish clearer connections between the WY ICB and the West Yorkshire Innovation Leadership Collaborative (Review 2025/26)			
3 Clear governance around Quality oversight in place with providers, working collaboratively to share learning and report via System Quality Group and ICB Quality Sub-Committee							3. Chief Digital and Information Officer attending Kirklees Board Development Session to share learning, next steps (Q2, 2025/26)			
4 Active participation in WY networks and programmes with evidence of having shared learning from Kirklees, and adopted it from elsewhere.										
Sources of assurance <i>(Where is the evidence that the controls work?)</i>							Link to place risk register:			
1 Evidence of early adoption and innovation in place e.g. UCR, Lung Health Checks, approach to neighbourhood working.							2445			
2 Reports to Kirklees Sub-Committees demonstrating provider collaboration, examples of innovation and shared learning. Papers and Mins.										
3 System Quality Group and ICB Quality Sub-Committee. Papers and Mins.										
Leeds Place lead: Tim Ryley							Nominated lead for <u>this</u> risk: Jason Broch (26.06.2025)			
ICB risk appetite		Place risk scores					Rationale for current place score			
		Target (Leeds)			Current (Leeds)		Earlier in the year the Leeds governance arrangements were established with a wide range of stakeholders, these were relatively new and establishing a rhythm and recognition of function. Throughout the last Quarter of 2024/25 and into 2025/26 there is a continual improvement approach to the Leeds governance and prioritisation. Our partnership governance arrangements have become more mature and we have identified some priority areas to collectively focus on as part of the Healthy Leeds plan. The biggest barriers to progress in these programmes tend to be digital and this is complex across competing providers with different needs as well as the Leeds digital infrastructure being a challenge when compared with the WY strategic approach.			
OPEN		Likelihood	2	4	Likelihood	3	12			
		Impact	2		Impact	4				
Key controls <i>(What helps us mitigate the risk?)</i>							Mitigating actions <i>(What more are we/should we be doing at place?)</i>			
1 Clear governance arrangements in place to provide assurance to the Leeds Committee of the ICB. Place partners working collaboratively through the Assurance Sub-Committees (Quality & People's Experience and Finance & Best Value).							1. There has been a lot of progress amongst senior clinical leaders to understand the wide range of interface issues in the city and a programme has been established to try and manage some of these better (2025/26)			
2 Regular contribution and representation at the ICB Quality Committee and System Quality Group							2. Leeds partnership has appointed a Lead Chief digital information officer (CDIO) from one of the partners to oversee partnership development work and facilitate integration.			
3 Regular contribution and representation at the WY ICB Safeguarding Oversight and Assurance Partnership							New governance around this is being developed to be in place by 2025/26. Although these governance arrangements are starting to become clearer they are also highlighting some of the competing ambitions between different partners. They are not yet in a clearer enough form for senior leaders to prioritise. There is a piece of work to look at developing provider collaborative in line with the direction the government is taking the NHS and in line with the ICB blue print which will hopefully address some of the digital issues.			
4 Leeds Academic Health Partnership membership with representation at Board and implementation levels.							3. All Leeds partnership across Leeds health and social care were working collaboratively with the University of Leeds to develop a research project (SEISMIC) to bring academic rigour to system improvements and integration for people with long term conditions and mental illness, facilitating the use of innovative technology. Unfortunately Leeds was unsuccessful in the bid but there is ongoing conversation to see how the partnership can capitalise on the work so far anyway.			
5 As a partner with Leeds Academic health partnership identifying opportunities from health professionals,										
6 The Clinical Professional Executive Group (CPEG) meet monthly and has been reviewing a system approach to risk and learnings from escalated cases to make sure there is a Leeds based approach to those learnings and that partners can better manage system risk collectively										
Sources of assurance <i>(Where is the evidence that the controls work?)</i>							Link to place risk register:			
1 Regular arrangements to evaluate the effectiveness of the Sub-Committees.							2480, 2487			
2 Emerging system-wide networking between Quality Improvement leaders across the partnership.										
3 WY ICB Safeguarding Oversight and Assurance Partnership. Papers and Mins										
4 ICB Quality Committee and System Quality Group. Papers and Mins										
5 West Yorkshire clinical and professional forum (monthly) - representation from Leeds										
6 The Clinical Professional Executive Group (CPEG) meet monthly										
Wakefield Place lead: Mel Brown							Nominated lead for <u>this</u> risk: Penny McSorley (30.06.25)			
ICB risk appetite		Place risk scores					Rationale for current place score			
		Target (Wakefield)			Current (Wakefield)		WDHCP governance arrangements are now well established and relationships strengthened. Examples of sharing and learning across key forums in the ICB and wider partners. Governance is in place with connection to West Yorkshire System Quality Group and WY Quality Committee. Risk score remains the same until the release of the 10 year plan.			
OPEN		Likelihood	2	4	Likelihood	3	12			
		Impact	2		Impact	4				
Key controls <i>(What helps us mitigate the risk?)</i>							Mitigating actions <i>(What more are we/should we be doing at place?)</i>			
1 Clear governance around quality, safety and patient experience with regular reports through to Integrated Assurance Committee, Wakefield District Health and Care Partnership and People Panel							Timescale 2025/26:			
2 Experience of Care Network - sharing good practice following feedback from service users							1. District plan has been agreed			
3 Transformation and delivery committee established to which shares good practice and focus on improving services							2. Clinical and professional engagement takes place and is collated and monitored.			
4 Patient safety priorities, development of place quality priorities, and alignment with West Yorkshire quality priority areas in place							3. Wakefield and district health and care partnership have commenced a neighbourhood health programme of work focusing on the 6 key elements of neighbourhood health in preparation for the 10 year plan (2025/26)			
5 Shared quality frameworks in place										
Sources of assurance <i>(Where is the evidence that the controls work?)</i>										
1 Reports provided of quality across the WDHCP of areas of transformation and improvement										
2 Minutes of meetings from multiple governance forums										
3 Recommendations and action plans from Care Quality Commission inspections and quality visits							Links to Place Risk Register			
4 Local performance dashboards and improvement plans							None.			

WYICB - Board Assurance Framework - ICB and places						Version: 11	Date: 12 March 2025
Mission 2	Failure to manage the strategic risk could result in a failure to MANAGE UNWARRANTED VARIATION IN CARE					Lead director(s) / board lead	Lou Auger
Strategic risk 2.3	There is a risk that we cannot measure and assess performance across the system in a timely and meaningful way, which impacts our ability to respond quickly as issues arise.					Lead committee / board	Finance, Investment and Performance Committee
ICB risk appetite	ICB risk scores					Rationale for current ICB score	
	Target (ICB)			Current (ICB)			The current likelihood is possible , given the limited business intelligence capacity in the ICB, limited access to near real-time performance data and lack of a comprehensive, shared performance dashboard. Failure to control this risk will lead to moderate impact on system performance. We could see a failure to meet national standards, a failure to address unwarranted variation, an inability to provide mutual aid in a timely way and regulatory breaches.
OPEN	Likelihood	2	6	Likelihood	3	9	
	Impact	3		Impact	3		
Key controls <i>(What helps us mitigate the risk?)</i>						Mitigating actions <i>(What more are we/should we be doing at ICB level?)</i>	
1 A comprehensive performance dashboard and exception report shared by the Board and its committees						1. Development of Business intelligence (BI) capacity across the ICB (Q3, 2025/26) .	
2 A system co-ordination centre is live to consolidate information and action on UEC pressures. The SCC meets the revised national specification.						☐	
3 Securing access to, and review of, comprehensive, up-to-date management data						☐	
4 System-wide meetings to share intelligence, review risk and agree mitigating actions						☐	
5 UEC-Raidr app is active and continues to be developed						☐	
Sources of assurance <i>(Where is the evidence that the controls work?)</i>						Links to ICB risk register <i>(Reference numbers/brief description)</i>	
1 Minutes of Board and committee meetings						None identified	
2 Minutes and action logs of System Oversight and Assurance Group (SOAG) and other system groups							
3 Evidence of access by system leaders to UEC app and national data sources							
4 3 x daily SCC reports to NHSE Regional Team and shared with senior leaders						See the separate Positive Assurance Log	
Bradford District and Craven (BD&C)						Nominated lead for <u>this</u> risk: Sohail Abbas and Kerry Weir (26.06.25)	
ICB risk appetite	Place risk scores					Rationale for current place score	
	Target (BD&C)			Current (BD&C)			Good processes and systems in place to monitor performance and capacity across providers and BD&C place . Performance dashboards which are regularly taken to System committees and transformation programmes. Ability to pull out performance data quickly on an ad-hoc basis when required.
OPEN	Likelihood	1	2	Likelihood	2	4	
	Impact	2		Impact	2		
Key controls <i>(What helps us mitigate the risk?)</i>						Mitigating actions <i>(What more are we/should we be doing at place?)</i>	
1 BDC HCP (place) governance assurance through sub-committees System Finance and Performance Committee to the Partnership Board						Partnership Board level outcomes report has been developed and includes health and inequalities metrics (control)	
2 BDC HCP (place) governance assurance through sub-committees System Quality Committee to the Partnership Board						1. Reviewed governance arrangements, which will help to triangulate performance across the range of areas (2025/26)	
3 HCP programme boards						#	
Sources of assurance <i>(Where is the evidence that the controls work?)</i>						Control	
1 Performance dashboard at System Finance and Performance Committee and robust processes in place to review performance (range of dashboards, reports to SF&P and HCP board)						Finance, performance and quality forum (inbetween the FIPC and QC quaterly meetings)	
2 Sub Committee of Quality committee receives performance dashboard focussing on patient experience and outcomes and statutory requirements, issues discussed at Quality Committee						performance reported monthly to the extended leadership team (ELT)	
3 Regular update on performance provided to WYICB to support development of SOAG report							
4 3 times weekly system resilience dashboard circulated across HCP partners							
5 Regular Performance reports to HCP programme boards and ICB executive meeting							
6 Core 20+5 and health inequality premium performance reporting							
7 Triple A reports from finance and quality committees to Health and Care Partnership Board							
8 Core 20+5 and health inequality premium performance reporting (assurance)						Links to Place Risk Register	
						2168, 2423	
Calderdale						Nominated lead for <u>this</u> risk: Neil Smurthwaite (17.07.25)	
ICB risk appetite	Place risk scores					Rationale for current place score	
	Target (Calderdale)			Current (Calderdale)			Established performance monitoring process across commissioners and providers. Recognise we have potential BI capacity issues but we are currently performing as expected.
OPEN	Likelihood	1	2	Likelihood	2	6	
	Impact	2		Impact	3		
Key controls <i>(What helps us mitigate the risk?)</i>						Mitigating actions <i>(What more are we/should we be doing at place?)</i>	
1 Oversight framework used as base of performance monitoring at CCPB.						(See WY response above regarding BI)	
2 Working with partners to provide singular view at WY and place level.						1. Calderdale has good oversight on the key national performance metrics and outperforms in a number of areas.	
Sources of assurance <i>(Where is the evidence that the controls work?)</i>						2. Joint UECB across CHFT footprint monitoring urgent care performance, including winter, discharge and ambulance performance.	
1 Performance monitoring at CCPB. Papers and Minutes.							
						Links to Place Risk Register:	
						2476, 2149, 62	
Kirklees						Nominated lead for <u>this</u> risk: Vicky Dutchburn (25.06.2025)	
ICB risk appetite	Place risk scores					Rationale for current place score	
	Target (Kirklees)			Current (Kirklees)			Kirklees has processes in place that monitor the current performance with main providers and as a Kirklees position. This is reported to the Kirklees Finance and Performance Sub-Committee. A local framework for daily escalations and service capacity is in place and monitored through our CHFT/ MYTT silver escalations.
OPEN	Likelihood	1	2	Likelihood	2	8	
	Impact	2		Impact	4		
Key controls <i>(What helps us mitigate the risk?)</i>						Mitigating actions <i>(What more are we/should we be doing at place?)</i>	
1 Detailed performance reports presented to Kirklees Finance and Performance Sub-Committee and ICB						1. The local dashboard and indicators will transition into the new national RAIDR KPIs when signed off (2025/26)	
2 Partnership processes for sharing timely data across the system partners						2. Data sharing agreement across primary and secondary care with regards to integrated neighbourhood team development (100% by Q2, 2025/26)	
3 Speciality level reports at Elective Care and Urgent Care Boards							
4 A Urgent and Emergency Care Board (UECB) has a system dashboard							
5 Community service and primary care performance indicators now in place in a local dashboard (reviewed daily)							
Sources of assurance <i>(Where is the evidence that the controls work?)</i>						Link to place risk register:	
1 Minutes of Finance and Performance Sub-Committee and Kirklees Health and Care Partnership Board						None.	
2 Action logs and performance slide packs from Elective Boards							
3 Minutes from system silver escalation calls							
4 Review the UECB dashboard and agree actions							
5 Data sharing agreement by the end of Q1, data flow is 80% and by the end of Q2, 100%							
Leeds						Nominated lead for <u>this</u> risk: Richard Irvine (23.06.2025)	
Place lead: Tim Ryley							

ICB risk appetite		Place risk scores					Rationale for current place score
		Target (Leeds)			Current (Leeds)		
OPEN	Likelihood	1	2	Likelihood	2	6	Reasonable oversight already of activity, capacity and performance via excellent place based relationships and working arrangements. Continues to be timely, automated and wide availability of data. Risk score remains.
	Impact	2		Impact	3		
Key controls <i>(What helps us mitigate the risk?)</i>							Mitigating actions <i>(What more are we/should we be doing at place?)</i>
1 System Resilience Operational and Coordination groups in place, and daily pressures meeting.							1. There is a wider set of dashboards, metrics and indicators that have been developed and are used to track both operational and transformational activity across Leeds. All data that feed the various dashboards in Leeds have been automated and all dashboards are accessible to individuals across a range of organisations as per access controls. Individuals and organisations (including the Population and Care Delivery Boards) use these data to manage strategic risk of unwarranted variation of care. 2. During Q1 2025/26, the Opel dashboard has been improved and General Practice data flows are being included (2025/26). The audience has widened and this dashboard provides timely awareness of pressures right across Leeds. The dashboard has high use with almost 100 managers and service leaders across Leeds accessing this on a daily basis.
2 Daily data shared via Opel System gives good oversight of volumes of attendances and pressures across sectors.							
3 Regular feedback from Trust Boards about performance risks and issues feeding local dashboards and delivery groups.							
4 The system visibility tool/ dashboard to support daily oversight of capacity and demand around system flow is in place and is mature							
5 The Opel dashboard is also available across the Leeds system, harnessing data from UEC-RAIDR and supplementing it with data from Leeds City Council/ Adult Social Care. Across the Leeds system all partners have access to this data and alerts our providers where thresholds are exceeded							
Sources of assurance <i>(Where is the evidence that the controls work?)</i>							Link to place risk register:
1 Minutes of meetings.							None
2 Partner Board reports demonstrate tight tracking on behalf of the system via their IQPRs.							
3 The use of data and insight (as evidence) is fast becoming central to a number of governance boards. For example, the Population and Care Delivery Boards have a compelling score card that describes performance for each population segment.							
Wakefield							Nominated lead for <u>this</u> risk: Natalie Tolson (14.07.25)
ICB risk appetite		Place risk scores					Rationale for current place score
		Target (Wakefield)			Current (Wakefield)		
OPEN	Likelihood	1	2	Likelihood	2	6	Good processes and systems in place. Performance dashboards which are regularly taken to Integrated Assurance Committee. Responsive narrative on a monthly basis to central core team. Ability to pull out performance data quickly on an ad-hoc basis when required. Risk score remains the same in Cycle 2.
	Impact	2		Impact	3		
Key controls <i>(What helps us mitigate the risk?)</i>							Mitigating actions <i>(What more are we/should we be doing at place?)</i>
1 Wakefield District and Health Care Partnership Committee, Integrated assurance committee and Transformation and Delivery Collaborative receives activity and performance report at each of its meetings							1 Currently working on the flow of community data to extend the OPEL framework to incorporate community services (2025/26) 2 Continue to strengthen collaborative / joint working between ICB BI and MYTT BI to support the efficient sharing of performance information, single version of the truth, access to live data and removal of duplication. MYTT will migrate to PowerBI across 2025 which will improve the accessibility of live information across the system - supporting the ability to make rapid decision making based on live data and intelligence (by March 2026) 3. Mid Yorkshire Teaching Hospital are actively engaging with the national federated data platform, adopting a number of applications that support performance delivery and access to timely data to support daily decision making (OPTICA, shared Patient Treatment List) Ongoing development 2025/26
2 System Outcomes Framework in place and is being re-evaluated as part of a new District Plan.							
3 Each transformation programme has it's own performance dashboard or a dashboard is in development which tracks performance, progress and supports evaluation							
4 MYTT share daily sit-rep data (DSIT) with the ICB BI team so we are sighted on current performance							
5 Investment in Business Intelligence, including the shared PowerBI tenancy with MYTT allows colleagues with easy access to performance information and 'live' performance information from within the Trust							
6 Recently appointed Data & Analytic Business Partners to support collaborative performance reporting / analytics across the Wakefield system / MYTT							
Sources of assurance <i>(Where is the evidence that the controls work?)</i>							
1	Minutes and papers from the Wakefield District and Health Care Partnership Committee, Integrated assurance committee and Transformation and Delivery Collaborative						
2	Tracking of key consitutional and local priority metrics through dashboards and reports - presented to Integrated Assurance Committee, Transformation Delivery Collaborative, Transformation programmes and Wakefield District Health and Care Partnership.						
3	The system visibility of tools/reports to support daily oversight of capacity and demand around system flow is in place and is mature (one suite of reports shared across ICB/MYTT)						
4	Use of RAIDR UEC Dahboard, OPEL information and feedback from System Meetings (to support on call and system command)						Link to Place Risk Register
5	Through collaborative working / shared BI roles across ICB/MYTT, the ICB is kept informed of any upcoming or changes to risks to performance and reporting.						None

WYICB - Board Assurance Framework - ICB and places						Version: 11	Date: 10 June 2025
Mission 2	Failure to manage the strategic risk could result in a failure to MANAGE UNWARRANTED VARIATION IN CARE					Lead director(s) / board lead	Jonathan Webb / Shaukat Ali Khan
Strategic risk 2.4	There is a risk that our infrastructure (estates, facilities, digital) hinders our ability to deliver consistently high quality care.					Lead committee / board	Finance, Investment and Performance. Transformation Committee - for Digital.
ICB risk appetite	ICB risk scores					Rationale for current ICB score	
	Target (ICB)			Current (ICB)			This risk relates to two specific areas; - the backlog of maintenance stood at £750m with operational capacity lower at £158m in the current financial year. - the risk that ICB / organisational IT have insufficient capacity to implement ICB and regional solutions due to increasing demands for solutions and the prioritisation of local vs regional projects, resulting in delays to progression of regional solutions, impacting delivery of benefits or reduced opportunities to implement ICB / regional solutions at scale.
OPEN	Likelihood	3	9	Likelihood	4	16	
	Impact	3		Impact	4		
Key controls (What helps us mitigate the risk?)						Mitigating actions (What more are we/should we be doing at ICB level?)	
1	Development and approval of ISC infrastucture strategy.					1.Consider approaches to 'carve out' an element of operational capital to support schemes more strategic in nature. 2. Digital investments to be increased within ICB and place budgets to strategise and to enable increased capacity and expectations, with the dedicated time allocated to regional and national programmes (2025/26 - 2026/27) 3. (Digital) - evaluating the current operating model to leverage the maximum benefit on resources and technical skills (2025/26)	
2	Regular oversight and assurance from ICS infrastructure strategy oversight groups.						
3	Digital Strategy Board - oversight of digital strategies and risks						
Sources of assurance (Where is the evidence that the controls work?)						Links to ICB risk register (Reference numbers/brief description)	
1	Minutes from - ICS Capital Infrastructure Oversight Group; ICS Finance Forum; Digital Strategy Board					2118 - Not able to spend all capital 2165 - There is a risk that place IT teams have insufficient capacity to implement regional solutions due to increasing demands for digital solutions and the prioritisation of local vs regional projects 2121 - There is a risk of the VCSE sector being left behind digitally due to lack of capacity, resource and understanding at statutory level as to what is needed by VCSE	
2	ICB / Regional digital projects are well planned with resources allocated. No milestone delays due to resource constraints.						
3	Initial feedback from NHSE national digital maturity assessment has shown considerable improvement from the previous year.					See the separate Positive Assurance Log	
Bradford District and Craven (BD&C)			Place lead:	Therese Patten		Nominated lead for this risk:	Robert Maden (01.07.2025)
ICB risk appetite	Place risk scores					Rationale for current place score	
	Target (BD&C)			Current (BD&C)			For digital, investment in AFT, BDCT will move us to a higher level of digital maturity over the next 18 months 2025/26. However, we have investment challenges in Primary Care persisting due to limited primary care capital. For estates, even allowing for investment in the Airedale Hospital development and Lynfield Mount, significant backlog maintenance remains an issue , both for the acute estate and the primary and community estate. Significant affordability issues remain in relation to primary care developments. The utilisation and modernisation fund for primary care has the potential to mitigate some of these issues, but funding for year 2 onwards remains to be confirmed, risk score will remain the same in this cycle.
OPEN	Likelihood	3	9	Likelihood	4	16	
	Impact	3		Impact	4		
Key controls (What helps us mitigate the risk?)						Mitigating actions (What more are we/should we be doing at place?)	
1	Programme Boards established to take forward the business cases for the new hospital at AFT and for the redevelopment of Lynfield Mount.					1. The existing WY digital strategy is undergoing review across the ICS. Each organisation will review and update its own digital strategy and plan alongside (2025/26) 2. Place health and wellbeing strategy has been developed which will shape the development of the new hospital at Airedale to support the shift of services into the community and deliver an affordable solution. This will also support the development of neighbourhood health services for BDC localities. 3. Initial Place Based Capital Infrastructure Strategy completed and will continue to be developed to ensure that our estate planning across health and care reflects changing service delivery models and supports safe and innovate service provision that is targeted at the areas of highest population need. Implementation will be overseen by the Strategic Estates Group on an ongoing basis. Ongoing. More emphasis on the better use of our existing estate as opposed to looking at new build solutions, unless there is no alternative option (2025/26) 5. Access to the utilisation and modernisation fund for primary care has outlined in the planning guidance for 2025/26. This provides a specific funding for addressing primary care capacity issues.	
2	Estates is an enabler in BDC HCP (place) operating model and is key to supporting the shift of services into the community.						
3	BDC HCP continues to be supported by the BDC Digital Programme Board and meets bi-monthly. It reports into BDC executive. Digital programme of work in place with formal workstreams identified, inclusive of partnership representation (Cyber Security, Work as One, Shared Care Records, workforce, Digital Inclusion). Additional subgroups focus on infrastructure and services, research and business intelligence linked to priority programmes.						
Sources of assurance (Where is the evidence that the controls work?)						Links to Place Risk Register	
1	Programme Board minutes for the Airedale and Lynfield Mount developments and regular updates to PLE.					2314, 2312, 2482, 2215	
2	Place Based Estates strategy being developed in support of the health and wellbeing strategy and regular updates to PLE.						
3	Minutes of the BDC Digital Programme Board.						
Calderdale			Place lead:	Robin Tuddenham		Nominated lead for this risk:	Neil Smurthwaite (17.07.2025)
ICB risk appetite	Place risk scores					Rationale for current place score	
	Target (Calderdale)			Current (Calderdale)			Our main mitigation is CHFT reconfiguration. Detailed work undertaken in primary care but biggest risk is capacity to bring partner plans together as a system.
OPEN	Likelihood	3	9	Likelihood	4	16	
	Impact	3		Impact	4		
Key controls (What helps us mitigate the risk?)						Mitigating actions (What more are we/should we be doing at place?)	
1	Regular round-table on financing of CHFT reconfiguration.					1. Need to be able to identify capacity and capability to support further estates and digital transformation - Operating Model clearly identified risks around estates and digital capacity gaps due to affordability. This hasn't been addressed fully. Local support purchased to enable invovlement in WY Infrastructure Strategy for primary care (2025/26) 2. Work still ongoing to identify local capacity for estates going forward (2025/26) 3. Digital need to be addressed by new Digital Director (2025/26) 4. Recruitment for CKW GP estates post hampered due to cost control (2025/26) and business case approved to use external company to support bids for national capital pot.	
2	Calderdale is a member of: ICS Capital Infrastructure Board; Finance Forum; Digital Strategy Board						
3	General practice PCN estate strategies in plan with support procured from external organisation for national bids.						
Sources of assurance (Where is the evidence that the controls work?)						Link to place risk register	
1	Reports to Committee					None	
Kirklees			Place lead:	Vicky Dutchburn		Nominated lead for this risk:	Alison Needham (02.07.2025)
ICB risk appetite	Place risk scores					Rationale for current place score	
	Target (Kirklees)			Current (Kirklees)			Place is refreshing Estates and IT strategies to understand the infrastructure needs of the wider system. Currently, constraints in both funding and resources have resulted in lower investment into
	Likelihood	3	9	Likelihood	4	16	

OPEN	Impact	3		Impact	4		the Kirklees Estates, which will create unwarranted variation of services for the Kirklees place.
Key controls (What helps us mitigate the risk?)							Mitigating actions (What more are we/should we be doing at place?)
1 Estates Strategy							1. Estates lead continues to focus on key developments in estates within the place and wider ICB. However, potential estates operational support is currently provided by independant consultant. This contract has ended June 2025. Paper has gone to panel to extend this support (2025/26)
2 IT Strategy							2. Support Primary Care to understand the need to develop and support services from an IT and an Estates perspective. Explore creative solutions with other public sector partners, particularly to develop primary care estate 2025/26.
3 Estates and IT leads							3. Ensure funding available flows into the Kirklees place.
4 Kirklees - one public estates forum now established							4. Work with partners and stakeholders to access capital resources to support development in primary care (2025/26)
5							5. On going round table meeting of senior leaders to support the ongoing development of the CHFT reconfiguration
Sources of assurance (Where is the evidence that the controls work?)							Link to place risk register: None.
1 Estates Forums							
2 IT and Digital Groups							
3 Reports to Committee							
4 Kirklees Estates Forum (partnership with providers) monthly							
5 Meeting with senior leaders to discuss CHFT reconfiguration							
Leeds				Place lead: Tim Ryley		Nominated lead for this risk: Tim Ryley 26.06.2025)	
ICB risk appetite	Place risk scores						Rationale for current place score
	Target (Leeds)			Current (Leeds)			The new hospitals scheme for Leeds General Infirmary rebuild is critical to the transformations in the Leeds Health and Care system. Currently we have only limited assurance that, despite all the processes completed to secure NHSE approval to proceed, the scheme will be allowed to finally proceed. Primary Care expansion of roles and the ambition for a neighbourhood health model is placing greater strain on estates in Primary Care with little access to capital. Risk score increased from 12 to 16 due to delayed funding for LTHT scheme.
	Likelihood	3	9	Likelihood	4	16	
OPEN	Impact	3		Impact	4		
Key controls (What helps us mitigate the risk?)							Mitigating actions (What more are we/should we be doing at place?)
1 Leeds City Strategic Estates Board and its Specific Programme Boards meet							1. LTHT working through medium term alternatives to the Leeds Way due to national delays until 2030 and beyond, this includes working with Leeds City Council to consider alternatives to the innovation hub.
2 City Wide Digital Resources are combined across Health and Social Care jointly							2. Exploring innovative joint ventures/schemes and strenghten a one city estates strategy across NHS and Local Authority and cutting-edge digital solutions with detailed plans in place by March 2026
3 Providers have strong infrastructure to manage capital planning and building.							3. City Wide Digital and Estates Strategies linked to our wider H&WB plans (2025/26)
							Link to place risk register: 2530
Sources of assurance (Where is the evidence that the controls work?)							
1 Providers have strong infrastructure to manage capital planning and building.							
2 Minutes of Strategic Estates and Programme Boards.							
Wakefield				Place lead: Mel Brown		Nominated lead for this risk: Colin Speers (02.07.2025)	
ICB risk appetite	Place risk scores						Rationale for current place score
				Current (Wakefield)			There is currently no process or forum for bringing together a total estates strategy across Wakefield Place. There is no identified capital resources for any estates across the sectors. The Digital Strategy is in delivery phase for place. The major programme of works is MYTT EPR procurement which is nationally and regionally assured, therefore there is no change to the risk score in Cycle 2.
	Likelihood	3	9	Likelihood	3	12	
OPEN	Impact	3		Impact	4		
Key controls (What helps us mitigate the risk?)							Mitigating actions (What more are we/should we be doing at place?)
1 Wakefield Place Digital Strategy in place and now being aligned across partners							1. Place digital forum brings together all sector and it delivers on the place digital strategy (2025/26)
2 Wakefield Place Finance Working Group linking into the West Yorkshire Integrated							Both business as usual replacement and innovation investment.
3 Leads at Place that are fully involved in the Integrated Care Board strategy meetings							
Sources of assurance (Where is the evidence that the controls work?)							Link to place risk register: 2481, 2440
1 Minutes from Digital Programme Board							
2 Place nominated lead on West Yorkshire groups							
3 Digital maturity assessments (annually) - national programme							

WYICB - Board Assurance Framework - ICB (no requirement for places to complete)							Version: 11	Date: 12 March 2025
Mission 2	Failure to manage the strategic risk could result in a failure to MANAGE UNWARRANTED VARIATION IN CARE						Lead director(s) / board lead	Lou Auger
Strategic risk 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.						Lead committee / board	ICB Board
ICB risk appetite	ICB risk scores						Rationale for current ICB score	
	Target (ICB)			Current (ICB)			The likelihood of a future pandemic is certain; the scale, severity and impact is unknown. This risk is based on the potential impact of a serious pandemic, based on learning from Covid. The scoring mirrors the regional NHS England score of 16 (4Lx4I).	
AVERSE	Likelihood	4	16	Likelihood	4	16		
	Impact	4		Impact	4			
Key controls (What helps us mitigate the risk?)							Mitigating actions (What more are we/should we be doing at ICB level?)	
1	Surveillance systems						1. Awaiting findings of the national Covid inquiry to incorporate learning into plans. Specific recommendations around the NHS are due by June 2025.	
2	Pandemic Plan							
3	Exercises							
4	Business Continuity Plans							
5								
Sources of assurance (Where is the evidence that the controls work?)							Links to ICB risk register (Reference numbers/brief description)	
1	EPRR Core Standards and assurance process provide evidence that plans are in place and tested - this is reported to the ICB Board annually						2456 - Health protection	
2	Local Health Resilience Partnership meets quarterly to review learning from incidents and							
3	Local Resilience Forum (multi agency) meets quarterly						Positive Assurance (see log)	

WYICB - Board Assurance Framework - ICB and places							Version: 11	Date: 12 June 2025
Mission 3	Failure to manage the strategic risk could result in a failure to USE OUR COLLECTIVE RESOURCES WISELY						Lead director(s) / board lead	Jonathan Webb
Strategic risk 3.1	There is a risk that we do not invest resources in a way which prioritises community, primary & prevention programmes and so doesn't maximise value for money.						Lead committee / board	Finance, Investment and Performance Committee
ICB risk appetite	ICB risk scores						Rationale for current ICB score	
	Target (ICB)			Current (ICB)			There has been a disproportionate increase of resource in recent years into acute hospital services in West Yorkshire and no clear plan to remedy this.	
OPEN	Likelihood	2	6	Likelihood	4	12		
	Impact	3		Impact	3			
Key controls (What helps us mitigate the risk?)							Mitigating actions (What more are we/should we be doing at ICB level?)	
1 Board approved Finance Strategy which sets out intentions.							(1) ICB Board could issue clear intent to all Places that there should be increased positive investment in community and primary care services, as part of planning during December 2024 / January 2025 after publication of planning guidance. (2) Place Committees to develop plans in line with this intent.	
2 ICS Financial Plan								
3 ICB Medium Term Financial Plan and Annual Plan								
4 Local plans implemented through Health and Wellbeing Strategy, Health and Wellbeing Boards and Place Committees								
Sources of assurance (Where is the evidence that the controls work?)							Links to ICB risk register (Reference numbers/brief description)	
1 Internal Audit Plan, Head of Internal Audit Opinion and individual internal audit reviews							None	
2 External Audit VFM opinion								
3 Performance Report alongside Finance Report into Finance Investment and Performance Committee and ICB Board								
4 Mental Health Investment Standard independent review							See the separate Positive Assurance Log	
Bradford District and Craven (BD&C) Place lead: Therese Patten							Nominated lead for this risk:	Karen Parkin (30.06.2025)
ICB risk appetite	Place risk scores						Rationale for current place score	
	Target (BD&C)			Current (BD&C)			Agree with the WYICB scores and these are relevant for place too. Financial position of Bradford and Craven Health and Care partners may mean we are unable to mitigate impact on community services.	
OPEN	Likelihood	2	4	Likelihood	4	12		
	Impact	2		Impact	3			
Key controls (What helps us mitigate the risk?)							Mitigating actions (What more are we/should we be doing at place?)	
1	Section 75 and Better Care Fund arrangements in place reporting to planning and commissioning forum which is embedded within our governance arrangements between NHS and Local Authority for Bradford district						1. Development of Better Care Fund benchmarking across West Yorkshire during 2025/26 subject to capacity. 2. Implemmentation of a integrated neighbourhood health West Yorkshire Board to oversee the distribution of £5m funding in order to accelerate integrated neighbourhood health teams. 3. Bradford District Care Trust are part of the community services review which is being led by an external partner. This wil enable better collection of activity information and a comparison across West Yorkshire and nationally. 4. There is now a new governance framework across BDC with three priority programmes, one is Airedale Bradford Collaboration of Acute Services (ABCAS), second is implementation of integrated neighbourhood health and the third is corporate services review and progressing with closing the gap. All of these have efficiency saving targets to meet.	
2	A new established governance framework which includes relevant committees and business meetings. This has a clear reporting structure.							
3	All VCSE sector awarded 25/26 uplift factor to help with sustainability. In addition, hospice sector allocated an extra £2m funding.							
Sources of assurance (Where is the evidence that the controls work?)							Link to Place risk register: 2447, 2386, 2227, 2486, 2040	
1	Better Care Fund submission 2025/26 and monitoring overseen by the Planning and Commissioning Forum							
2	Much tighter monitoring arrangements for efficiency savings, closing the gap and difficult decisions. All Bradford and Craven NHS organisations have robust monitoring frameworks in place.							
3	New priority programmes established and regular reports to those business meetings.							
Calderdale Place lead: Robin Tuddenham							Nominated lead for this risk:	Neil Smurthwaite (17.07.2025)
ICB risk appetite	Place risk scores						Rationale for current place score	
	Target (Calderdale)			Current (Calderdale)			Significantly pressured financial environment with acute hospital in deficit. This means lack of resources to move funds to invest in other areas or services. Current allocations suggest we are utilising more financial resource than we should, therefore not able to invest new money in additional areas to integrate services. Development of Provider collaboration in its infancy and with 10 year plan we should be able to develop strategies for more proportionate distribution of funding.	
OPEN	Likelihood	2	4	Likelihood	4	12		
	Impact	2		Impact	3			
Key controls (What helps us mitigate the risk?)							Mitigating actions (What more are we/should we be doing at place?)	
1 Partnership Board in place has membership from all place organisations.							1. Financial strategy in development (2025/26) 2. Need to understand the place-based allocation process to clearly identify where we are using more resource than currently indicated (2025/26)	
2 Joint Forward Plan has been signed off - which includes health, social care and fourth sector priorities.								
3 Ongoing review around sustainability of fourth sector and voluntary sector.								
4 New strategic finance group has been set up with an aim to develop a Calderdale financial strategy (2025/26) and medium to long term financial strategy.								
Sources of assurance (Where is the evidence that the controls work?)							Link to place risk register:	
1 Finance and performance a key component of partnership board meetings. Papers and Minutes.							2163, 2469	
2								
3								
Kirklees Place lead: Vicky Dutchburn							Nominated lead for this risk:	Alison Needham (02.07.2025)
ICB risk appetite	Place risk scores						Rationale for current place score	
	Target (Kirklees)			Current (Kirklees)			The planning guidance and funding allocations does not allow for significant investment within primary care and the community. As stated in the WY narrative, funding is heavily weighted to the acute sector. Kirklees place whilst working collaboratively across the system, due to these challenges and the contractual form does not allow funding to flow around the system to allow services to align and increase investment in those areas. Review of target score against risk appetite, agreed to reduce the target risk score from 8 to 4 as the place is willing to take reasonable risks and tolerant of a certain amount of uncertainty.	
OPEN	Likelihood	2	4	Likelihood	3	12		
	Impact	2		Impact	4			
Key controls (What helps us mitigate the risk?)							Mitigating actions (What more are we/should we be doing at place?)	
1 Place committees, which comprise of partner organisations to discuss utilisation of resources							1.Continue the development of the provider collaborative and the Wells agenda to allow the discussions to support more joined-up working - 2025/26 2. Priority setting across Kirklees partnership in relation to maximising the utilisation of resources (2025/26) 3. Using the financial strategy to break down the boundaries currently in place and allow the system to work to maximise resources of staff and funds.	
2 Financial Strategy has been developed to support how resources are utilised within the place, which links to the overarching West Yorkshire Strategy								
3 Development of PMO function to enable investment are review in order to ensure value for money and consideration of specific service impact.								
Sources of assurance (Where is the evidence that the controls work?)							Link to place risk register: None.	
1 Kirklees Finance Sub-Committee and Transformation Sub-Committee to agree on utilisation of resources. Papers and Minutes.								
2 All investments reviewed via a priority matrix								
3 PMO reports and financial review against Value for Money criteria								
Leeds Place lead: Tim Rley							Nominated lead for this risk:	Nick Earl 27.06.2025 Cycle 3 review will be undertaken by Alex Crickmar

ICB risk appetite	Place risk scores						Rationale for current place score
	Target (Leeds)			Current (Leeds)			Despite progress for a more integrated approach to financial planning across LHCP there remain challenges based on organisational boundaries and ongoing financial pressures. Additional challenges in Q3 and Q4 anticipated given reduction in ICB resources and associated restructure.
OPEN	Likelihood	2	4	Likelihood	3	9	
	Impact	2		Impact	3		
Key controls (What helps us mitigate the risk?)							Mitigating actions (What more are we/should we be doing at place?)
1 Integrated finance reports through LHCP governance - Leeds Finance and Best Value Committee oversees Leeds System Financial and Commissioning positions.							1. A programme of work is underway to continue to develop our joint approach to financial planning and decision-making to allow us to make the most value-driven decisions on resource allocation across the LHCP. To be actioned within the medium term financial plans (2025/26) 2. Increasing focus on quantifying impact for and transformational change for larger partnership programmes and release of benefits (alongside their quantification)
2 Analysis of spend through lens of populations and sub-groups as well as service lines.							
3 Strategic Finance Executive Group and Joint Planning Process across the partnership							
4 Finance sub-committee oversees financial planning and decisions.							
5 Regular attendance of DOFs at LHCP Partnership Exec Group and guiding priority programme ambition							
Sources of assurance (Where is the evidence that the controls work?)							Links to Place Risk Register 2414
1 Finance sub-committee receives financial planning and decisions. Papers and Minutes							
2 DOFs at LHCP Partnership Exec Group. Papers and Minutes							
3 Benefits realisation assessments for priority programmes							
Wakefield Place lead: Mel Brown							Nominated lead for this risk: Jenny Davies (26.06.25)
ICB risk appetite	Place risk scores						Rationale for current place score
	Target (Wakefield)			Current (Wakefield)			Continued development of the Wakefield Place working together, investment in services, greater understanding required of service join-up within Place in order to invest more wisely. Greater involvement of system partners in decision making, for example - voluntary sector. A requirement for more robust return on investment modelling within place. Risk score increased from 9 to 12 in line with WY ICB.
OPEN	Likelihood	2	4	Likelihood	4	12	
	Impact	2		Impact	3		
Key controls (What helps us mitigate the risk?)							Mitigating actions (What more are we/should we be doing at place?)
1 Partnership Committee comprises of partner organisations and Integrated Assurance Committee looks in more detail at financial decision making							1. Within Wakefield place, there is Transforming Development Collaborative (TDC) whereby they engage with all parties to ensure there is investment in the right areas and in 2025/26 planning there will be a commitment to increase investment within primary care. A balanced financial plan was submitted, monitoring continues on a monthly basis (2025/26).
2 The Wakefield Place Finance Leaders meeting is now established, forming a wider financial strategy, including the voluntary sector and local authority.							
3 Each place finance lead closely connected with director of finance for Integrated Care Board therefore strategies aligned.							
4 Shared posts across partner organisations - link services together to make more informed decisions around							
5 A framework for investment decisions agreed and implemented							
6 Financial Plan in place							
Sources of assurance (Where is the evidence that the controls work?)							Links to Place Risk Register None.
1 Minutes from meetings (TDS and Wakefield management meetings)							
2 Honorary contracts in place							
3 Regular reporting mechanisms for quality, performance and finance in place							
4 Monthly review at Wakefield Senior Leadership Team meeting							

WYICB - Board Assurance Framework - ICB and places						Version: 11	Date: 12 June 2025
Mission 3	Failure to manage the strategic risk could result in a failure to USE OUR COLLECTIVE RESOURCES WISELY					Lead director(s) / board lead	Jonathan Webb
Strategic risk 3.2	There is a risk that we don't operate within our available system and organisational resources (revenue and capital) and so breach our statutory duties.					Lead committee / board	Finance, Investment and Performance Committee
ICB risk appetite	ICB risk scores					Rationale for current ICB score	
	Target (ICB)			Current (ICB)			Despite a number of years of strong performance as an ICS, the 2024/25 position and 2025/26 plan were only balanced after receipt of significant non-recurrent financial support from NHS England, and as such there is a challenging plan to deliver this year and risks are materialising.
	Likelihood	3	9	Likelihood	4	20	
Impact	3		Impact	5			
Key controls (What helps us mitigate the risk?)						Mitigating actions (What more are we/should we be doing at ICB level?)	
1 Financial Framework document agreed by FIPC						(1) ICB Board sponsored across all places and organisations to improve financial underlining positions. (2) Development of a robust and credible medium term financial plan.	
2 All Plans are signed off by the organisational Boards							
3 Escalation and joint approach with NHS England for Trusts in NOF3							
4 Finance Forum, SOAG, FIPC, EMT and Board all have oversight							
5 Place Committees and their finance sub-committees have oversight and provide assurance upwards							
Sources of assurance (Where is the evidence that the controls work?)						Links to ICB risk register (Reference numbers/brief description)	
1 Quarterly review meetings with NHS England and outcome letters						2431 - managing within capital limits; 2430 - financial breakeven	
2 Agendas, reports and minutes of all meetings above							
3 Internal Audit and External Audit							
4 External review commissioned into Finance by WYAAT (July 2024) and across the ICS (November 2024).						Positive Assurance Log - see separate	
Bradford District and Craven (BD&C) Place lead: Therese Patten						Nominated lead for this risk: Karen Parkin (30.06.2025)	
ICB risk appetite	Place risk scores					Rationale for current place score	
	Target (BD&C)			Current (BD&C)			Due to the current financial pressures there is a significant risk that Bradford and Craven will fail to operate within current resource envelopes. Target risk score increased from 6 to 9 due to cautious risk appetite.
	Likelihood	3	9	Likelihood	4	20	
Impact	3		Impact	5			
Key controls (What helps us mitigate the risk?)						Mitigating actions (What more are we/should we be doing at place?)	
1 System Finance & Performance Committee oversight of Place financial position						1. Implementation of closing the gap programme now included within the corporate services priority programme. 2. Difficult decisions list established and being prioritised 3. Robust and regular monitoring of all Bradford and Craven NHS organisations by the ICB and by NHSE. All frameworks and monitoring processes have been strengthened and implemented. Actions to de-risk efficiency saving plans are being developed. 4. Development of plans for the further stretch of £12m is underway with the establishment of the new priority programmes as part of the new governance structure.	
2 BDC follows the West Yorkshire established principles and process.							
3 Regular detailed review of in-year financial performance by Place DoFs with full transparency of cost pressures and sources of mitigation.							
3 Ongoing closing the gap programme reports to Place Leadership and Partnership Board							
4 Overarching programme board which oversees the three priority programmes							
5 Organisations under regulatory scrutiny meet monthly by ICB/ NHSE							
Sources of assurance (Where is the evidence that the controls work?)						Alignment to place risk register:	
1 SF&PC minutes. Place financial performance reported to System F&P on a regular basis and key messages reported to BDC Health and Care Partnership Board.						2433, 2337, 2314, 2039, 2047	
2 Strategic Partnering Agreement updated January 2025.							
3 Programme Board minutes							
4 NHSE letters of assurance following scrutiny visits.							
5 BDC system F&P committee approved financial and operating plans in April 2025. Regular monthly monitoring of financial and operating plans.							
Calderdale Place lead: Robin Tuddenham						Nominated lead for this risk: Neil Smurthwaite (17.07.2025)	
ICB risk appetite	Place risk scores					Rationale for current place score	
	Target (Calderdale)			Current (Calderdale)			As a place we are in deficit due to acute pressures. Whilst we are assessing the risk at place level a lot of this is controlled via WY working at DoF level and little influence on this via ICB place team. Its monitored and understood but difficult to influence for the BAF. Target risk score increased from 6 to 9 due to cautious risk appetite.
	Likelihood	3	9	Likelihood	4	20	
Impact	3		Impact	5			
Key controls (What helps us mitigate the risk?)						Mitigating actions (What more are we/should we be doing at place?)	
1 Strategic finance group established with a aim to develop a Calderdale financial strategy.						1. As WYICB above. However we are also undertaking work in strategic finance group to understand where our acute and commissioning budgets are overspending compared to best practice and allocation tool to be clear where we need to target to bring down costs (meet monthly, then quarterly) 2025/26	
2 Financial Framework document agreed by FIPC, monitored by partnership board.							
3 Robust budget setting in open book approach so all places understand allocations and basis							
Sources of assurance (Where is the evidence that the controls work?)						Link to place risk register:	
1 Financial Framework as agreed by FIPC.						2163, 2469	
2 Bi-monthly monitoring at CCPB, evidenced in minutes. Detailed board reports.							
Kirklees Place lead: Vicky Dutchburn						Nominated lead for this risk: Alison Needham (02.07.2025)	
ICB risk appetite	Place risk scores					Rationale for current place score	
	Target (Kirklees)			Current (Kirklees)			Due to the current financial pressures there is a real risk that Kirklees Place will fail to operate within current resource envelopes. Target risk score increased from 6 to 9 due to cautious risk appetite.
	Likelihood	3	9	Likelihood	4	20	
Impact	3		Impact	5			
Key controls (What helps us mitigate the risk?)						Mitigating actions (What more are we/should we be doing at place?)	
1 Financial Strategy						1. Engage in WY-wide work to drive transformation and efficiency, including leading efficiency programmes undertaken on a WY footprint (2025/26) 2. Develop priority setting of resources within Kirklees place (2025/26) 3. We have developed a long list of difficult decisions around contracts and services that could be paused/ stopped/ slowed down across the Kirklees place. Ensuring decisions made align with West Yorkshire principles, and consider the prioritisation and disinvestment / decommissioning framework across the place (2025/26) 4. We have developed a working group across Kirklees place and neighbouring partners to review all services and spend that can improve the financial position of the Kirklees system (2025/26) 5. Review of all contracts commissioned by the ICB as to whether they can be stopped	
2 Review of Financial position and plans by Kirklees Finance Sub-Committee and ICB Committee, both locally and at a West Yorkshire level.							
3 Kirklees & Calderdale Recovery group							
4 Collaborative meetings to discuss how services can be undertaken differently to maximise resources							
5 Utilisation of the cross- partner Finance Forum to strengthen ownership of place based solutions.							
Sources of assurance (Where is the evidence that the controls work?)							
1 Financial plan will be signed off by the ICB Committee and risks identified							
2 PMO function to support financial recovery for the ICB and its wider system							

3	Aligned to West Yorkshire ICB approach to planning and final plan signed off by WY Committees	or reduced (2025/26) 6. We have developed a PMO process to develop recurrent efficiency schemes to improve the financial sustainability within the current year and future (2025/26) Link to place risk register: 2533

Leeds		Place lead: Tim Rley		Nominated lead for this risk: Alex Crickmar (reviewed 23.06.25)			
ICB risk appetite	Place risk scores					Rationale for current place score	
	Target (Leeds)			Current (Leeds)			Due to the current financial pressures there is a significant risk that Leeds Place will fail to operate within current resource envelopes. Target risk score increased from 6 to 9 due to cautious risk appetite.
CAUTIOUS	Likelihood	3	9	Likelihood	4	20	
	Impact	3		Impact	5		
Key controls (What helps us mitigate the risk?)						Mitigating actions (What more are we/should we be doing at place?)	
1	Leeds Finance, Investment and Best Value Committee oversees Leeds System Financial and Commissioning positions.					(1) Development of a number of key transformation business cases for change aimed at changing suboptimal care pathways with potential for significant savings longer term (timing: ongoing and part of planning for 25/26) (2) Review of potential opportunities and mitigating financial actions within each organisation and across Place, including delaying/stopping spend, focus on efficiencies and productivity (3) Integrated Commissioning Executive share plans between LCC and NHS and present jointly to Adults and Health Scrutiny (ongoing).	
2	Strategic Finance Executive Group						
3	Financial Framework and controls within each organisation at Place						
4	Robust Budget setting and financial planning						
5	Leeds Health and Care Partnership Committee oversight of City wide statutory duties on behalf of the WY ICB.						
Sources of assurance (Where is the evidence that the controls work?)							
1	Agendas, reports and minutes of all meetings above						
2	External Review of system finances (PwC report)						
3	Internal and External Audit						
4	Fortnightly meetings between DoFs to review position						
5	Budgets/Financial plans set						
6	PMO functions within each org					Links to Place Risk Register	
						2530	

Wakefield				Place lead: Mel Brown			Nominated lead for this risk: Jenny Davies (26.06.25)		
ICB risk appetite	Place risk scores						Rationale for current place score		
	Target (Wakefield)			Current (Wakefield)			Due to the current financial pressures there is a real risk that Wakefield Place will fail to operate within current resource envelopes. Target risk score increased from 6 to 9 due to cautious risk appetite.		
	Likelihood	3	9	Likelihood	4	20			
CAUTIOUS	Impact	3		Impact	5				
Key controls (What helps us mitigate the risk?)							Mitigating actions (What more are we/should we be doing at place?)		
1	Monthly monitoring of Integrated Care Board delegated financial position to assurance committee including efficiency savings						1. Review of difficult decisions/choices across organisations/place (timing: ongoing first draft was submitted February 2025)		
2	Monthly monitoring of Wakefield partners financial position to assurance and partnership committees						2. Set financial plans in line with planning guidance (2025/26)		
3	Robust budget setting with place programmes						3. Agree Quality, Improvement and Performance Productivity (QIPP) to identify savings and reduce pressures whilst improving patient quality (2025/26)		
4	Regular sharing of information and agreements via the Integrated Care System Finance Forum						4. Work with all system partners to increase efficiency and effectiveness (2025/26)		
5	Consistency Checks within Wakefield against other places.								
Sources of assurance (Where is the evidence that the controls work?)									
1	Minutes from Wakefield District Health and Care Partnership and Integrated Assurance Committee meetings								
2	Financial plans or any amendments to financial plans presented and discussed at partnership committee.						Links to Place Risk Register		
3	Principles already established at Wakefield District Health and Care Partnership Committee						2329		

WYICB - Board Assurance Framework - ICB and places							Version: 11	Date: 10 March 2025
Mission 3	Failure to manage the strategic risk could result in a failure to USE OUR COLLECTIVE RESOURCES WISELY						Lead director(s) / board lead	Rob Webster
Strategic risk 3.3	There is a risk that ICB capacity and infrastructure is not sufficient nor targeted effectively towards key priorities.						Lead committee / board	ICB Board
ICB risk appetite	ICB risk scores						Rationale for current ICB score	
	Target (ICB)			Current (ICB)			We have developed the new operating model which clarifies roles and responsibilities and ensures capacity in the right areas. Ongoing demands following new Government ambitions coupled with reductions in staffing means difficult choices continue to be made. There is recognition of additional uncertainty through NHSE reduction in staff and the ICB organisational change programme which may impact on the ICB's ability to deliver.	
OPEN	Likelihood	3	9	Likelihood	3	12		
	Impact	3		Impact	4			
Key controls (What helps us mitigate the risk?)							Mitigating actions (What more are we/should we be doing at ICB level?)	
1 An agreed operating model, approved through the Board and set out in the constitution and handbook							1. Place Partnership Delivery (led by Anthony Kealy) to support the development of Place model and infrastructure will be implemented by September 2025. 2. Ongoing organisational development work across Executives to support level of agility required in current context.	
2 Agreed objectives for all directors, including places, cascaded throughout the ICB								
3 Business planning processes that align capacity to our plans								
4 Place partnership review concluded in March 2025.								
5 MAUs with provider collaboratives specifying their responsibilities for delivery								
Sources of assurance (Where is the evidence that the controls work?)							Links to ICB risk register (Reference numbers/brief description)	
1 Annual business plan approved by the Executive and ICB Board							2165 - insufficient IT team capacity to deliver digital priorities	
2 CEO and director appraisals, with outcome reported to Remuneration and Nominations Committee								
3 Annual review of governance and statement of internal control, reported through Audit to Board							See the separate Positive Assurance Log	
Bradford District and Craven (BD&C) Place lead: Therese Patten							Nominated lead for this risk: Matt Sandford (26.06.2025)	
ICB risk appetite	Place risk scores						Rationale for current place score	
	Target (BD&C)			Current (BD&C)			The move to a new Operating Model, where BDC significantly reduced its capacity is still embedding, along with current vacancy controls due to the financial challenges, means that, similar to other Places, Bradford place is carrying a number of vacancies. A further impact will be felt following the organisational change by Q3. Bradford is utilising partnership relationships to help boost that capacity by building on current joint roles, to identify opportunities for further targeted shared and aligned resources across our Place so they can continue to deliver against both local and national standards and priorities.	
OPEN	Likelihood	1	4	Likelihood	3	12		
	Impact	4		Impact	4			
Key controls (What helps us mitigate the risk?)							Mitigating actions (What more are we/should we be doing at place?)	
1	The Partnership Leadership Executive oversee the deployment of resources (including ICB capacity) in pursuit of the BDC HCP strategy agreed by the Partnership Board						1. Utilise strength of our Health and Care Partnership, building on current joint roles, to identify opportunities for further targeted shared and aligned resources across Place (February – September 2025) 2. Annual business planning process to align resources to required activity/ priorities (April/ May 2025) 3. Priority Programme and Programme Board oversight of key system transformation plans (including workforce) and related activity, to review resource requirements against transformation delivery plans (February – September 2025) 4. Place level 'difficult decisions' programme to target resources at activity that delivers strategic and financial priorities (February – Apr 2026) 5. Adoption of WY Vacancy Control measures into Place level governance to ensure grip and control, alongside overarching understanding of Place resource requirements (already in place - ongoing) 6. Developed Health, Care and Wellbeing strategy (clinical strategy) at Place in full co-production with partners including citizens and our workforce. The strategy focuses on clear alignment of services, pathways and models of care driven by population health needs. This strategy will enable us to target and deploy resources in the most effective way. Three strategy delivery boards are being established focused on integrated acute services, integrated neighbourhood services and integrated corporate services, these are our core priorities for delivery and resource management 7. Specific Integrated Neighbourhood Team (INT) development work is underway across the BDC system is ongoing (2025/26) 8. Work has begun locally on the development of a BDC provider collaborative approach to be implemented by September 2025 (2025/26). 9. Developed Healthcare and Wellbeing strategy (clinical strategy) at place in full co-production with partners such as citizens and our workforce. The strategy focuses on clear alignment of services, pathways and models of care driven by population health needs. This strategy will enable us to target and deploy resources in the most effective way. Three strategy delivery boards are being established focused on integrated acute services, integrated neighbourhood services and integrated corporate services, these are our core priorities for delivery and resource management <u>Link to place risk register</u> 2447	
2	System transformation priorities and enablers established through our operating model using a distributed leadership approach							
3	Place based lead influence deployment of ICB resource for BDC HCP							
4	Closing the Gap programme – already established – with widened scope to incorporate Investment/ Business Case review							
5	Difficult Decisions programme has commenced and incorporates all partners across the system. This provides targeted focus on delivery of our efficiency programme whilst identifying risks associated with capacity.							
6	Place Clinical Strategy; and Place Financial Recovery Plan – providing greater oversight of resource							
7	3 x Strategic Delivery Group meetings (Integrated Acute Care; Integrated Neighbourhood Health & Care; Integrated Corporate Support & Closing the Gap will bring together all partners across the system to provide greater oversight on delivery of the core priorities we have set out in our health, care and wellbeing strategy.							
Sources of assurance (Where is the evidence that the controls work?)								
1	An agreed BDC HCP operating model approved by the PLE and the PB within the BDC HCP governance handbook							
2	Priority Programmes in place including: access; healthy communities; healthy minds; workforce and children and young people improvement. Enablers in place including: reducing inequalities alliance; digital, data, intelligence and insight; living well; and Estates. All priorities and enablers report into PLE							
3	ICB SORD sets out place role within both the WY ICB SORD (WY Governance Handbook) and BDC HCP Strategic Partnering Agreement and Governance Handbook set our the way we work, including our operating model, SORD and Terms of Reference.							
4	Closing the Gap programme – Partnership led and supported – Reviewed via System Finance and Performance Committee, PLE and Partnership Board.							
Calderdale Place lead: Robin Tuddenham							Nominated lead for this risk: Neil Smurthwaite (17.07.2025)	
ICB risk appetite	Place risk scores						Rationale for current place score	
	Target (Calderdale)			Current (Calderdale)			Capacity and capability within Calderdale Place team is severely limited for both finance and transformation resource. This impacts on our ability to address all ICB and place priorities. Whilst Operating Model work enabled no real impact on Calderdale financial the place team is still small and not resilient. Consolidated teams will impact on local resource and will work with colleagues to manage impact.	
OPEN	Likelihood	1	4	Likelihood	4	16		
	Impact	4		Impact	4			
Key controls (What helps us mitigate the risk?)							Mitigating actions (What more are we/should we be doing at place?)	
1 Work undergoing with neighbouring places to ensure resilient finance function.							1. Transformation delivery plans list seven key priorities and discussions are ongoing at operational and senior leadership meetings (2025/26) 2. Senior Leadership team continue to monitor risks relating to resource, intensified given NHS changes and 50% cuts. 3. Working collaboration with KW partners on sharing resource in difficult situation of zero recruitment and future reduced resource.	
2 Partnership board regularly conducts deep dives for tranformational priorities.								
3 Prioritisation takes place on a weekly basis to assess place workload and ability to respond to asks.								
Sources of assurance (Where is the evidence that the controls work?)							<u>Link to place risk register:</u> 1998, 2484	
1 Tranformation delivery plan approved by Calderdale Care Partnership Board.								
2 Prioritisation process as part of annual planning round.								
Kirklees Place lead: Vicky Dutchburn							Nominated lead for this risk: Vicky Dutchburn (25.06.2025)	
ICB risk appetite	Place risk scores						Rationale for current place score	
	Target (Kirklees)			Current (Kirklees)			There are specific challenges in Kirklees place related to leadership changes in several	

OPEN	Likelihood	1	4	Likelihood	3	12	parts of the health and care partnership and the transition period could lead to uncertainty. Time will have to dedicated to establish new working relationships when leadership changes take effect. The impact of the operating model changes are still being felt and challenges remain in some functions.
	Impact	4		Impact	4		
Key controls (What helps us mitigate the risk?)							Mitigating actions (What more are we/should we be doing at place?)
1 Weekly SLT meetings to discuss current priorities and ensure capacity is dedicated to the right areas							1. Organisational change review ongoing will include a Kirklees integrator function to be consulted on (Q3, 2025/26) 2. Ongoing development prioritisation and review within and across Teams in Kirklees (2025/26) 3. Specific Integrated Neighbourhood Team (INT) development work across Kirklees system (2025/26) 4. Ongoing local development of the Kirklees provider collaborative approach by September 2025.
2 Health & Care Executive to support cross sector prioritisation within the Health & Care Partnership							
3 Business planning processes to support confirmation of priorities							
Sources of assurance (Where is the evidence that the controls work?)							Link to place risk register: None
1	Clear examples of where capacity is being used to best effect by sharing teams with other places, in particular Calderdale (where there is a history of shared teams) and increasingly with Wakefield. Examples of capacity from across the partnership (not just the ICB) supporting our work e.g. Place Director of Finance role. Other examples of programme leadership from beyond the ICB team in place.						
	2 Staff survey results relating to the ability of individuals to undertake their role within their designated hours, clarity of objective setting and additional hours worked.The action plan agreed to respond to findings of staff survey.						
	3 Agreement from the Kirklees ICB Committee as to our shared priorities, supported by teams within partner organisations dedicating capacity to these priorities (e.g. Discharge, community services transformation)						
Leeds				Place lead:	Tim Rley		Nominated lead for this risk: Sabrina Armstrong (30.06.2025)
ICB risk appetite	Place risk scores						Rationale for current place score
	Target (Leeds)			Current (Leeds)			
OPEN	Likelihood	1	4	Likelihood	4	16	The move to a new Operating Model in April 2024, where Leeds reduced its capacity by 20% was still bedding in when the national announcement was made for reduction in ICB staff by 50%. Leeds was holding a number of vacancies whilst it settled and due to vacancy control they can no longer be filled. The latest organisational change programme is likely to exacerbate this issue. Failure to address these issues is likely and this could lead to a failure to meet national standards, broadening of inequalities, financial distress and regulatory breaches in line with the definitions. Risk score remains the same.
	Impact	4		Impact	4		
Key controls (What helps us mitigate the risk?)							Mitigating actions (What more are we/should we be doing at place?)
1 Agreed Operating Model with WY ICB and Leeds Health & Care Partnership							1. The ICB in Leeds has agreed a number of city priorities with partners in the Leeds Health and Care Partnership (LHCP). The ICB in Leeds needs to ensure that the majority of its capacity is working on these priority areas. Apr - Mar 2026 2. Refreshed OD priorities in place to support staff within the ICB in Leeds to deliver the capabilities needed to deliver the above priorities. However the OD plan has been extended to provide support and resilience training to staff during the organisational change (2025/26) 3. ICB in Leeds Business Plan for 25/26 in place, outlining the BU actions to deliver the LHCP priority programmes and work has been prioritised to take account of diminishing capacity due to both people leaving and people working on the organisational change 4. Action plan on staff survey results most pertinent to Leeds, 2025/26 5. Leeds Directors will continue to review capacity and reprioritise as necessary (2025/26)
2 Capacity aligned to Healthy Leeds Plan and LHCP objectives							
3 Director accountabilities finalised and objectives set by end of April							
Sources of assurance (Where is the evidence that the controls work?)							Link to place risk register: None
1 Healthy Leeds Plan and Business Plan reviewed monthly in line with LHCP priority work							
2 Ongoing appraisal throughout year with all directors in place							
3 Staff Survey results							
Wakefield				Place lead:	Mel Brown		Nominated lead for this risk: Mel Brown 27.06.2025
ICB risk appetite	Place risk scores						Rationale for current place score
	Target (Wakefield)			Current (Wakefield)			
OPEN	Likelihood	1	4	Likelihood	3	12	The current likelihood is possible, given the movement to a new operating model for the NHS and the Integrated Care Board. Failure to control this risk will lead to major impact on a number of financial, quality, operational and people fronts. We would see a failure to meet national standards, broadening of inequalities, financial distress and regulatory breaches in line with the definitions. Wakefield place are working with other places and the strategic commissioning functions between June and September 2025 to mobilise a new operating model to go live in April 2026.
	Impact	4		Impact	4		
Key controls (What helps us mitigate the risk?)							Mitigating actions (What more are we/should we be doing at place?)
1 Agreed operating model in place aligned to Integrated Care Board structures and went live in April 2024, some reviews have been underway due to leadership changes							1. Continue to review gaps in strategic capacity across the leadership team at Wakefield and confirm these objectives through PDR processes in the summer of 2025 2. Working with partner organisations across Wakefield district to maximise capacity to and to deliver objectives in 2025/26 3. Reviewing everyones PDR objectives to ensure any areas that need capacity are appropriately addressed such as EDI leadership (End of Summer 2025) 4. Contributing to the organisational change programme in place across WY ICB to shape the integrator teams
2 Agreed objectives for all directors							
3 Wakefield place plan agreement in May 2025, signed off objectives and plans for Wakefield district							
4 Business planning processes that aligns both to the WY ICB 10 ambitions and the Wakefield district plan (annual review)							
5 Developed a new business planning process that aligns with our Integrated Care System strategy and place delivery plan in line with national guidance							
6 Some Directors have previously undertaken leadership roles with partner organisations, these directors are now working full time for the ICB, such as Director of Nursing and Director of Strategy.							
Sources of assurance (Where is the evidence that the controls work?)							Links to Place Risk Register
1 Delivery plan approved including Outcomes Framework.							
2 The Mutual Accountability meetings chaired by Rob Webster, quarterly meetings, these provide assurance of the progress against the functions in Wakefield place.							
3 Director appraisals conducted and regular one to ones are mobilised across the Wakefield district, this ensures flexibility in responding to new work that emerges from WY ICB.							None.
4 Contribute to the annual governance review.							
5 Regular one to ones between Accountable officer and Cheif Executive WY ICB							

WYICB - Board Assurance Framework - ICB and places							Version: 11	22 April 2025
Mission 4	Failure to manage the strategic risk could result in a failure to SECURE BENEFITS OF INVESTING IN HEALTH AND CARE						Lead director(s) / board lead	Ian Holmes
Strategic risk 4.1	There is a risk that partnership working on wider societal issues is deprioritised to meet current operational pressures.						Lead committee / board	ICB Board
ICB risk appetite	ICB risk scores						Rationale for current ICB score	
	Target (ICB)			Current (ICB)			Wider societal issues contribute significantly to health, wellbeing and inequalities. Working with partners to address these is a key part of our health and care strategy. We have dedicated capacity supporting this work which we will protect through the business planning process. The key is ensuring sufficient leadership focus.	
OPEN	Likelihood	2	8	Likelihood	2	8		
	Impact	4		Impact	4			
Key controls (What helps us mitigate the risk?)							Mitigating actions (What more are we/should we be doing at ICB level?)	
1	ICS strategy and 10 big ambitions will be used to create priority and focus on these issues. These will be tracked annually via an outcomes framework and associated integrated dashboard.						1. Economic Inactivity Accelerator work to be delivered throughout 2025/26 ensuring dedicated capacity and the establishment of a programme board with WY Combined Authority to oversee it.	
2	We have established dedicated capacity working on these issues at WY level, together with appropriate programme boards, working with the Combined Authority - focusing on issues such as poverty, climate change, violence reduction, housing and employment							
3	Business planning process describes how we use our capacity to support delivery of all ambitions.							
4	Memorandum of Understanding with WY Combined Authority which describes shared priorities, capacity and ways of working.							
5	Consultant in Population Health appointment ensures focus on wider societal issues.							
5	Director objectives, subsequently cascaded to teams, reflect partnership working.							
Sources of assurance (Where is the evidence that the controls work?)							Links to ICB risk register (Reference numbers/brief description)	
1	Progress against the strategy and 10 big ambitions is overseen by the Partnership Board, together with deep dives - evidenced in agenda and minutes						None identified	
2	ICB Board receives six monthly updates on 10 big ambitions - agenda / minutes							
3	SOAG - minutes evidence review of progress against 10 big ambitions						See the separate Positive Assurance Log	
Bradford District and Craven (BD&C)							Place lead: Therese Patten	
Nominated lead for this risk: Helen Farmer, 23.06.2025								
ICB risk appetite	Place risk scores						Rationale for current place score	
	Target (BD&C)			Current (BD&C)			Challenging financial circumstances for all partner organisations may increase likelihood of retrenchment into siloed, short term approaches, emphasising direct operational delivery over longer term outcome focused system thinking, which evidence shows will have a bigger impact on the determinants of health and wellbeing outcomes.	
OPEN	Likelihood	2	8	Likelihood	2	8		
	Impact	4		Impact	4			
Key controls (What helps us mitigate the risk?)							Mitigating actions (What more are we/should we be doing at place?)	
1	Our BDC health and care strategy localises the WY strategy and clearly establishes the focus on the wider contribution of the health and care system to the determinants of health, and encourages stewardship for the future as well as short term delivery focus.						1. All district partners (including those outside health and care) will sign up to a new district strategy to improve the wellbeing, both health and economically in Bradford district (2025 - 2028) 2. Our reducing inequalities alliance continues to lead the way in identifying our wider determinants and mitigating the impact, including leading on our economic accelerator programme 3.,The BD&C HC&P has now finalised the healthcare and wellbeing strategy and we are moving to implementation through our new governance arrangements. This jointly agrees the safe and sustainable service models and pathways across all partners, driven by the health and care needs of our population, ensuring a holistic approach to delivery (2025/26) <u>Link to place risk register:</u> 2317, 2386, 2221	
2	The Wellbeing Board (HWB for Bradford District) is comprised of the leaders of all local strategic partnerships and all local anchor organisations. Its focus is firmly on the ‘wider determinants’. The BDC Partnership Board and its Committees have broad based participation across VCSE, Local Government and Care sectors. Our approach is to engage with communities through locality based Listen In visits and to take our Partnership Board meetings into communities, to understand the strengths and challenges of communities and what will help - which includes focus on the 'wider determinants' - e.g. development session on sustainability, Partnership Board papers on anti poverty actions etc.							
3	Our closing the gap business case appraisal process takes into account impact on wider health and care and public sector and population including health inequalities, social value etc (ongoing)							
4	People priority include focus on inclusive community recruitment.							
5	Our partnership work is focused on five Strategic Priorities and four key Enablers. This includes a prevention focus through Living Well, Reducing Inequalities, an asset based approach to Healthy Communities, and a focus on net zero and local economic development through our partnership Estates work.							
Sources of assurance (Where is the evidence that the controls work?)								
1	See strategy and closing the gap process on partnership website https://bdcpartnership.co.uk/							
2	Wellbeing Board (Bradford district) on the BMDC wellbeing web page https://bdp.bradford.gov.uk/about-us/health-and-wellbeing-board/ See partnership governance structure, TORs, meeting papers including Listen In reports - on website							
3	See priorities and enablers scoping documents on partnership website https://bdcpartnership.co.uk/our-strategic-priorities-re-set-programme/							
Calderdale							Place lead: Robin Tuddenham	
Nominated lead for this risk: Neil Smurthwaite (17.07.2025)								
ICB risk appetite	Place risk scores						Rationale for current place score	
	Target (Calderdale)			Current (Calderdale)			Wider societal issues contribute significantly to health, wellbeing and inequalities. Working with partners to address these is a key part of our health and care strategy. Risk score reduced from 12 to 8.	
OPEN	Likelihood	2	8	Likelihood	2	8		
	Impact	4		Impact	4			
Key controls (What helps us mitigate the risk?)							Mitigating actions (What more are we/should we be doing at place?)	
1	Joint membership of HWBB and CCPB by each chair to ensure societal issues continue across.						1. The Transformation delivery plans list seven key priorities, these aim to address wider societal challenges in Calderdale, there is ongoing work at senior leadership level to ensure governance arrangements align with the transformational priorities (2025/26) <u>Link to place risk register:</u> None	
2	ICS strategy and 10 big ambitions will be used to create priority and focus on these issues. These will be tracked annually. We also have Health and Wellbeing Strategy, monitored via HWBB.							
3	Business planning process will describe how we use our capacity to support delivery of all ambitions.							
4	The senior leadership group terms of reference refers to operational delivery as a "must do" so that our transformational plans are able to flourish							
Sources of assurance (Where is the evidence that the controls work?)								
1	Progress against health and wellbeing priorities is undertaken at every meeting. Evidenced by papers and minutes.							
2	We also have an inclusive economy strategy led by the local authority.							
3								
Kirklees							Place lead: Vicky Dutchburn	
Nominated lead for this risk: Steve Brennan (25.06.2025)								
ICB risk appetite	Place risk scores						Rationale for current place score	
	Target (Kirklees)			Current (Kirklees)			As Kirklees place we have signed up to 4 top tier strategies that cover areas of joint working beyond just health and care, including the wider societal issues. These are: 1. Health and Wellbeing Strategy 2. Inclusive Communities Framework 3. Inclusive Economy Strategy 4. Environment Strategy. However, whilst we have agreed this strategic approach, there are still challenges of delivery to be navigated. Operational pressures are significant, alongside significant financial challenges across the partnership. This means that our ability to deliver on these in the short term is challenged. Due to capacity constraints realising the full benefits of the Economic Inactivity Accelerator and related programmes will be challenging, but progress is being made. Uncertainty around ongoing ICB organisational change and what this will mean for local partnership working in Kirklees and the ICBs ongoing role in this as we potentially move to a CKW footprint. Risk score to remain the same.	
OPEN	Likelihood	2	8	Likelihood	3	12		
	Impact	4		Impact	4			

Key controls <i>(What helps us mitigate the risk?)</i>							Mitigating actions <i>(What more are we/should we be doing at place?)</i>						
1 4 top tier strategies for Kirklees that go beyond just health and care and cover wider societal issues.							1. Commitment to the 4 top tier strategies reiterated at the Kirklees partnership executive. There is a programme of work agreed for 2025/26 overseeing by the partnership executive.						
2 Ownership of these 4 strategies assigned to partnership boards or forums.													
3 Partnership Executive in place which includes business, education in addition to health, care and LA.													
Sources of assurance <i>(Where is the evidence that the controls work?)</i>							Link to place risk register:						
1 Reporting to the relevant board/partnership forum on progress against each of the 4 strategies.							None						
2 Use of other partnership forums to support this e.g. Partnership Forum, ICB committee.													
Leeds							Place lead: Tim Rley						
							Nominated lead for this risk: Tim Rley (26.06.2025)						
ICB risk appetite		Place risk scores						Rationale for current place score					
		Target (Leeds)			Current (Leeds)			Wider societal issues contribute significantly to health, wellbeing and inequalities. Working with partners to address these is a key part of our health and care strategy. We have dedicated capacity supporting this work which we will protect through the business planning process. The key is ensuring sufficient leadership focus.					
OPEN	Likelihood	2	8	Likelihood	3	12							
	Impact	4		Impact	4								
Key controls <i>(What helps us mitigate the risk?)</i>							Mitigating actions <i>(What more are we/should we be doing at place?)</i>						
1 Health & Wellbeing Board Strategy							1. Creation of a joint neighbourhood model between NHS and Local Authority (2025/26) 2. Monitor and report on anchor institution work to test impact for the city (ongoing piece of work) 3. Continue to drive digital and medical technology innovation through the Integrated digital service, Leeds Academic Health Partnership and the Leeds Health & Care Hub. 4. Implement action plan arising from Marmot city programme led through public health (2025 - 2027) 5. Leeds Health and Care Partnership have signed off four priority programmes all with a strong health inequality focus including links to wider social determinants (2025/26)						
2 Active participation and alignment to Marmot City agenda													
3 Shared goals across Leeds Health & Care Partnership reflecting 10 big ambitions and requiring addressing													
4 Continuing monitoring of metrics by ethnicity and deprivation as routine													
Sources of assurance <i>(Where is the evidence that the controls work?)</i>													
1 Progress against 10 big ambitions in Leeds							Link to Place Risk Register						
2 Reporting on key Healthy Leeds Plan metrics by deprivation													
3 Health & Wellbeing Board monitoring of HWB strategy													
4 Director of public health annual reports													
							None						
Wakefield							Place lead: Mel Brown						
							Nominated lead for this risk: Ruth Unwin, Becky Barwick (02.07.2025)						
ICB risk appetite		Place risk scores						Rationale for current place score					
		Target (Wakefield)			Current (Wakefield)			Impact score is high as there is strong evidence that failure to address social determinants leads to poor population health and increased demand on care services. Risk score remains the same this cycle.					
OPEN	Likelihood	2	8	Likelihood	2	8							
	Impact	4		Impact	4								
Key controls <i>(What helps us mitigate the risk?)</i>							Mitigating actions <i>(What more are we/should we be doing at place?)</i>						
1 Wakefield District Health and Wellbeing strategy provides a framework for tackling wider determinants of health							1. A district plan is being developed under the joint leadership Wakefield Together (statutory, voluntary and commercial sectors), which includes plans to improve population health by addressing wider determinants. Plan will be in place by Autumn 2025. 2. The bid to the local vestment panel supported protection for the previous Core 20 plus 5 funding but not protecting all of the uncommitted resource.						
2 Wakefield Forward Plan includes work to deliver Health and Wellbeing Board priorities													
3 Core20plus5 funding directed to addressing social determinants, to be confirmed via the investment panel for 2025/26.													
Sources of assurance <i>(Where is the evidence that the controls work?)</i>													
1 Regular reports to Health and Wellbeing Board & Wakefield District Health and Care Partnership Committee on work to address priorities							Link to Place Risk Register						
2 Outcomes framework has been developed for both the Health and Wellbeing Board and Wakefield District Health and Care Partnership Committee and being reported through both committees													
3 Impact of investment in Core20plus5 programmes was reported to Wakefield District Health and Care Partnership Committee November 2023													
							None.						

WYICB - Board Assurance Framework - ICB and places							Version: 11	22 April 2025
Mission 4	Failure to manage the strategic risk could result in a failure to SECURE BENEFITS OF INVESTING IN HEALTH AND CARE						Lead director(s) / board lead	Ian Holmes
Strategic risk 4.2	There is a risk that we are unable to achieve our ambitions on equality diversity and inclusion due to ingrained attitudes that persist in society and across our health and care organisations.						Lead committee / board	Quality Committee
ICB risk appetite	ICB risk scores						Rationale for current ICB score	
	Target (ICB)			Current (ICB)			Our health and care partnership has done significant work on the race equality agenda, but we know that systemic problems still exist in all organisations in our system. We will continue to work with focus and energy on this agenda and broaden our focus to include other protected characteristics.	
BOLD	Likelihood	2	8	Likelihood	3	12		
	Impact	4		Impact	4			
Key controls <i>(What helps us mitigate the risk?)</i>							Mitigating actions <i>(What more are we/should we be doing at ICB level?)</i>	
1 Five Year Integrated Care Strategy - Ambition 8							(1) Equity and Fairness Strategy was approved Partnership Board in January 2025. This will be overseen by the Partnership Board including a number of objectives for delivery by the Partnership Board. Transformation Committee will oversee ICB actions in relation to the strategy. (2) The Race Equality Review undertaken in 2020 will be reviewed by Donna Kinnair during 2025/26. The findings reported to the Partnership Board in January 2025 and actions identified were included in the Equity and Fairness Strategy.	
2 Race Equality Review Action Plan overseen by the Partnership Board								
3 EDI Oversight Group maintains oversight of statutory requirements and objectives								
4 ICB People Plan, with a strong focus on inclusivity								
EQIA process embedded to inform decision-making								
5								
Sources of assurance <i>(Where is the evidence that the controls work?)</i>							Links to ICB risk register <i>(Reference numbers/brief description)</i>	
1 Internal Audit Review 2023/24							None identified	
2 People Plan had ICB Board sign off in September 2024								
3 Staff survey data								
4 WRES data								
5 EMT discussion and oversight of priorities and responses to audit actions								
6 Agenda and minutes of EDI Oversight Group								
7 Examples of reports and minutes showing consideration of EQIAs during decision-making								
8 Transformation Committee discussion and oversight of strategy action plan.							See the separate Positive Assurance Log	
Bradford District and Craven (BD&C) Place lead: Therese Patten							Nominated lead for <u>this risk</u> : Kez Hayat (30.06.2025)	
ICB risk appetite	Place risk scores						Rationale for current place score	
	Target (BD&C)			Current (BD&C)			Concerted work on all aspects on EDI is required to meet the needs of our population and ensure our colleagues experience at work enables them all to flourish. Our data and qualitative information tells us that much remains to be done, building on the strong commitment shown already EDI leads have identified that 'If we are unable to improve outcomes for our population and workforce by advancing our collective approach to EDI then our population and workforce will continue to experience inequality of outcome, unfair treatment and discrimination'. Risk reviewed and the risk score remains the same for Cycle 2.	
BOLD	Likelihood	2	8	Likelihood	3	12		
	Impact	4		Impact	4			
Key controls <i>(What helps us mitigate the risk?)</i>							Mitigating actions <i>(What more are we/should we be doing at place?)</i>	
1	Place wide (broader than health and care - all sectors) EDI group, chaired by Prof Udi Archibong. Good engagement from EDI leads Acting As One. ICB input through Act As One partnership EDI lead Kez Hayat. 6-8 weekly Systems Equalities Group meeting to ensure collective plan for EDI stays on track.						Continue with three priorities which align with the WY ICB strategic equality objectives for 2025/26; 1. Continue with our focus and efforts on reducing health inequalities across the district with particular focus on 'Access, Experience and Outcomes' for our diverse communities and wider communities of interest. This will foster collaborative processes that actively listen to patients and service users and act on their feedback to shape access, experiences, and outcomes. 2. To work with place level partners in influencing the development of an anti-racist approach/strategy for Bradford and Craven district with focus on targeted engagement and involvement with communities and wider workforce. REN currently taking the lead with system partners onboard with focus on co-producing an anti-racist approach for Bradford and Craven 3. Improve and advance our role and position in ensuring we have diverse senior leaders at band (8b) and above across our place with particular focus on positive action approaches for diverse staff across place. This links with the WY Race review that Professor Dame Donna Kinnair chaired. <u>Link to place risk register:</u> None	
2	EDI reporting is carried out by each large organisation in line with national requirements e.g. WRES, WDES, EDS2, PSED and use of EQIAs/QEIA's for NHS Trusts/FTs. Also Public Sector Equality Duty annual reporting by all statutory bodies, includes 'place partnership view' fed into WY ICB report.							
Sources of assurance <i>(Where is the evidence that the controls work?)</i>								
1	Minutes of the systems EDI group							
2	BDC People Board							
3	Assurance provided via Executive Leadership Executive, minutes.							
4	BDC Extended Leadership Team meeting, minutes.							
5	NHSE website for WRES and WDES data. WYICB PSED report on website							
Calderdale Place lead: Robin Tuddenham							Nominated lead for <u>this risk</u> : Neil Smurthwaite (17.07.2025)	
ICB risk appetite	Place risk scores						Rationale for current place score	
	Target (Calderdale)			Current (Calderdale)			Our health and care partnership has done significant work on the race equality agenda, but we know that systemic problems still exist in all organisations in our system. We will continue to work with focus and energy on this agenda and broaden our focus to include other protected characteristics.	
BOLD	Likelihood	2	8	Likelihood	3	12		
	Impact	4		Impact	4			
Key controls <i>(What helps us mitigate the risk?)</i>							Mitigating actions <i>(What more are we/should we be doing at place?)</i>	
1 Race equality standard compliance is monitored at place level.							1. Suporting the EDI strategy in West Yorkshire (2025/26) <u>Link to place risk register:</u> None	
Sources of assurance <i>(Where is the evidence that the controls work?)</i>								
1 Outcomes of staff survey is discussed at Calderdale senior leadership team meetings								
Kirklees Place lead: Vicky Dutchburn							Nominated lead for <u>this risk</u> : Steve Brennan (25.06.2025)	
ICB risk appetite	Place risk scores						Rationale for current place score	
	Target (Kirklees)			Current (Kirklees)			Place have history of tackling issues related to inclusion, but recognise the need to go further given the diversity of our population, experiences of care and access to services and how our colleagues improve practice.	
BOLD	Likelihood	2	8	Likelihood	3	12		
	Impact	4		Impact	4			
Key controls <i>(What helps us mitigate the risk?)</i>							Mitigating actions <i>(What more are we/should we be doing at place?)</i>	
1 Inclusive Communities Framework adopted by Place Committee							1. EDI Strategy is being developed for approval at ICB Board in January 2025 (assurance). This will be overseen by the Partnership Board including a number of objectives which have been developed for delivery by the WY Partnership Board. The Kirklees objectives of the EDI strategy have been developed and agreed and work is progressing (2025/26)	
2 EQIAs embedded as part of PMO functions								
3 Community champions / Community voices								
Sources of assurance <i>(Where is the evidence that the controls work?)</i>							<u>Link to place risk register:</u> None	
1 ICB (Kirklees) self-assessment against the ICF during 2025/26 (last completed 2023)								
2 Examples of EQIAs and subsequent action / mitigation								
3 Examples of voice and influence from diverse population in planning and transformation								
Leeds Place lead: Tim Rley							Nominated lead for <u>this risk</u> : Nick Earl 27.06.2025	
							Cycle 3 review will be undertaken by Sharon Moore	
ICB risk appetite	Place risk scores						Rationale for current place score	
	Target (Leeds)			Current (Leeds)			ICB in Leeds works proactively in relation to EDI in respect of our workforce.	

BOLD	Likelihood	2	6	Likelihood	3	9	organisational development and commissioning responsibilities. The controls currently in place should limit any breaches in statutory duty. Although the risk appetite is set at BOLD, the target risk score was reviewed and the impact increased from 2 to 3, even though we can influence the likelihood, the impact will remain moderate, target risk is therefore 6 rather than 4. .	
	Impact	3		Impact	3			
Key controls (What helps us mitigate the risk?)							Mitigating actions (What more are we/should we be doing at place?)	
1 Compliance with the requirements of the Equality Act 2010 Public Sector Duties in relation to our workforce and commissioning responsibilities.							1. Supporting the EDI strategy in West Yorkshire (2025/26) and leading on the development of Leeds EDI priorities 2. Increased focus on personal wellbeing within objective setting which will include EDI components (2025/26) 3. On going improvement and development in relation to the integration of Equality Impact Assessments within the business process cycle and all decision making processes	
2 NHS Equality Delivery System 2 (EDS) and transition to EDS 2022; Workforce Race Equality Standard (WRES); Workforce Disability Equality Standard (WDES); Gender Pay Gap (GPG) report and subsequent action plans.								
3 Integration of our Equality Impact Assessment and Quality and Equality Impact Assessment within all decision making processes								
4 Ongoing interaction/partnership working in relation to our insights, communication and involvement team and equality, diversity, and inclusion.								
Sources of assurance (Where is the evidence that the controls work?)							Link to place risk register:	
1 Development of ICB in Leeds equality, diversity, and inclusion (EDI) priorities; annual contribution to WYICB Public Sector Equality Duty Report; equality impact assessments completed for commissioning programmes/projects and in relation to decisions.							None.	
2 Ongoing partnership working across Leeds Health and Care partnership and the wider WYICB partnership in relation to the EDS transition and development of key priorities. WYICB WRES; WDES; GPG actions plans.								
3 Continuation of ICB in Leeds REN; continued implementation of the REN recruitment and selection procedure/ guidelines.								
Wakefield							Place lead: Mel Brown	Nominated lead for this risk: Ruth Unwin, Dasa Farmer (07.07.25)
ICB risk appetite	Place risk scores						Rationale for current place score	
	Target (Wakefield)			Current (Wakefield)				
BOLD	Likelihood	2	8	Likelihood	3	12	Impact assessed as high due to evidence that people with different protected characteristics have poorer health outcomes. Likelihood assessed as high due to Wakefield District Health and Care Partnership having limited ability to change deeply ingrained attitudes.	
	Impact	4		Impact	4			
Key controls (What helps us mitigate the risk?)							Mitigating actions (What more are we/should we be doing at place?)	
1 Equality, Diversity and Inclusion network established for place							1. A proactive approach to monitoring population health and uptake of services by groups with protected characteristics. Linked data model implementation for children and young people and other cohorts continuing (2025/26) 2. Supporting delivery of WY wide equality and fairness strategy through localised objectives. The delivery will be monitored via the People Panel. 3. Workforce alliance has a dedicated pillar of work in addressing equality, diversity and inclusion in all aspects of workforce, recruitment, development and training (2025/26)	
2 Local equality objectives in place								
3 Work programme to ensure compliance with Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), Public Sector Equality Duty (PSED)								
4 Local, multi-agency health inequalities alliance developed.								
5 The workforce alliance has a specific workstream for belonging to ensure equality of opportunity in recruitment and career progression								
6 Communication, Involvement and EDI at place								
Sources of assurance (Where is the evidence that the controls work?)							Link to place risk register:	
1 People panel (partnership committee) receives and scrutinises delivery of equality agenda							None.	
2 Formal reports - WRES,DES, PSED, Equality Delivery System to People Panel								
3 Equality and fairness strategy has been presented to the People Panel, to place management team and Healthcare Inequalities Steering Group								

WYICB - Board Assurance Framework - ICB (no requirement for places to complete)						Version: 11		Date: 3 April 2025			
Mission 4		Failure to manage the strategic risk could result in a failure to SECURE BENEFITS OF INVESTING IN HEALTH AND CARE				Lead director(s) / board lead		Shaukat Ali Khan/ Lou Auger			
Strategic risk 4.3		There is a risk that threatens 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.				Lead committee / board		ICB Board/Transformation Committee			
ICB risk appetite		ICB risk scores				Rationale for current ICB score					
		Target (ICB)		Current (ICB)		This risk relates to the ability of the ICB to work with partners to mitigate the impact of a significant incident on the delivery of healthcare services. Our current score has been assessed against the operation of the controls during recent EPRR events and incidents . We have evidenced significant system ability to respond to an emergency, however there are limited controls the ICB can put in place for the largest scale event such as a future pandemic.					
AVERSE		Likelihood	3	9	Likelihood					3	12
		Impact	3		Impact					4	
Key controls (What helps us mitigate the risk?)						Mitigating actions (What more are we/should we be doing at ICB level?)					
1 Engagement with all partners and direct alignment to WY Resilience Forum						1. Directorates and Places to complete Business Impact Assessments by June 2025 to support further development of business continuity plans. 2. Scheduled cyber security summit in June 2025 - a workshop to build awareness on cyber security. The second half of the day will feature a role play exercise to stress test our approach to real life scenarios. (2025) 3. Data Security Protection Toolkit is in progress and audit has commenced in April 2025. There remains substantial work to be done to complete the evidence and associated statements (2025/26) 4. Cyber Security Discovery exercise: we have undertaken a cyber security discovery to identify risks and mitigation to improve cyber security resilience. An action plan will be developed to begin implementation by June 2025.					
2 Training at senior level - Principles of Health Command Training - Strategic Health Commander											
3 WY CIO Forum inc Place CIOs											
4 System Winter Plan with mitigating actions for surge and escalation inc Strategic Coordination Centre											
5 EPRR Compliance and Action Plans for each NHS organisation											
6 WY ICB has established arrangements for 1st and 2nd on-call.											
7 Business continuity plans are in place in the event of a prolonged IT system issue.											
8 WY ICB attends or facilitates a range of WY EPRR exercises during the course of each financial year.											
9 EPRR Team have completed testing and exercising of business continuity plans in March 2025											
Sources of assurance (Where is the evidence that the controls work?)						Links to ICB risk register (Reference numbers/brief description)					
1 Reporting of EPRR Compliance to Board						2194 - industrial action 2036 - Airedale Hospital structural RAAC 2166 - Risk of a successful cyber attack, hack and data breach on ICB. 2234 - Risk of cyber attack on commissioned services 2295 - Business continuity arrangements					
2 Minutes of Audit Committee and Internal Audit Meetings											
3 WY EPRR exercises - outputs, from papers and Mins.											
4 Significant learning from incidents											
5 Regular reporting on progress with DSPT annual self-assessment to WY ICB Audit Committee and internal audit assurance of DSPT submission											
6 There is a newly established directorate called Digital, Data and Technology (DDaT) - output from papers.						Positive Assurance - see separate log					

WYICB - Board Assurance Framework - ICB (no requirement for places to complete)							Version: 11		22 April 2025	
Mission 4	Failure to manage the strategic risk could result in a failure to SECURE BENEFITS OF INVESTING IN HEALTH AND CARE						Lead director(s) / board lead		Ian Holmes	
Strategic risk 4.4	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.						Lead committee / board		Transformation Committee	
ICB risk appetite	ICB risk scores						Rationale for current ICB score			
	Target (ICB)			Current (ICB)			Climate change is already affecting us in West Yorkshire. International, national, regional and local strategies and actions are insufficient at present to avert the worst effects. In West Yorkshire, we are most likely to be directly affected by flooding, heatwaves, wind and wildfire, but specialist (medical) and general (food, office supplies) supply chains will be disrupted. There is a real risk of disruption to power, internet and gas grids at a regional level. We need to reduce our environmental impact (mitigation) and change what we do to make us ready for the new normal (adaptation).			
OPEN	Likelihood	4	12	Likelihood	4	16				
	Impact	3		Impact	4					
Key controls (What helps us mitigate the risk?)							Mitigating actions (What more are we/should we be doing at ICB level?)			
1 Climate Change strategy approved by Partnership Board December 2023							No specific actions at this point, however consideration is being given to developing actions focused on adaptation.			
2 Regular meetings and data submission to national Greener NHS team										
3 Transformation Committee will take oversight of ICB organisational response.										
4 Board Level Net Zero Leads network and the Operational Leads Network.										
5 Regional Greener NHS steering group.										
Sources of assurance (Where is the evidence that the controls work?)							Links to ICB risk register (Reference numbers/brief description)			
1 Minutes of Partnership Board focus on Big Ambition number 9 (climate change)							None identified.			
2 Dashboard received by ICB Board on 10 big ambitions										
3 Quarterly data submission to the National Greener NHS team										
4 Minutes of the Transformation Committee							Positive Assurance - see separate log			

ITEM 21a

Wakefield Health and Care Partnership Wakefield Transformation and Delivery Collaborative Meeting

Minutes of the Wakefield Transformation and Delivery Collaborative Meeting held on
Tuesday 22 April 2025 from 1.30pm via Microsoft Teams

Core Members Present:

Ruth Unwin (RU),	Director of Strategy, Wakefield Place (Chair)
Amrit Reyat (AR),	Strategic Programmes and Health Inequalities Lead, Wakefield Place
James Brownjohn (JB),	Programme Manager for Planned Care, Wakefield Place
Colin Speers (CS),	Medical Director for Integrated Community Services, Wakefield Place
Claire Vodden (CV),	Communications and Marketing Manager, Wakefield Place
Michala James (MJ),	Head of System Delivery, Wakefield Place
Laura Elliott (LE),	Senior Head of Quality, West Yorkshire ICB
Jayne Whitehouse (JW),	
Becky Barwick (BB),	Associate Director for Partnerships and System Delivery, Wakefield Place
Stephanie Gillis (SG),	Director of Clinical Services, Prince of Wales Hospice
Joanne Fitzpatrick (JF),	Associate Director of Population Health, Personalisation and Engagement
Amanda Miller (AM),	Associate Director of Operations, South West Yorkshire Partnership NHS Foundation Trust
Joe Hazell (JH),	Senior Transformation Manager, Urgent Care Redesign, Wakefield Place
Pauline Riddett (PR),	Primary Care Network Representative
Paula Bee (PB),	Chief Executive, Age UK Wakefield
Pravin Jayakumar (PJ),	GP Clinical Advisor
Chris Skelton (CSk),	Associate Director of Primary Care, Wakefield Place
John Lemm (JL),	Programme Manager – System Workforce Office
Michele Ezro (ME),	Programme Director for Mental Health Transformation, South West Yorkshire Partnership NHS Foundation Trust and Chair of the Mental Health Alliance
Paulette Huntington (PH),	Deputy Chair of the People Panel
Jenny Lingrell (JL),	Service Director for Children's Health and Wellbeing, Wakefield Council

Claire Goodhind (CG), Lynsey Warwick-Giles (LWG), Natalie Tolson (NT), Steve Knight (SK), Matt England (ME), Samiullah Choudhry (SC), Joanna Dunne (JD), Jemma Harris (JH), Gilbert Gandashanga (GG),	Programme Management Officer, Wakefield Place Research Associate, Health Organisation, Policy and Economics Research Group Joint Service Lead for Data and Analytics, Wakefield Place and Mid Yorkshire Teaching NHS Trust Chief Executive, Conexus Associate Director of Planning and Partnerships, Mid Yorkshire Teaching NHS Trust Head of Medicines Optimisation, Wakefield Place Senior Programme Management Office Manager, Wakefield Place Governance Manager (minutes) Risk Officer (minutes)

Administration

T001/25 Welcome and Apologies

RU welcomed all to the meeting.

The following apologies for absence were noted and accepted:
Melanie Brown, Penny McSorley, Leanne Brown and Jon Parnaby.

T002/25 Quoracy and Declarations of Interest

It was confirmed that the meeting was quorate.

In terms of declaration of interest PJ advised that he no longer worked for Mid Yorkshire Teaching NHS Trust and would therefore only represent the Primary Care Network for Wakefield at the meeting moving forward.

T003/25 Minutes of the previous meeting held on Thursday 20 March 2025

The minutes of the previous meeting held on Thursday 20 March 2025 were accepted and approved as a true and accurate record.

T004/25 Action Log

The following updates against actions were provided:

- **Action 51** - In her update on links between single point of access and emergency care, JL advised that the proposed meeting had

been rescheduled due to changes in team leaders. An update would be provided at the next meeting.

- **Action 56** - work on priority provider alliance to primary care CS advised that a meeting was held on 22 April 2025 to map the way forward and that general practice would make the appropriate decisions. Action Closed.
- **Action 57** – It was confirmed that the slides had been shared. Action closed.

Programme Delivery:

T005/25 Programme Highlight Reports

- a) **Adult Community Transformation, Urgent Community Response and the Adult Community Transformation Group:** CS presented the update and highlighted the risks a reduction in capacity to support the end-of-life care board, which is a priority area for neighbourhood health. This was previously funded from transformation allocation, and it was hoped that it could have been funded through the additional investment that had been awarded to the Hospice. There were efforts to source funding from primary care and other community services though there was concern about the long-term sustainability.

The Primary/Secondary Care interface link had been established on a six-month pilot basis to identify areas of concern and prioritise the work programme. This would also support the successful implementation of Advice and Guidance Enhanced Service nationally.

There was an increase in online consultations rates. Detailed guidance had been provided to practices and this was linked specifically to the capacity and access improvement payments due in March 2025.

There had been education with Yorkshire Ambulance Services (YAS) and care homes to improve the quality of end-of-life care with assistance from Adult Community Services, as an area of transformational quality improvement for the year.

The falls programme had undergone transformation into a one stop shop within the Community Diagnostic Centres (CDCs), though it was not aligned to the existing MYTT falls pathways.

A pilot project within the specialist services such as elderly care had been undertaken with satisfactory outcomes. This would be progressed through the financial year as a business case to ensure funding within more West Yorkshire Places.

The virtual ward remote monitoring technology that had been purchased had not been for the frailty virtual ward and had been transferred to respiratory and oncology to be used for both monitoring patient at exacerbations and as part of the Pancreatic Enzyme Therapeutic Replacement Therapy (PERT) scheme and for patients receiving chemotherapy.

SG requested an update on the virtual ward pilot project for palliative end of life care and the proposed options for the frailty virtual ward. CS advised that the pilot project was carried out for a relatively short period and there were some areas to be improved on and the need to address funding challenges.

PH sought clarification on the system interface challenges that had been experienced resulting in duplicate data being captured by clinicians. CS advised that these were perennial challenges, which it was hoped would be addressed through the roll out of the MYTT new Electronic Patient Record.

RU requested CS to provide additional details on the impact of the identified risks and the corresponding mitigatory measures and described how these aligned to the neighbourhood health agenda. CS advised that future highlight reports would be changed to reflect the requirements of the neighbourhood health agenda.

a) Primary Care: CSk presented the update and highlighted the below.

There was a 3.16% increase in the number of patients with learning disability who had a health check.

There was an increase in the number of health checks from the previous year.

General Practice (GP) Appointments continued as predicted with increased activity both in and out of hospital urgent care settings. This was in line with seasonal trends.

The number of appointments available in GP practices had remained

above the national average in February 2025.

There was an increase in the number of patients registered to use the NHS App and online Consultation rates had continued to increase across all Primary Care Networks (PCNs). All practices had been enabled to accept new patient online registrations in line with contractual guidance.

Compliance with the diabetic Eight Care Processes had increased by 4.7% from the previous year.

The GP contractual documentation and requirements for the 2025/26 financial year had been received. There was requirement for improvements in patient access as well as greater clarity on expectations for GPs.

The Patients' Charter would be made available to patients and other stakeholders setting out the requirements for commissioners and providers.

PH requested CS's view on the continued increase in GP online consultations considering the patient and organisational perspectives. CS advised that this was aimed at extending access and choice to patients in accessing services and it was also the aim at ensuring all forms of access were offered by practices and that the service was consistent whatever platform was used. No patient would be forced to use an online platform if this was not suitable. It was anticipated that the Patients' Charter would clarify contractual requirements for GP practices to give patient's the ability to make a choice. He welcomed the feedback and advised that this would be used to inform training of frontline staff for improved service.

JBj added that, since the Covid-19 period, there had been need for improved access to medical services. Changes in the way services were offered reflected the need to make optimum use of limited resources as well as changing patients' expectations.

RU emphasised the need for effective communication and engagement with the public to address the misalignment between public's expectations and the actual service being delivered.

CSk advised that they awaited more detailed information from NHS England regarding the guidance to ICB Commissioners and this would be reflected in the risks identified in the highlight report.

In response to RU's request for clarification on outstanding risks, CSk advised that the highlighted risks regarding planning guidance and contracts would be retained until the conclusion of the Patients' Charter and the discussions on commissioning and ICBs transformation improvement programme.

- b) **Medicines Optimisation:** CS presented the highlight report and said that during the period 2024/25 the team had generated most of the QIPP savings. The slight underachievement of the plan was due to a change in the concessionary price toward the final quarter.

The achievement of savings was due to engagement with PCN colleagues and continued work on managing prescribing growth through a shared benefits approach.

The PCN pharmacies comprising pharmacists and pharmacy technicians were working on quality and safety improvements and some genuine cost saving by switches of prescribed items.

They were also considering the move on nutritional supplements from PF10 by using an enhanced dietician model which led to improved quality through more regular dietician reviews to ensure people got dietician supplements under the food first approach.

There was focus on reduced prescribing costs while investing in dietetic service with the intention to roll out similar approaches in wound care.

- c) **Children's Alliance:** JL presented and advised that the Children's Alliance had reported to Children and Young People's Overview and Scrutiny Committee and the Special Education Needs and Disabilities (SEND) Strategic Board on progress made since the SEND inspection.

The key areas for development were noted as waiting times for Speech and Language Therapy, Core Child and Adolescent Mental Health services (CAMHS) pathways and Autism Spectrum Disorder

(ASD) and Attention Deficit Hyperactivity Disorder (ADHD) diagnostic pathways.

WY ICB Programme had led on system-wide work to improve outcomes for children and young people. The Wakefield System including the Children's Alliance and colleagues from social care and SEND were engaged in the programme.

Since the last SEND inspection there had been improvements in waiting times for speech, language and communication and Core CAMHS Pathways where the waiting period had been eliminated. The only exception was art therapy, though alternative therapies were being offered.

There had been data flow challenges experienced especially within Mid Yorkshire pathways, with service providers resorting to manual reports. The manual reports showed that the ASD referrals had increased from the previous month with only 40% of the cases progressing to the multidisciplinary assessment.

A detailed outline of the efforts to address the needs of children with complex needs with acute trusts of West Yorkshire had been compiled.

JL asked for support from CS and CSk to help to secure engagement with primary care colleagues around neighbourhood working to support children as primary care was not represented at the Children's Alliance meetings.

- d) **Digital and Business Intelligence:** NT presented and noted that the West Yorkshire Digital Strategy all-stakeholder engagement was on course and the feedback had been gathered. The ICB Board Development Session was scheduled for 29 April 2025 to consider the outcome of the findings of the strategy. Details would be made available after the session.

West Yorkshire was in discussion with the Federated Data Platform (FDP) to explore participation in the population health pilot.

The Optica discharge module had been rolled out at Mid Yorkshire and the next area of focus was expected to be the Referral to Treatment (RTT) waiting list or support to some other aspect of planned care.

The linked data model for population health data was being worked on in respect of data and analytics from non-NHS organisations. A new data set from adult social care had been established and there was ongoing engagement with Age UK regarding their data quality.

The team had also been supporting the Benefits Realisation Assessment Working Group regarding benefits realisation assessment on existing scheme to support Emergency Department (ED) demand and admission avoidance.

The exercise to identify potential opportunity impact using the Newton Europe model in Leeds was projected to be completed in two weeks when the programme would be summarised and fed back to the West Yorkshire transformation programme and would support development of the North Star metrics.

The team had also been supporting the Economic Accelerator programme and working through the information governance issues.

NT reported that Beta Version, a new version of the Population Insight report named had been developed and was accessible through the Population Health App. There were planned training sessions on use of the new version.

There had been a request from the public health teams to support with the respiratory network, specifically the spirometry results and that was being considered.

She said that the outcome of the hypertension intervention decay model to be linked to the medicine's pathway would be shared with colleagues once completed.

The Health Pathways programme for unplanned care had started, initially focussed on developing the first dashboard or the insight data pack, and the increase in pathology tests within pathology would be considered as part of GP direct access review work.

CS requested NT to consider looking into other disease areas like cholesterol levels and haptoglobin achievement in diabetes prevention in future and NT accepted that.

RU acknowledged that Wakefield was in an advanced position compared to the other Places in West Yorkshire and requested NT to provide a more detailed update on the ICB data strategy and the implications for Wakefield at a future meeting. **ACTION: NT.**

- e) **Mental Health Alliance:** ME verbally provided following highlights: Following the £2.2m saving in the 2024/25 financial year the 2025/26 budget allowed the disordered eating service procurement approval to progress. The specification would be finalised to ensure alignment with the regional specialist service with the needs of primary care.

The 24-hour well-being service would also be progressed, operating from Queen Elizabeth House. The well-being hub would support the Mid Yorkshire system and its low-level support intervention with a potential for mental health beds. It was projected to develop as a medium-term project as a 24-hour place of safety in line with Section 136 of the Mental Health Act.

There would also be increased capacity for mental health 111 West Yorkshire Places in response to increased number of calls being received, following agreement from all five places across WYICB to put in additional funding from Q4 2025/26.

The reporting for the financial year 2024/25 final quarter was being concluded in relation to SMI and LD health checks with tentative indications of significant improvement.

RU suggested that Jeremy Wainman, Senior Commissioning Manager for Adult Mental Health, join a future meeting to provide an update on the 24-hour well-being facility. In response ME welcomed the invitation. **ACTION: JH/ME**

- f) **Urgent escalations from other programmes:** There were no further escalations to report.

T006/25 2025/26 Programme Management Office Efficiency Tracker

JD presented the update on Programme Management Office (PMO) Efficiency Tracker with the following highlights.

The PMO was working with the Benefits Realisation Working Group to develop activities relating to measurement and monitoring though this would only be progressed when the respective matrix framework was available.

The development of the existing handbook was in progress, and this would be aligned to the work being done with other partners/colleagues.

The report confirmed the 2024/25 efficiency programme had been delivered and included an explanation of why some aspects had not been achieved.

The 2025/26 PMO Dashboard had been developed and was in operation.

Other Agenda Items

T007/25 Neighbourhood Health

BB explained that in January 2025 NHS England had published Neighbourhood Health Guidelines which included a set of requirements for Integrated Care Boards and Place partnerships. Partners across Wakefield were already successfully collaborating and progressing elements of the agenda whilst reiterating their commitment in line with the guidance.

She led members through the paper which outlined the contents of the new guidance and summarised the gap analysis that had been undertaken against each of the components and the progress made against its delivery.

The Purpose Statement was confirmed as 'Together we will work with the people of Wakefield district to create a connected system that supports people in their homes and communities to live healthier happier lives'. She said that this had been the vision for Wakefield since 2022 and that the new guidance would only support the acceleration of the vision and the achievement of the combined patient journey.

The six components of Neighbourhood Health were confirmed as below, with each noted as interdependent and would be progressed as a whole Neighbourhood Health picture rather than as separate service workstreams:

- 1) Population Health Management
- 2) Modern General Practice



- 3) Standardising community health services
- 4) Neighbourhood multidisciplinary teams
- 5) Integrated intermediate care with a 'Home First' approach
- 6) Urgent neighbourhood services

BB led members through the below specific requirements that systems had been asked to focus on during 2025/26:

- 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 gap analysis considered the requirements and the six components and was reviewed at a development session in March 2025 where the visions were discussed and a Senior Responsible Officer for each component agreed, who would support the production of an initial action plan. The session also identified that currently Wakefield were amber or yellow against each of the components.

BBJ asked how alliances would be aligned to the component workstreams in support of each moving in the same direction. He recognised that each alliance was already moving towards a community first focus but clarity was needed on how the component work would feed into the alliances. BB said it did not feel like the right time to review structures that were in place as all alliances were progressing valuable work and contributing already towards the Neighbourhood Health agenda. The key would be to amalgamate a structure that would sit across each alliance and there could be several ways to do that without adding additional bureaucracy. If anyone had thoughts on that she would be happy to discuss.

RU commented saying that there was work to do on that and suggested that each alliance could become the lead for an element of the programme and support cross fertilisation.

It was noted by PJ that neighbourhoods had been around for a few years now, yet the programme still seemed light on the full involvement of general practice and primary care who know the population better than anybody. She appreciated and agreed that progress was needed through



a multidisciplinary approach and was on board with the ethos and the aim but felt that the knowledge from those who have cared for people for years was lacking. BB agreed and said it was not a deliberate omission and it was recognised that primary care was a key component of neighbourhood health multidisciplinary working for the reason highlighted.

SK agreed with PJ that general practice did need to become more integrated. He then said he felt an area of struggle was that in the past focus had been on the form and perhaps the function had not been right. He asked if it was clear as a collective what impact we want to achieve so that we can hold ourselves accountable down the line on successes and the impact. He felt that a push in that direction needed to be stronger. BB agreed noting that there was a lot of work to do on that.

CS agreed with those comments and recognised that there remained a significant amount of work to do. He believed that the voice of general practice was beginning to strengthen and move on the journey with support from clinical directors. He also agreed it was a fair challenge that broader representation to support the journey was needed to move at the pace required, as well as to prioritise the resource that we have and be able to measure it by working closely with business intelligence and use that intelligence in a connected and joined up way to show that the model is working.

PJ challenged members that the focus should not be on those patients that already have high attendances and are high users of services as that would be extremely resource heavy. Instead, he suggested that patients just below that threshold should be focussed on before they become a high user to support them to stay at home and keep them well. CS agreed that long term impact is where we strive to be, but the politics led to prioritisation of financial targets which in year one is focussed on acute flow. BB also agreed with PJ and said that the evidence was compelling.

BB took members through the progress of developing the neighbourhood multidisciplinary teams (MDTs) confirming that a meeting had taken place to look at the priority cohort and start to design what that might look like operationally with a follow up meeting to that scheduled. A road map had also been drafted which included the Gantt chart of the initial activity.

BB confirmed that the TDC would act as Programme Board given the broad range of representation. In the future a Provider Alliance would be developed on a Wakefield Place footprint, which was being promoted by the West Yorkshire ICB in line with the national direction of travel.

She led members through the two 'north star' metrics that had been agreed for the Neighbourhood Health programme and which would be adopted for all five Places within West Yorkshire. The two 'north star' metrics are below:

1. Reduce preventable unplanned care utilisation across health settings (with the biggest improvement in the most deprived decile).
2. Increase prevention and early intervention (with the biggest improvement in the most deprived decile).

SK questioned whether the requirement to save money should be explicitly included in the metrics. BB agreed that saving money was definitely part of the conversation and would consider that pulling that more front and centre.

Members of the Wakefield Transformation and Delivery Collaborative were asked to consider the recommendations and proceeded as below:

- **RECEIVED** the update on Neighbourhood Health developments
- **APPROVED** the proposal that the Wakefield Transformation and Delivery Collaborative Meeting will initially act as the Neighbourhood Health Programme Board
- **APPROVED** the proposal to develop contributory metrics toward north star metric 1
- **DISCUSSED** the proposal that programme and alliance reporting is reviewed to give emphasis to the Neighbourhood Health agenda

T008/25 2025/26 NHS Planning Process and Update

RU advised that to narrow the financial gap there had been some adjustments to the final submission, which was compliant for acute performance and productivity. Mid Yorkshire had developed a plan to achieve performance targets but with a narrow margin.

RU said it was projected that there would be full compliance in respect of performance standards relating to patient flow, community mental health, and the disordered eating service. It was noted that the number of mental health targets had been reduced in the operating planning guidance but that the partnership would continue to monitor a wider range of performance metrics through performance reports, including primary health assessments for people with severe mental illness and learning disability. There was ongoing work to address the gap analysis on the neighbourhood health work, as previously outlined.

In terms of the financial position the ICB had a savings target of £7.2m and MYTT had a savings target of £39.5m, which would place the Trust in a in a £22.8m forecast deficit position. South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) had submitted a plan to deliver £28.3m savings and was projected to break even. That illustrated the level of financial risks in the system. It was not yet known whether there would need to be a further round of financial submissions to address the overall deficit position of the West Yorkshire ICB.

ME noted that the ICB had been advised of funding offer for Individual Placement and Support (IPS), though details for the Wakefield allocation were not available. Meetings would be held with other Places for a collective agreed ICB position as to whether to accept the funding.

Standing/Final Items

T009/25 Items for escalation to the Wakefield District Health and Care Partnership Committee

RU confirmed no escalations.

T010/25 Any Other Business

AR noted that an invitation had been sent out to staff to join the Wakefield Reducing Healthcare Inequalities Community of Practice Event. She confirmed that the event would take place on Wednesday 21 May 2025 between 9.00am and 3.00pm at the Salvation Army in Castleford. She asked members to join the event if able and to share with their teams.

Meeting Close

There being no further items of discussion the meeting closed at 3.21pm.

Date and Time of the Next Meeting:

The next meeting of the Wakefield Transformation and Delivery Collaborative is scheduled to take place on Tuesday 13 May 2025 from 1.30pm via Microsoft Teams.

ITEM 21b

Wakefield Health and Care Partnership Wakefield Transformation and Delivery Collaborative Meeting

Minutes of the Wakefield Transformation and Delivery Collaborative Meeting held on
Tuesday 13 May 2025 from 2.30pm via Microsoft Teams

Core Members Present:

Melanie Brown (MB)	Interim Wakefield Place Lead (chair)
Amrit Reyat (AR)	Strategic Programmes and Health Inequalities Lead
James Brownjohn (JBj)	Programme Manager for Planned Care, Wakefield Place
Jon Parnaby (JP)	Programme Manager for Urgent Care Redesign
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 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
Matt England (ME)	Associate Director of Planning and Partnerships, Mid Yorkshire Teaching NHS Trust
Pauline Riddett (PR)	Primary Care Network Representative
Leanne Brown (LB)	Service Director for Housing, Vico Homes
Chris Skelton (CSk)	Associate Director of Primary Care
Kirsty Stead (KS)	Deputy Director of Operations from Adult Social Care and Mid Yorkshire Community Services, Mid Yorkshire Teaching NHS Trust
Pravin Jayakumar (PJ)	GP Principle – Trinity Medical Centre Clinical Co-Director – Trinity Health Group
Lynsey Warwick-Giles (LWG)	Research Associate, Health Organisation, Policy and Economics Research Group
Claire Vodden (CV)	Head of Communications, Wakefield Place
Jeremy Wainman (JW)	Senior Commissioning and Transformation Manager, Mental Health and Learning Disabilities

Gemma Howorth (GH)	Senior Insight and Analytics Manager, Wakefield District and Health Care Partnership
Natalie Tolson (NT)	Head of Business Intelligence, Wakefield Place/Mid Yorkshire Teaching NHS Trust
Matt England	Associate Director of Planning and Partnerships, Mid Yorkshire Teaching NHS Trust
Stephen Knight (SK)	Chief Executive - Conexus Wakefield
Joanne Fitzpatrick (JF)	Associate Director of Population Health, Personalisation and Engagement
Domonic Blaydon (DB)	Wakefield Place, System Director for Workforce
Michelle Page (MP)	H Head of Unplanned Care Improvement, MYTT (representing Jackie Tatterton)
Tim Hodgkins (TH)	Managing Director, Site Services, Mid Yorkshire Teaching NHS Trust
Karen Ashmead (KA)	Strategic Programmes and Health Inequalities Fellow
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
Jemma Harris (JH)	Governance Manager, Wakefield Place
Gilbert Gandashanga (GG)	Risk Officer (minutes)

Administration

T009/25 Welcome and Apologies

MB welcomed all to the meeting.

The following apologies for absence were noted and accepted:

Abdul Mustafa, Becky Barwick, Linda Harris, Tracey Lowe, Michelle Ezro (Jeremy Wainman attending), Joanna Dunne (Claire Goodhind attending), Paulette Huntington.

T010/25 Quoracy and Declarations of Interest

It was confirmed that the meeting was quorate; there were no declarations of interest to record.

T011/25 Minutes of the previous meeting held on Tuesday 22 April 2025

The minutes of the previous meeting held on Tuesday 22 April 2025 were accepted and approved as a true and accurate record.

T012/25 Action Log

The following updates against actions were provided:

- **Action 51** – JP advised that discussions with JL would continue outside the meeting to ensure there were no overlaps in operations. Closed.
- **Action 52** – In NT's absence (at the time of discussion), the update would be provided at the next meeting.
- **Action 54** – CS advised that the preoperative care was considered inappropriate place for the tech enabled care to be explored for pre-operation assessment. There were, however, views to improve its use within the respiratory and oncology. Closed.
- **Action 58** – In NT's absence (at the time of discussion), the update would be provided at the next meeting.

Programme Delivery:

T013/25 Programme Escalations

JBJ escalated the following from the Planned Care Alliance:

- Following increased GP demand during the fourth quarter of 2024/25, there was an increase in referral demand and GP services. To discuss with the Unplanned Care Alliance and provide updates at future meetings once reviewed are complete
- The use of the remote weight management service, Oviva, was suspended pending the outcome of ongoing investigations. This could affect GP practices as they had failed to access the remote provider, Oviva.
- During commissioning discussion in West Yorkshire Planned Care and Elective matrix meetings the review of activity performance was advancing with the aim of removing activity caps. This was discussed at the most recent Planned Care Alliance meeting which focussed on reducing patient waiting times.
- There was an imbalance in waiting times within West Yorkshire, including the independent sector and this would be addressed through developing a fair, sustainable and affordable model.



ME asked how the measures would affect waiting times. JBJ responded that there were resource challenges in setting up the mental health wellbeing hubs but consultations remained ongoing to establish urgent mental health centres near people's homes to help prevent mental health crisis. JW added that plans to set up the mental health hub were progressing and that ongoing discussions on the location of an urgent treatment centre in Wakefield would incorporate mental health.

AR then updated on the ongoing discussions for the Health Accelerator Programme following confirmation of funding for the fiscal year 2025/26 outlined within the Staffing and Recruitment Framework which also addressed contractual issues for some interventions. She confirmed that discussions with contracting colleagues were in progress. MB highlighted the need to mitigate against identified risks which was acknowledged by AR who reiterated that the risks would be continuously monitored and addressed where required. RU raised concerns about potential delays in fund disbursement, which could impact resource mobilisation, but was assured that AR would oversee the situation.

A presentation was provided by CS covering an update on the Integrated Neighbourhood Ambitions and the following were pulled out as key highlights:

- Three meetings had been held with various stakeholders to discuss the 2025/26 NHS England neighbourhood guidelines, which focussed on addressing patient concerns about spending excessive time in hospitals and care homes.
- The focus for 2025/26 would be supporting adults, children and young people with complex health and social care needs who required support from multi-disciplinary organisations.
- The proposed West Yorkshire ICB metrics include reducing preventable unplanned care usage across all health services along with enhancing prevention and early intervention efforts.
- The 10% target for admission reductions was not confined to the Primary Care Network (PCNs) but to the whole system.
- The next phase of the programme outline would cover the evaluation matrices such as customer and staff satisfaction.

JW advised that the Dementia Strategy Group in Wakefield could be used to assist in intercepting and preventing unnecessary hospital admissions through the education of carers. CS acknowledged this and confirmed the programme had considered the Dementia Strategy following consultations with those living with or caring for those with dementia.

PJ emphasised the need for patient centred programmes to support reduction of hospital admissions and to ensure financial resource availability. The financial savings from the programme would then be reinvested into the community to support more proactive care with patients. ME pointed out the need to follow through the business case process and outline the investment proposals, benefits realisation, apportionment of risks, gains and overall evaluation of the programme. He offered his support to review the template if necessary.

Action: CS agreed to meet the PCN Directors to discuss the business case perspective of investment, benefits realisation and risk sharing and give to update on the outcome at the next meeting.

Other Agenda Items

T014/25 Neighbourhood Health: Integrated intermediate care with home first approach

PM joined the meeting and presented the vision for the intermediate care cohort, focussing on delivering a seamless, single pathway for patients. This vision emphasised providing high quality support as close to home as possible with the goal of empowering individuals to regain their independence. Initial actions for 2025/26 were agreed with Mid Yorkshire and system partners implementing the Optica tool which enabled visibility of the patient journey through hospital admission and into community setting. Efforts are required to determine how the Optica tool can be applied at Place level, how capacity can be enhanced for intermediate care, and establish the appropriate bed model. These decisions will be guided by a working group that includes therapy representatives. The inaugural meeting of the working group had taken place received strong support from MB, Chris Evans, Chief Operating Officer at Mid Yorkshire Teaching NHS Trust and Local Authority colleagues with considerable enthusiasm for advancing the patient first approach.

KS confirmed that the workshop held with frontline staff to look at the opportunities for redesign was well attended with representatives from Local Authority, Adult Community Services and the Acute Trust. A collective view of what could be done differently with rehabilitation beds was noted and work to progress and understand what that would mean for the Wakefield Intermediate Care Unit based at Pontefract Hospital was to be undertaken with an agreed model expected in the next few weeks. JP gave assurance that the programme was bringing all aspects of

intermediate care including benefit realisation together and reviewing as one.

TH advised of the challenges experienced with Optica's refresh rate and efforts to resolve them were underway and PM confirmed that links with NHS Humber and North Yorkshire ICB to share experiences on Optica usage and its application and service delivery had been established.

CS sought clarity on the projected scope of Optica use in Wakefield with KS confirming that there had been some reluctance to embrace Optica until the reported delays in performance were resolved. **Action: CS agreed to link with Lee Thompson from Local Authority regarding the use of Optica.**

T015/25 Neighbourhood Health: Urgent Neighbourhood Services

RU and JP presented the above update with the following highlights:

- Outlined the four components of urgent treatment which included Virtual Ward, Urgent Community Response (UCR), Same Day Emergency Care (SDEC) and Discharge to Assess.
- The Virtual Ward and UCR outlined requirements for 12 hours daily single point of access, with consideration for opportunities for other teams to support some of the Virtual Ward work through extended hours.
- The Virtual Ward review was underway within community and medical divisions within Mid Yorkshire with proposals to limit length of service. This required investment and staff consultation over an estimated two-year timeline.
- Pontefract would continue to be used as the Urgent Treatment Centre since it met the necessary requirements with the delivery model based on the demand profile. There were also plans to extend the scope and coverage of SDEC.
- A workshop with acute and primary care representatives was held to review the suitability of King Street walk in centre in Wakefield considering its location, operational hours and service model.
- The Implant Care Alliance would provide project oversight and discussions with the Unplanned Care Alliance Chairperson were ongoing.

The following risks and challenges were noted:

- There were numerous points of access into the service.



- The digital interface was not good in terms of services being on different platforms that did not communicate with each other.
- Some recording methods were not in line with the latest national guidance.
- There were requirements for investment as the Estates required the therapies to be moved from the site before the expansion project.
- There was a requirement for staff consultation.
- There were also concerns on oversight of components though most of the them fell under the Unplanned Care Alliance, except virtual ward and urgent care.

CSk felt the need to focus on patients and to develop a framework that interfaced with system partners with MB confirming that this was part of the work with a meeting held focussed on benefits realisation, patient experience and patient satisfaction on neighbourhood health.

SK noted the need for multidisciplinary and multi-organisational approaches within the urgent neighbourhood delivery framework, utilising the GP care spread across six sites. **Action: RU and PJ agreed to schedule a meeting with SK and CS to progress the project in line with the national directive.**

ME sought clarification on the impact of the Urgent Treatment Centre (UTC) at Pontefract Accident and Emergency (A&E) Centre. JP responded confirming there would be minimum impact with consultations were ongoing. EH pointed out the need for a more sustainable approach for the UTC, a model that created the appropriate environment for patients' bookable services and proximity to their homes. JO also advised that discussions with Yorkshire Ambulance Services (YAS) were ongoing.

Action: TH agreed to consider the points raised and update at the next meeting.

T016/25 Benefits Realisation and Opportunity Impact Modelling for 2025/26 Transformation

NT and GH confirmed that the Benefits Realisation Group was established to identify potential opportunities from local transformation programmes for 2025/26. The Wakefield Data and Analytics Team carried out a benefits realisation exercise for existing transformation schemes that supported admission avoidance and/or urgent care demand to determine whether the service had the intended impact on the system. The opportunity impact modelling was conducted for the expected future



impact of transformation schemes on the system, including those with potential opportunities from the benefits realisation work. The model to be used was based on Newton Europe that was used in Leeds to calculate the expected benefits and associated cost savings for local schemes. The work would then feed into Wakefield District Health and Care Partnership (WDHCP) transformation programme and West Yorkshire transformation priorities work outline.

The transformation scheme would contribute to the West Yorkshire Transformation Priorities Programme and the Mid Yorkshire's non-elective bed bridge gap. The opportunity modelling methodology was applied to multiple programmes to understand potential benefits to the system in 2025/26 and an outline of the summary of the opportunities to reduce A&E attendances via commissioned service and transformation programmes in 2025/26.

The method applied related to working with transformation leads, opportunity modelling, understanding the potential benefits, outline of interventions, the expected impact on the system and the changes to the model that might influence activity.

ME pointed out the need to include the projected financial benefits from the system, particularly at King Street, including the comparison of increasing capacity in relation to reduced daily costs. She advised that several meetings had been held to address the confidence levels of the schemes.

LE then highlighted the need to manage patients' expectations and behaviour change with NT and CSk confirming that the opportunity modelling and evaluation outlined the costing, justification, and assumptions for the programme that would manage that expectation.

NT advised that the nine-month intervention model that outlined the non-elective opportunities for admission avoidance through Emergency Department and supported discharge, in terms of Age UK Health Transport Services. The interventions for the virtual wards related to admission avoidance and supported discharge.

MB also said that the collaboration with Improvement Together would be considered at the forthcoming Unplanned Care Alliance meeting.

EH and TH pointed out the need for an integrated approach to avoid duplication through coordination between Mid Yorkshire, the Improving

Together Pathway and ambulance conveyances. MV explained that this was the initial phase, and all stakeholders would be engaged to ensure that patients and residents receive care and support in the settings where they feel most comfortable. The role of the Transformation and Delivery Collaborative would then as part of the provider partnership be accountable through monitoring, oversight and information sharing.

Action: MB asked CS and TH to collaborate, ensuring monitoring, oversight and information flow were managed under the Unplanned Care Alliance with CS also to coordinate programmes within the Integrated Neighbourhood Teams.

ME pointed out the need to coordinate the short, medium and long term plans for effective programme delivery within the available resources with MP reiterating EHs earlier remarks for an integrated approach to the programme execution to support enhanced capacity and coordination of resources. **Action: ME and JT to present a long-term overview of the programme at future meetings.**

Standing/Final Items

T017/25 Annual End of Year Effectiveness and Recommendations

Positive feedback from members with the acknowledgement of the participation, coordination and contributions of partners was highlighted by RU from the self-assessment survey results. Members also fed back that the work plan was broad and often ICB business heavy and this had been addressed with a streamlined focus and work plan included within the paper pack.

She referenced the organisation change work that was being worked through locally and nationally with significant organisational restructuring programmes to be implemented following the Government's announcement for ICBs to reduce running costs by up to 50% by December 2025. Some preliminary adjustments had already been proposed for the Transformation and Delivery Collaborative with focus to be given to neighbourhood and population health and updates from alliances to be given by exception.

As part of the organisation change and adjustments to structures with Wakefield and surrounding Places working towards a Provider Alliance model the changes to the Transformation and Delivery Collaborative will support the transition.

MB added to and emphasised the value of the streamlined meeting as it focussed on neighbourhood health, modelling benefits realisation, provider partnership and the transition. She also acknowledged the high attendance by clinical and partnership representatives.

Members present agreed with the way forward and agreed to progress with the 2025/26 work plan with the caveat of in year changes due to organisation change and progression to a Provider Alliance.

T018/25` Items for escalation to Wakefield District Health and Care Partnership Committee and other Committees

There were no issues to escalate.

T019/25 Any Other Business

There were no items to discuss.

Meeting Close:

There being no further items of discussion, the meeting closed at 4:35pm.

Date and Time of the Next Meeting:

The next meeting of the Wakefield Transformation and Delivery Collaborative is scheduled to take place on Tuesday 17 June 2025 from 2.00pm via Microsoft Teams.

ITEM 21c

Wakefield District Health and Care Partnership Wakefield Transformation and Delivery Collaborative Meeting

Minutes of the Wakefield Transformation and Delivery Collaborative Meeting held on
Tuesday 17 June 2025 from 2.00pm via Microsoft Teams

Core Members Present:

Amrit Reyat (AR)	Strategic Programmes and Health Inequalities Lead
James Brownjohn (JBJ)	Programme Manager for Planned Care, Wakefield Place
Jon Parnaby (JP)	Programme Manager for Urgent Care Redesign
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 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
Samiullah Choudhry (SC)	Head of Medicines Optimisation, Wakefield Place
Ruth Unwin (RU)	Director of Strategy, Wakefield Place (Chair)
Jackie Tatterton (JT)	Interim Head of Transformation and Continuous Improvement
Matt England (ME)	Associate Director of Planning and Partnerships, Mid Yorkshire Teaching NHS Trust
Pauline Riddett (PR)	Primary Care Network Representative
Chris Skelton (CSk)	Associate Director of Primary Care
Kirsty Stead (KS)	Deputy Director of Operations from Adult Social Care and Mid Yorkshire Community Services, Mid Yorkshire Teaching NHS Trust
Pravin Jayakumar (PJ)	GP Principle – Trinity Medical Centre Clinical Co-Director – Trinity Health Group
Claire Vodden (CV)	Head of Communications, Wakefield Place
Natalie Tolson (NT)	Head of Business Intelligence, Wakefield Place/Mid Yorkshire Teaching NHS Trust
Stephen Knight (SK)	Chief Executive - Conexus Wakefield
Dominic Blaydon (DB)	Wakefield Place, System Director for Workforce
Tim Hodgkins (TH)	Managing Director, Site Services, Mid Yorkshire Teaching NHS Trust
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
Jo Hinchliffe (JH)	Public Health Commissioning Manager
Lizzie Greenwood (LG)	Public Health Principal on Partnership Commissioning
Jemma Harris (JH)	Governance Manager, Wakefield Place
Gilbert Gandashanga (GG)	Risk Officer (minutes)
Becky Barwick	Associate Director of Partnerships and System Delivery, Wakefield Place
Ian Currell (IC)	Operational Director of Finance, Wakefield Place
John McSorley (JM)	Head of Operations, Yorkshire Ambulance Service
Paulette Huntington (PH)	People Panel Representative
Emma Hankinson (EH)	Senior Mental Health Alliance Lead
Paula Bee (PB)	Chief Executive, Age UK Wakefield
Lewis Smith-Connell (LSC)	Chief Executive, Healthwatch Wakefield
Michele Ezro (ME)	Programme Director for Mental Health Transformation, South West Yorkshire Partnership NHS Foundation Trust and Chair of the Mental Health Alliance

Administration

T020/25 Welcome and Apologies

RU welcomed all to the meeting.

The following apologies for absence were noted and accepted:
Melanie Brown (MB), Amy Whittaker, Jo Fitzpatrick and Phillip Marshall.

T021/25 Quoracy and Declarations of Interest

It was confirmed that the meeting was quorate; there were no declarations of interest to record.

T022/25 Minutes of the previous meeting held on Tuesday 13 May 2025

The minutes of the previous meeting held on Tuesday 13 May 2025 were accepted and approved as a true and accurate record.

T023/25 Action Log

The following updates against actions were provided:

- **Action 52** – NT advised that this would be presented as part of update in the next meeting. Closed.

- **Action 58** – NT advised that this would be presented as part of Business Intelligence highlight report in the next update. Closed.
- **Action 59** – CS advised that this would be discussed as part of the agenda during the meeting. Closed
- **Action 60** – CS advised that this would be presented as part of the agenda during the meeting. Closed.
- **Action 61** – RU advised that the scheduled meeting had been held, and it was agreed that the primary care elements would be considered as a part of unplanned care agenda. Closed.
- **Action 61** – The points were considered as part of the meeting outlined in Action 60 above. Closed.
- **Action 62** – JH to liaise with ME and JT to present a long-term overview of the programme at future meetings.

Programme Delivery Highlight Reports:

T024/25 Population Health Management and Digital

In her update, NT highlighted the following:

- Work had been undertaken on the development of data packs to support the planned Multi-Disciplinary Team (MDT) Workshop focussed on Chronic Obstructive Pulmonary Disease (COPD), dementia and end of life care.
- A Data Working Group had been set up to support the development of the programme outcome metrics for various interested stakeholders.
- Children's non-NHS data flow into the Population Health Management (PHM) linked data model was in progress with priority on children with complex needs and child protection register data as the first stage of data flow into the linked data model. The next steps would be progressed by the Children's Business Intelligence Team.
- The Governance framework was in place, with the Children Business Intelligence Team's next stage being to work on the NHS number coverage to allow data flow and to set up the register for the organisational code and to submit that data.
- Discussions were held with Vico regarding housing data and the exercise would be implemented on a phased basis, starting with the independent living and care link data. The other phase to follow would cover batch tracing the NHS number for the service and review meetings would be held with the children's team. The last phase covered the intermediate care modelling opportunities, the inclusion groups and those within the PHM think tank data.



JL confirmed that the education dataset, which had previously been held on a separate system, was now part of Liquid Logic though maintained within a separate module. Consequently, the system dataset now included school attendance. JH then asked whether the born and bred in Wakefield data was part of the outlined dataset as she felt it would be useful to include. NT advised that it was not included since most of the children involved in the project were identified through the maternity services dataset, and some of the children in the Born in Bred research project were Kirklees residents.

PM asked whether data on initial health checks, looked after children, and review health checks were adequately captured noting concerns about progress and health inequalities. JL confirmed the data was recorded in Liquid Logic and reported on but highlighted inconsistencies and ongoing efforts to improve accuracy.

T025/25 Planned Care Commissioning Intentions (Minimum Waiting Times and Indicative Activity Plans (IAPs))

Amanda Miller, Pravin Jayakumar and Tim Hodgkins joined the meeting

JBj delivered a presentation outlining the ICB's intentions to implement IAPs following the 2025/26 contract update. He explained that the initiative was designed to support overall performance improvement and achieve financial balance. The introduction of IAPs would include the use of additional tools to enable more effective delivery and introduce the concept of setting minimum or average wait times while maintaining patient access through the right to choose initiative. The next steps would be to seek approval from the West Yorkshire ICB Transformation Committee for the introduction of IAPs in West Yorkshire, specifically with independent sector hospitals and ophthalmology providers with a minimum referral to treatment time of 16 weeks for full treatment. An impact assessment to support that had been completed.

CS pointed out the challenge of explaining the proposal to the public and RU emphasised the need for an effective communication strategy to inform the public and stakeholders in this regard.

CS asked if there were actual examples where the proposed timeframes had resulted in improved waiting times for those on other waiting lists as resources could be redirected towards them. He felt that the extended waiting period was due to limited resources. This would lead to extended waiting times and poor patient experience. This also breached the social



contract between the society and NHS, as the projected £6 million saving did not consider the wider impact for people in terms of quality of life and potential inability to work. In response, JBJ advised that the time frames related specifically to referrals to the independent sector, not NHS providers. He explained that the number of cataract cases for Wakefield was 20% higher than NHS England. CS commented that the proposal seemed inconsistent with NHS values. He felt that it would be inappropriate to redirect the saving in West Yorkshire to other areas of the country. IC explained that the financial saving benefit realised from the programme would not be reallocated to other ICBs and savings realised during the year would result in the avoidance of reduced funding for other essential services like the new weight management service at the Mid Yorkshire.

CSk asked whether the proposal meant that patients would not start the care process, or they would not be able to complete the treatment journey. He also asked of the providers' expectation, whether care provided within the time frame would be funded. He was concerned this could negatively affect patient experience and asked for the impact assessment to be shared. There was risk of unutilised capacity in the short term if the independent sector was to delay treatment of patients. JBJ explained that the whole treatment pathway was proposed to be 16 weeks, not the waiting period. He acknowledged the risk of unutilised capacity would be for one financial year only.

ME noted the need for equity in treatment, considering that some specialties had waiting periods of up to 37 weeks. The one-off savings to be realised during the year would not be experienced in following years. He also asked about the impact assessment for the change in direction for referrals with people moving from the independent sector to NHS. IC advised that, due to legal and contracting considerations, the timeframe would need to apply for NHS and the independent sector. JBJ confirmed that the minimum waiting requirement would only apply to the independent sector.

PJ observed that the feedback by patients and colleagues highlighted the difference in service between the Mid Yorkshire Hospitals and the independent sector, leading to some dissatisfied patients. There was need for consistent standards to avoid costly referrals and second opinions. LE requested PJ to share details of quality concerns about independent sector providers to be shared for quality and contract monitoring processes with the respective providers. PJ referred LE to the Local Medical Committees (LMC) that had records of some of the concerns

raised regarding the independent sector. PJ also highlighted the need for streamlined pre-referral advice and guidance within the independent sector and the NHS providers.

PB pointed out the need to manage staff expectations through engagement and involvement in the process to address concerns and for the workforce to embrace the proposed changes in their way of working.

LE acknowledged members' valuable feedback and contributions and acknowledged the need to address any inequalities identified through the EQIA process. She highlighted the importance of independent sector providers being included in quality and contract monitoring processes.

JBj advised that consultations were ongoing and welcomed comments and suggestions after the meeting. He would liaise with LE for contributions on impact assessment, quality, and equality before finalising the document.

T026/25 Modern General Practice

Kirsty Stead joined the meeting

CSk advised that a baseline assessment had recently been undertaken to understand the status of all Wakefield practices in relation to the Modern General Practice requirements in the neighbourhood health model. The assessment had also been carried out across West Yorkshire to compare performance and inform resource prioritisation. The outcome showed Wakefield to be in a strong position with around two thirds of practices actively progressing with the model and just under a third requiring additional information.

He said that Wakefield was unlikely to benefit from national GP improvement programme resources due to prioritisation of other areas. A proposal had therefore been submitted to the Integrated Neighbourhood Health Board for additional local funding. Alongside that efforts were underway to develop clear and consistent guidance for Clinical Directors and Primary Care Networks (PCNs) particularly around expectations for implementing access models, priority indicators, and effective use of allocated resources. Planning for an engagement workshop aimed at supporting effective patient communication and engagement was underway. The objective would be to ensure practices and PCNs had the right tools and knowledge.

Next steps would be to continue the work securing local funding, finalise planning and delivery of the engagement workshop, development and distribution of clear guidance and roll out of peer support initiatives.

JH appreciated that the work was moving at pace but asked how patients would be engaged in the ongoing work. CSk advised that a communication framework was in place and would be implemented with available resources to communicate the changes.

AR recognised the ongoing efforts to optimise contact channels within general practice but noted that there remained concerns regarding barriers to care introduced by digital platforms. CSk acknowledged the challenge with access and that it had not yet fully resolved as an issue with significant culture change required. He noted that the challenges extended beyond the current programme but, in support, recent work had focussed on analysing population health data and service activity enabling the team to better understand who was engaging, and who was not.

Paulette Huntington left the meeting

T027/26 Adults Neighbourhood Multidisciplinary Team

CS explained that meetings were held regularly with focus on proactive care for defined population groups. A target population was agreed to contribute to 2 – 4% intervention group across the cohort. The selected cohorts included individuals receiving end of life palliative care, people living with dementia and individuals diagnosed with Chronic Obstructive Pulmonary Disease (COPD).

Ongoing discussions among service providers continued to explore how each organisation currently supports the cohorts and to identify any challenges in meeting system wide expectations. The goal was to bring providers closer together to form effective MDTs with the collaborative approach intended to improve outcomes by delivering integrated and proactive care.

In terms of overall progress, the work was rated amber with delivery against key milestones remaining challenged. However, there was noted optimism that greater clarity would be achieved.

EG sought clarity on the evidence review of success stories implemented in other cohorts and whether there was insight beyond the quantitative clinical data. She asked if there were network and partnership groups that they were working with to build community assets. CS advised that they

had considered wider metrics including views and experiences of those delivering and receiving care. An update on the Connecting Care Review workshop would be presented at the next meeting. This was a key neighbourhood network component.

CS advised of the ongoing working relationship with community organisations and delivery partners to ensure a shared vision across the district. LE advised that they had some qualitative insight reports for each of the three cohorts, covering experience of care and clinical audits and the details would be shared at the forthcoming workshop. MJ advised that several organisations like Age UK, Alzheimer's Society, hospitals and carers were involved in the networks.

AR asked what insights there were from feedback or experience of people who had faced barriers, in particular analysing sectors of the population or communities that were not accessing health services. CS explained discussions with Healthwatch were taking place to gain all the available feedback and welcomed all information from colleagues.

Laura Elliott, Matt England and Jackie Tatterton left the meeting

T028/25 Children's Neighbourhood Multidisciplinary Team

JL updated confirming the aim to align with national guidance while building on the existing Wakefield Families Together Multi Agency Framework. Historically the framework had limited involvement from primary and secondary care but current efforts focussed on improving engagements with GPs and paediatricians. Positive progress had been made on that, particularly as a result of recent productive discussions. Challenges with data quality and availability, especially within the MYTT system, were noted as a barrier to fully understand need and next steps. While the current highlight report rated progress as red, work was ongoing and showing improvements. She confirmed that several areas were progressing well, including sleep and asthma with task and finish groups and partner engagement underway. Youth engagement work led by the local authority was also developing.

It was noted that local delivery must balance national policy drivers including the Children and Families Bill and Families First, alongside the Integrated Neighbourhood Team development. Delivery was currently being achieved using existing, although future transformation may require additional funding. Assurance was given that any opportunities to use new funding flexibility would be explored.

Amanda Miller left the meeting

CSk raised a query regarding the interface with the West Yorkshire system, specifically whether children's work was sitting under the Integrated Health Board or a separate group. JL confirmed there was no standalone group but believed that the programme was represented at the West Yorkshire Integrated Health Board. She also made reference to newly issued guidance which placed significant emphasis on primary care. It was noted that the case studies included in the guidance strongly influenced the current approach, supporting the structure of the ongoing work. It was felt that initiatives such as the development of a sleep pathway would align well with the intentions outlined in the case studies.

NT provided an update on the Autism Spectrum Disorder (ASD) dataset confirming it had now been moved into the West Yorkshire modern data platform. Validation and reporting work had begun with outputs expected by July. The delay was due to the need to remap data from SystmOne requiring input from both business intelligence and service teams.

Natalie Tolson and Pauline Riddett left the meeting

T029/25 Urgent Neighbourhood Services

In his update JP advised that progress continued on the Urgent Treatment Centre (UTC) options for Wakefield. He said that if the options were adopted by the task and finish group the governance would then be progressed and a business case developed.

JP noted that positive funding prospects had emerged with the recent launch of the Urgent and Emergency Care (UEC) plan which allocated £250m for the development of UTCs. A key challenge for Wakefield had been the preference for co-locating UTCs on acute hospital sites. As there was no viable option to establish a UTC on the Pinderfields Hospital site a suitable central Wakefield location had been put forward as the preferred option.

In relation to the UTC at Pontefract, JP advised that activity levels had significantly exceeded initial projections from when the service was launched in 2018. As a result, a review of the workforce model and associated cost envelope was underway with initial discussions planned with the Senior Leadership Team (SLT).

He confirmed that discharge to assess (D2A) service continued to operate efficiently and formed part of the broader opportunity model. The number



of commissioned D2A beds had been reduced from 25 to 20 alongside ongoing efforts to reduce length of stay. This review formed part of a larger programme of work focused on intermediate care capacity and the model of service being undertaken in collaboration with partner organisations.

It was noted as a further priority to improve access pathways across West Yorkshire with the goal of enabling the Yorkshire Ambulance Service (YAS) to have consistent direct access to Same Day Emergency Care (SDEC). Additionally work continued on the progress of the Virtual Ward and Urgent Community Response.

TH acknowledged the significant improvement work ongoing across the board highlighting the recent publication of the UEC plan. He emphasised the importance of triangulating all activities to ensure coherent planning. An internal flow summit was scheduled to take place at the end of June 2025 to further align plans related to patient flow. He also noted work was beginning to look at the winter plan, anticipated to be published in September 2025. PJ raised a concern regarding the primary care offer noting that much of the activity was not reflected in the same day care data across districts. He suggested that this should be included given its significance and this was agreed. SK added that it was not about new initiatives but rather about understanding how primary care pressures influence and inflate system wide pressures.

T030/25 Integrated Intermediate Care

PM provided an overview of the programme confirmed it aimed to support people transitioning from hospital discharge to independence either at home or in a care setting. The programme had two main workstreams, the first focussed on right sizing the current bed base across Wakefield to ensure value and appropriateness of provision, the second centred on enhancing home first approaches and wraparound services to support recovery outside hospital.

Work was underway to repurpose some existing facilities including the Wakefield Intermediate Care Unit (WICU) following Care Quality Commission (CQC) recommendations. Recent workshops had gained a consensus on the way forward including therapy resource review to align better to community provision and improve patient outcomes.

The Optica discharge planning system had been implemented at MYTT with the potential to extend and use that within community services. The programme was being jointly sponsored by Chris Evans and Mel Brown

with governance arrangements in place through dedicated task and finish groups.

KS added that from the perspective of the task and finish group focussing on community beds, efforts would continue to be made to engage a broad range of partners to ensure that all views and potential impacts were considered. JP then said having been involved in the work to date that it was encouraging to see the enthusiasm among all parties.

Jenny Lingrell left the meeting.

T031/25 Standardising Local Community Care

CS explained that the development of the community model was focussed on two areas equitable availability of community services across the country, and standardising the way those services are described and recorded. That would enable consistent data collection allowing for meaningful comparisons of capacity and demand across England. He recognised that while hospital data was well developed and general practice data was becoming more mature, there remained a lack of maturity and consistency in data relating to community services. Further development was required but the complexity of community services presented ongoing challenges. Various pieces of work were taking place across multiple service areas.

AR recognised the complexities and highlighted the need to ensure that efforts to standardise community services did not exacerbate existing inequalities. She stressed the importance of coproducing any approach with those who have a lived experience. CS responded and noted that the focus was on standardising service descriptions, rather than the service offer itself, to reduce confusion and improve comparability across regions.

T032/25 Escalation from Programmes/Alliances and Delegation to Programmes/Alliance

There were no items to escalate.

Standing/Final Items

T033/25 Finance Update

Amanda Miller rejoined the meeting.

IC provided an update on the financial position as at month two, along with information regarding additional savings targets allocated to the Integrated Care System.

He reported that MYTT aimed to conclude the financial year with a £22.8m deficit, however at month two the organisation was £800k off that plan. SWYPFT's financial plan was to breakeven, and at month two were 0.2% off track. At the ICB level the overall plan was also to breakeven and this remained the position at month two, however, it was noted that prescribing and continuing health care data had been delayed.

With respect to the additional savings targets at the Integrated Care System level there was a shortfall of £73m. NHS England had agreed to support that shortfall by giving £40m with the caveat that the remaining £33m be identified. It was noted that this would be subject to close performance management. The Wakefield share of the £33m was confirmed to be £3.7m representing a 0.4% of the original allocation. The local team had responded to this requirement and to date identified schemes totalling £2.7m. They remained committed to identifying the remaining balance.

T034/25` Items for escalation to Wakefield District Health and Care Partnership Committee and other Committees

There were no issues to escalate.

T035/25 Any Other Business

There were no items to discuss.

Meeting Close:

There being no further items of discussion, the meeting closed at 3.38pm.

Date and Time of the Next Meeting:

The next meeting of the Wakefield Transformation and Delivery Collaborative is scheduled to take place on Thursday 17 July 2025 from 2.00pm via Microsoft Teams.

ITEM 21d

Wakefield Health and Care Partnership Wakefield Transformation and Delivery Collaborative Meeting

Minutes of the Wakefield Transformation and Delivery Collaborative Meeting held on Thursday 17 July 2025 from 2.00pm via Microsoft Teams

Core Members Present:

Melanie Brown (MB)	Interim Wakefield Place Lead (chair)
James Brownjohn (JBj)	Programme Manager for Planned Care, Wakefield Place
Colin Speers (CS)	Medical Director for Integrated Community Services, Wakefield Place
Ruth Unwin (RU)	Director of Strategy, Wakefield Place
Joanne Fitzpatrick (JF)	Associate Director of Population Health, Personalisation and Engagement
Tim Hodgkins (TH)	Managing Director, Site Services, Mid Yorkshire Teaching NHS Trust
Domonic Blaydon (DB)	Wakefield Place, System Director for Workforce
Claire Vodden (CV)	Head of Communications, Wakefield Place
Stephanie Gillis (SG)	Director of Clinical Services, Prince of Wales Hospice
Nick Mant	Paediatric Physiotherapist
Natalie Tolson (NT)	Head of Business Intelligence, Wakefield Place/Mid Yorkshire Teaching NHS Trust
Becky Barwick (BB)	Associate Director of Partnerships System Development, Wakefield Place
Michala James (MJ)	Head of System Delivery, Wakefield Place
Jemma Harris (JH)	Governance Manager, Wakefield Place
Gilbert Gandashanga (GG)	Risk Officer (minutes)
Michele Ezro (ME)	Programme Director for Mental Health Transformation, South West Yorkshire Partnership NHS Foundation Trust and Chair of the Mental Health Alliance
Meinir Smith (MS)	Head of Quality, Wakefield Place
Ian Currell (IC)	Operational Director of Finance, Wakefield Place
Emma Marshall (EM)	Senior Primary Care Manager, Wakefield Place
Claire Gilbert (CG)	Acting Consultant, Public Health Wakefield
Joe Hazel (JHa)	Senior Service Development and Transformation Manager
Paula Bee (PB)	Chief Executive, Age UK
Samiullah Choudry (SC)	Associate Director for Primary Care, Wakefield Place

Kirsty Stead (KS)	Deputy Director of Operations from Adult Social Care and Mid Yorkshire Community Services, Mid Yorkshire Teaching NHS Trust
Rachel Gillott (RG)	System Partnership Director, Yorkshire Ambulance Service
Amanda Miller (AM)	Associate Director of Operations and member of the Mental Health Care Group, South West Yorkshire Partnership NHS Foundation Trust
Heather Heeley (HH)	Partnership Officer
Hayden Risdale (HR)	Senior Strategy and Transformation Programme Manager – West Yorkshire ICB

T036/25 Welcome and Apologies

MB welcomed all to the meeting.

The following apologies for absence were noted and accepted: Laura Elliot, Philip Marshall, Emily Seymour, Paulette Huntington, Stephen Knight, Suzy Jubb, Emma Hall, Jon Parnaby, Chris Skelton, Pravin Jayakumar and Jenny Lingrell.

T037/25 Quoracy and Declarations of Interest

It was confirmed that the meeting was quorate; there were no declarations of interest to record.

T038/25 Minutes of the previous meeting held on Tuesday 17 June 2025

The minutes of the previous meeting held on Tuesday 17 June 2025 were accepted and approved as a true and accurate record.

T039/25 Action Log

The following updates against actions were provided:

- **Action 62** - ME confirmed that an update on Improving Together had been scheduled onto the work plan for the August meeting. Action closed.
- **Action 63** - MB asked CS and TH to collaborate, ensuring monitoring, oversight and information flow were managed under the Unplanned Care Alliance with CS also to coordinate programmes within the Integrated Neighbourhood Teams.



JM advised that the imbedding of information flow with the Unplanned Care Alliance interconnecting with the Community at neighbourhood Multi-Disciplinary Teams (MDTs) was in progress. The urgent neighbourhood health services would set up task and finish groups to ensure they were embedded with the unplanned care alliance.

TH confirmed there was standard measurement framework of all systems and NT was assisting with the respective coordination for the Kirklees update. He emphasised the need for simple, standard and uniform methodology, measurement, and monitoring of all Key Performance Indicator (KPI) schemes to track changes and impact.

TH assured that the Unplanned Care Alliance had an agreed work plan that acknowledged the interdependence of projects with the Community Alliance.

MB asked if there were coordination concerns between the Wakefield and other places' models. TH and NT confirmed there were no coordination issues between benefits realisation for Mid Yorkshire and Wakefield. They awaited Kirklees colleagues to share details of their programmes data. Action closed.

James Brownjohn joined the meeting

Neighbourhood Health Highlight Reports

T040/25 Population Health Management (PMH) and Digital

NT outlined the ongoing development of the Population Health Management (PMH) linked data model (LDM). All governance formalities were complete for the non-NHS data. The work with Vicor to set up the flow of independent living scheme data into the linked in data model was progressing except the long-term gathering of non-NHS children's data.

The work on having some vulnerable group flags into the population insight tool that had been gathered through colleagues' work done with primary care was progressing. This entailed using population insight tool gathered through colleagues' work that was led by the primary care team. Some indicators had been identified through the Integrated Neighbourhood Team (INT) and Multi-Disciplinary Team (MDT).

The support for integrated neighbourhood teams was ongoing. This included preparation of data packs for the Multi-Disciplinary Team (MDT)

workshop and the steering group meetings. Meetings would be held to support colleagues to identify the stable, low rising and high-risk groups to define the selected cohorts, including categorisation into the above outlined groups.

CS advised that the main digital focus was to ensure visibility of data at the point of care. The auction for care record to be delivered was in the deployment phase across various organisations within the district.

The Service Development Funding (SDF) had approved the West Yorkshire digital team's funding bid for neighbourhood health programme for the development of the read and write share care planning function that would be used as an extension Y&H shared care record. Following the funding approval, the next steps would be the procurement and design to provide service in West Yorkshire. The commencement of delivery was scheduled for the 2025/26 financial year. Wakefield was one of the highest users of the auction record where it had been deployed in General Practice. Organisations in Yorkshire and Humber Care Record (YHCR) faced the challenge of lack of appreciation of the useful information and the publication. The central digital team had provided support and continued to roll out and seize opportunities to get organisations to embrace this positively as it would be one of the digital enablers supporting the drive and adoption of the optional record.

MB thanked CS, NT and the team for the valuable work and securing the £1m investment that would help address some of the challenges experienced relating to the number of shared care records as part of developing the population health management tools.

T041/25 Adults Neighbourhood Multidisciplinary Team

BB provided an update on the identification of the 2-4% of the population with complex health and social care needs to be supported from multiple services and organisations within the first year. A workshop was held in June 2025 for the analysis of the three cohorts of Dementia, Chronic Obstructive Pulmonary Disease (COPD) and end of life. A steering group was set up to work on the next steps and refine the interventions for the three cohorts, including risk stratification approach, identifying cohorts with stable, rising and high risk of hospital admission or service utilisation. The Primary Care Networks (PCNs) were scheduled to review the test models, using the data led approach for delivery plans from all neighbourhoods by 12 September 2025.



CS thanked individuals and organisations for the support in developing a multi-organisational, multi-professional, less hierarchical and less medical centric care model. Following the successful approval of the SDF funding bid for the organisational development plan, there was need for cultural change through building trust, mutually led set of multi-disciplinary teams coming together as focal point of multi-disciplinary team meetings. This required individuals with desire for change towards prevention and proactive care.

MJ advised that the interim report following the review of first phase of the connecting hub care review was complete. This would be followed by review of the connecting care hubs within the neighbourhoods and neighbourhood MDTs model. An audit to establish the types of referrals to go through the connecting care hubs would follow before development of the next steps.

MB thanked MJ and colleagues within the council and the ICB for the outstanding work. BB emphasised the importance of culture change, ways of working and ethos behind the neighbourhood MDTs, which entailed organisations taking shared responsibilities at Neighbourhood levels for shared outcomes, improving people's health outcomes and reduced onward referrals. There was need to change ways of working and focus of the outlined cohorts.

Kirsty Stead and Rachel Gillott joined the meeting

CS advised that they had started sourcing the 2026/27 financial year cohorts and engagements with mental health alliance relating to the integrated neighbourhood teams and staffing framework were held, focussing on data sharing and population health management data sets. There was interest in all age groups to include Home of Health as part of international delivery to bring together singular all ages health.

MB requested outline of risks or challenges related to timeframes for partners to support. In response, CS highlighted the risk of barriers to acceptance and implementation of change, underpinned by culture change. It was important to cascade collaborations at management and grassroots levels with openness and transparency. The impact of change would be felt during implementation, hence the need for training in Organisational Development (OD) and cultural change to build trusted relationships during the phases of standard group theory of forming, storming, norming and performing. The review was scheduled to be complete by 12 September 2025, to be followed by the mobilisation of

resources commencing 15 September 2025, including the OD through the OD Support Officer who would work with the frontline staff to implement changes, effective the winter period. BB noted the excitement and enthusiasm caused by the new programme would be a mitigating factor against the outlined risks. JF highlighted the need for awareness on the programme and to address the non-clinical cultural determinants that would impact on people and medical outcomes.

ME advised that the next phase of the programme would cover more mental health issues with emphasis on dementia, working with South West Yorkshire Partnership Foundation Trust (SWYPFT) on data sharing to address risk stratification, risk sharing and coordinated communication framework for the neighbourhood health and the 10-year plan. Discussions were held to clarify mental and physical health support requirements for the existing cohorts.

MB thanked CS and the team for the leadership and comprehensive update on mechanisms for change. There was need to be open and transparent especially when considering frontline staff suggestions for change. It was important to prioritise frontline OD cultural training as part of the local investment. She observed relevance of proposed programme to the national blueprint framework.

MB thanked DB and MJ and the team for successfully bidding of £180k funding for the OD cultural training. DB and MJ agreed to present an update on the approved funding secured for OD in future. DB acknowledged BB and her team's contribution and support in preparing the well-received bid, which was the only fully funded bid application.

Action: DB and MJ agreed to present an update on the approved £180k funding that had been secured for approved OD bid.

Amanda Miller joined the meeting

T042/25 Children's Neighbourhood Multidisciplinary Team

In his update, NM highlighted that most key deliverables were on schedule. The main limitation was the urgent need for children's data to show demand and intersectionality of need across social care, education and health to enable the design of the Integrated Neighbourhood Teams (INTs) offer. Fortnightly meetings with partners within the local authority were being held to improve the data limitation outlined above.

The main barrier had been the unique identifier that was meant to link with the local authority systems. Discussions were in progress for a proposed prototype model, to pilot children's team. The utilisation of neighbourhood health teams and existing models would be piloted in more challenging areas within the district. Data was key in identifying children to target for established pathways like asthma and epilepsy, as opposed to those not using the services effectively and to identify opportunities for improvements in child development services. Engagements with the Mid Yorkshire were held to set up links for the E-Consult model templates. The asthma, respiratory and three other templates were being evaluated for effectiveness for primary and secondary care.

Discussions with Connexus regarding the utilisation of spare capacity for spirometry clinics were ongoing. The financial consideration would be for equipment and consumables as the human resources were available.

The funding for the emotional health mental wealth single access point had been secured and SWYPFT had commenced staff recruitment, with a targeted rollout of October 2025. The neuro-diversity pathways recruitment was progressing within the Mid Yorkshire and the initial focus would be on attention deficit hyperactivity disorder (ADHD) and autism spectrum disorder (ASD) data checks to monitor in a more assured way as the current data was unreliable.

NM reiterated the previously highlighted risk of inadequate, unreliable data and limited capacity for onward planning and convening the system.

Heather Heeley joined the meeting

MB thanked NM for the update and requested updates in future for evidence on children's social care team regarding the impact of family hubs, how the early intervention referrals had increased, and the drop in demand for children's social care needs following the launch of the family hubs, for reference by MJ and RB.

In a related development, MB outlined the following highlights regarding the invitation to be part of the Neighbourhood Health National Programme:

- The document outlining the proposed programme had been published and shared with partners.
- Partners within the place to meet to consider submitting the joint application for the programme.



- The national programme was projected to have 20% national coverage in three years.
- All partners had to agree to be part of the programme as partial teams would not be considered.
- The deadline for application submission was 8 August, results for the 42 successful places would be announced on 5 September and the programme was scheduled to start on 8 September.
- Part of the bid submission requirements included the support of the ICB as a sponsor, evidence of risk stratification, Section 251 agreements to be in place, and data sets within all organisations.
- There was need for a coordinated approach by all parties.
- Updates would be provided in future meetings.

CG requested outline of the risks, benefits and financial considerations related to the proposed programme. In response, MB advised that there was no financial consideration, but benefits included being part of the national 10-year plan, gaining access to the latest improvement methodologies, some national enabler workstreams and the new emerging neighbourhood health centre policy changes. Wakefield Council had expressed its interest and had been invited to Oxford for the total place programme. JF reiterated MB's comments and advised that Wakefield would be part of the influencers in shaping policy if it joined the national programme. This would partly support the ongoing organisational development and cultural change. If successful, opportunities existed to share and co-produce tools and resources, frameworks and to network. MB welcomed those interested in participating in the working group to attend the preparatory meetings to be held. She however predicted stiff competition during the bid.

Action: To circulate the information on the Neighbourhood Health National Programme to members.

Other Items

T043/26 Benefits Realisation - Wakefield Improving Together

In her update, NT outlined the progress for the monthly tracker interventions as follows.

- The following interventions were in progress - King Street Walk in Centre for supporting reduction in attendance and the rest of the issue, care and home transport, service, virtual ward, discharge to assess intermediate. These would be monitored progressively.



- The interventions for the supported front door floor and admission avoidance were scheduled to start during the year. These would be monitored to track the impact for the schemes relating to supporting the front door and admission avoidance through monitoring bed admissions.
- The focus was however on emergency admissions that were 2.5% below 2024/25 level, as driven by the reduction in April 2025.
- The overall 2025/26 attendances for Accident and Emergency (A and E) matched the previous year trends. Pinderfields Hospital experienced a 1.9% reduction while there were increase in other centres like Dewsbury and other areas.
- The mitigating measures put in place were based on the projected 1% growth population, hence similar attendance levels. The same day urgent care demand, the walk in centre and General Practitioner (GP) appointments had decreased compared to the previous year.
- The number of walk-in patients at King Street was projected to increase to 40,000, corresponding with reduced attendances at Pinderfields Hospital A & E, due to identifying patients eligible for treatment at the walk-in centre. Measures were in place to redirect eligible patients attending Pinderfields A and E to the walk-in centre.
- The expected impact for the virtual ward for the frailty would be the reduction in the number of non-elective admissions and bed-days through increased admissions via step up pathways and reduced average length of stay via step down.
- Admissions for the virtual ward increased by 37%, compared to 33% in the previous year. The update for Age-Uk Home Transport service data was not available at the date of the meeting. Future updates would be presented in retrospect. The objective of the exercise was to reduce the non-elective admissions and bed days by supporting an increase in referrals to the service from Emergency Department (ED) by 5%.
- The intermediate care intervention objectives were to increase the discharge to access at Wakefield Integrated Care Unit (WICU), increase admissions into the service and reduce the average length of stay access. The length of stay was reduced from 37 to 21 days, though there was need to adjust for seasonal fluctuations.
- Admissions for intermediate care to WICU decreased from 54 in the previous year to 38, though this was subject to adjustments for fluctuations.

MB thanked NT for the update and acknowledged that the tracking covered a relatively shorter period which did not provide for seasonal fluctuations.

MB invited TH to provide context to the reduction in patients' attendance at Pinderfields Hospital. TH explained that the data covered a relatively short period and a more comprehensive analysis would be available progressively. Preliminary indications attributed this to the positive contribution from utilising the King Street walk-in facility. A progressive outline would be available later in the year. He acknowledged the value of the comprehensive perspective that considered the full spectrum. MB noted the need for a consolidated review of the exercise.

IC noted that the Wakefield data compared favourably against other places in West Yorkshire as evidenced by stable and at times reduced number of patients for ED and non-elective care. There was need to identify Wakefield's strong areas of performance compared to other places. Nat Tolson agreed to include the WY benchmarking data in future updates.

CG pointed out that the relevance and value of considering applying for the national offer for the neighbourhood health bid as it referred to key issues like bed days, admissions and the elective care in the neighbourhood care guidance

TH noted that while the target for 52-week Referral to Treatment (RTT) rate was 1%, the Mid Yorkshire actual and national positions were 0.0835% and 2.7% respectively. From the clinical and time perspective, there was need to strike a balance for waiting lists yearly. There was an overlap between elective and non-elective care as some patients who would have waited longer for an operation would end up in the ED for treatment.

MB emphasised the need to consider and respond to patients and stakeholder experience and feedback available through partners like Healthwatch, GP care appointments and GP access to dentistry.

Samiullah Choudry left the meeting

T044/25 Provider Alliance Developments

In her update, RU provided an update on progress towards establishing a Provider Alliance for health and care services in the Wakefield District as outlined below:

- The Wakefield provider alliance started in Autumn 2024 following recommendations from the leadership review and the subsequent ICB Blueprint to develop partnerships and coordination through collaboration providers.
- This was part of the evolution of existing partnership arrangements with the expectation of changing some governance and operational structures with the partnership alliance expected to change and eventually assume functions of the existing partnership committee and potential of the Transformation and Delivery Collaborative.
- It was projected that the provider alliance model would be adopted throughout West Yorkshire.
- The model was to assume delegated functions from the ICB by the third quarter 2025/26 and projected to take over formal delegated function by April 2026. This was however subject to the 10-year plan outcomes, though the provider alliance would assume some gradual decision-making authority during the shadow period.
- The recommendation was to have phased arrangement to assume more functions over some years.
- The recommended future arrangements would be to include all providers, including NHS statutory providers, council, voluntary sector and primary care. It was projected to cohort the voluntary sector organisations who focused on health care and social care provision for strong representation.
- The ICB was expected to maintain its representation in the proposed provider alliance, though the delegated functions would not be directed through the ICB Accountable Officer.
- The proposed model was predominantly focused on the neighbourhood model and would initially be part of the provider alliance, including those within the community contract and the community elements of mental health provision.
- All elements of the Neighbourhood model were projected to end up in the provider alliance in the early stages, including out of hospital services provided by Mid Yorkshire, the community contract and community elements in the mental health provision.
- A governance working group had been established to consider the governance arrangements that were within the existing and future legislative framework in view of the 10-year NHS plan and the ICB Blueprint.

- RU welcomed members' feedback on feasibility and proposed timeframes.

Hayden Risdale joined the meeting

MB thanked RU for the update and pointed out the need to avoid duplications in meetings and roles. She advised that, if approved, TDC meetings would be merged into the provider partnership arrangement, and partners would not need to attend two meetings. Discussions on the proposed changes were ongoing.

RG sought clarity on how the ambulance service would evolve out of the existing partnership committee and support the emerging place provider collaborative, as they were not part of the existing arrangement. She requested background information outlining the stated developments and proposals for sharing with colleagues at her organisation to solicit the requisite YAS commitment. In response, MB advised of the representation from Voluntary, Community and Social Enterprises (VCSE) like GP and Local Medical Committees (LMCs) representation and they planned to be as inclusive as possible. The (Yorkshire Ambulance Service (YAS) Chief Executive Officer was part of the West Yorkshire Transition Board and had been attending discussions outlined above. All relevant documents had been shared with the YAS team, and MB was happy to share the available information with RG. RU advised that, in terms of provider alliance and neighbourhood services, YAS was a key member for the direction of people using the 111-platform relating to emergency transfers. It was acknowledged that, due to its limited spread across the West Yorkshire, YAS would be stretched to have representation in all places.

JBJ acknowledged the developments outlined on provider care alliance, in view of the focus on neighbourhood care approach. He expressed his willingness to discuss the developments with RU and her team to identify synergistic relationships in terms of community or primary care, contracts and team alliances within planned care. RU advised her readiness to discuss to ensure a comprehensive and integrated framework where all relevant partners would be involved. Trust and confidence would be developed gradually as organisation needed to concede and segment decision making into organisations.

MB advised that the proposed new partnership would result in budgets delegated to the partnership (like the mental

health alliance framework), multiple staff and budgets among organisations, delegation of more transformative responsibilities to partners and distributed leadership. The proposal dovetailed into the 10-year strategic plan.

Steph Gillis and Natalie Tolson left the meeting

T045/25 West Yorkshire Integrated Neighbourhood Health Blueprint

In his update, HR outlined the following:

- The Wakefield Blueprint was considered by the TDC and signed by the ICB Board on 24 June 2025. TDC members had contributed valuable feedback and contribution during the blueprint preparation.
- The document outlined the neighbourhood teams' vision, expectations and delivery plans.
- The vision addressed issues of holistic care, delivering patient centred care close to where people live and expectations of the neighbourhood teams and Neighbourhood health within West Yorkshire, covering population health management, addressing health inequities and good practice.
- The blueprint, which was published on the ICB website, outlined the five places' delivery plans, and the themes supporting the neighbourhood teams and Neighbourhood health. Its themes included workforce, estates, digital transformation, data, financial capacity and resources.
- There were consultations on delivery of the blueprint within a dynamic and changing context, regionally and nationally.
- Its compilation coincided with the several ongoing changes and developments including the digital framework.
- The National Neighbourhood Health Implementation programme noted Neighbourhood health as a key element of the 10-year plan.
- During the development of the place provider partnership and the ongoing West Yorkshire Integrated Neighbourhood Health Board, the blueprint would be aimed at bringing people together to convene and collaborate on areas for common challenges, scaled learning and sharing good practices. These would help address common challenges, be enablers to policy issues, financial queries or deployment of SDF resources.
- There were plans to utilise £3.9m for Neighbourhood health-based transformation.
- He invited input on challenges and how to support Neighbourhood health at places and across West Yorkshire.

MB thanked RH for the update and pointed out that the blueprint was shared with the place management team and endorsed by the ICB Board. MJ advised that the Neighbourhood MDT steering committee meetings had been referred to blueprint as a guide during discussions as part of operationalising and mainstreaming the document.

Nick Mant and Amanda Miller left the meeting

Standing/Final Items

T046/25 Escalations from Programmes/Alliances and Delegation to Programmes/Alliance

JHa advised that the work on the first phase of the winter plan was underway and progressing, with due date of 31 July 2025. He invited colleagues to assist his team in information gathering. MB acknowledged the tight working schedule that JHa and his team were working under.

JBj advised that while there had been no agreement to date, the proposed programme for minimum waiting times that was part of the indicative activity plan for all planned care services would proceed as proposed. the panel was in place. It had been agreed the panel the cataract referral management service was being established to consider the quality of cataract referrals from Ophthalmologists. The team were working with Connexus on this as part of West Yorkshire Association of Acute Trusts (WYAAT) to assess demand management.

T047/25 Any Other Business

There were no items to discuss.

Meeting Close:

There being no further items of discussion, the meeting closed at 3:32pm.

Date and Time of the Next Meeting:

The next meeting of the Wakefield Transformation and Delivery Collaborative Meeting is scheduled to take place on Thursday 28 August 2025 from 2.00pm via Microsoft Teams.

Information Items:

Neighbourhood Health Highlight reports for information:

- a) Modern General Practice
- b) Urgent Neighbourhood Services
- c) Integrated Intermediate Care
- d) Standardising Community Services

West Yorkshire Integrated Neighbourhood Health Board

- a) Minutes of the meeting held on 15 April 2025

APPROVED 28.0.2025

ITEM 22**Wakefield District Health and Care Partnership**

Minutes of the Wakefield Integrated Assurance Sub-Committee held on Thursday 1 May 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
Melanie Brown (MB)	Interim Accountable Officer, Wakefield Place
Jenny Davies (JD)	Associate Director of Finance, Wakefield Place
Jenny Lingrell (JL)	Service Director for Children's Health and Wellbeing, Wakefield Council
Penny McSorley (PM)	Director of Nursing and Quality, Wakefield Place
Darryl Thompson (DT)	Chief Nurse/Director of Quality and Professions, South West Yorkshire Partnership NHS Foundation Trust
Ruth Unwin (RU)	Director of Strategy, Wakefield Place

In attendance:

Laura Elliot (LE)	Senior Head of Quality, Wakefield Integrated Care Board
Meinir Smith (MS)	Head of Quality, Wakefield Integrated Care Board
Jemma Harris (JH)	Governance Manager, Wakefield Place

Administration**I001/25 Welcome and Apologies**

RH welcomed everyone to the meeting which commenced at 2.00pm and accepted apologies on behalf of Stephen Hardy, Becky Barwick, Maddy Sutcliffe, Talib Yaseen and Colin Speers.

RH also acknowledged that Jenny Lingrell would leave the meeting at 3.00pm.

I002/25 Quorum and Declarations of Interest

The meeting was quorate in line with the terms of reference; there were no declarations of interest associated to agenda items recorded.

I003/25 Minutes of the last meeting held on Thursday 23 January 2025

The minutes of the previous meeting held on Thursday 23 January 2025 were approved as a true and accurate record following amendment from Annual Assurance Framework for Adult Social Care to Quality Assurance Framework for Adult Social Care on page 13.

DT also noted the misspelling of his name which would also be corrected.

I004/25 Action Log and Matters Arising

Updates against actions from the meeting on 23 January 2025 were provided as below:

- Item 5, action 1: PM advised that additional quality actions had been added to support risk 2439. The additional actions would support the backlog mitigations and the audit report and associated actions to be reported on at the next meeting. It was therefore agreed to close the action.
- Item 5, action 2: PM confirmed that she had added four new risks following the last meeting, all included within the risk register report, and had included quality and people's experience in Wakefield. It was therefore agreed to close the action.
- Item 8: CS was not present at the meeting therefore JH would seek an update and update members prior to the next meeting
- Item 11: PM confirmed that she had discussed the infection control concern and estate issues at Dewsbury Hospital with Talib Yaseen, Chief Nurse at Mid Yorkshire Teaching NHS Trust (MYTT). An after action review had been undertaken with many themes identified including cleanliness and movement of staff and patients when the hospital is under pressure. The practice of patients moved within 48 hours of a confirmed bacteraemia had been addressed.

The estate issue related to a lack of hand basins at the entrance of ward areas enabling visitors to wash their hands with soap and water as hand gel does not suppress the spread of norovirus. This issue had also been identified on the Pinderfields site and therefore MYTT were in the process of identifying capital to ensure sufficient hand basins on both hospital sites.

The committee were assured that progress had been made and that escalations as and when required would be made. It was therefore agreed that the action could be closed.

Updates against actions from the meeting on 24 October 2024 were provided as below:

- Item 8: PM confirmed that the Continuing Health Care Audit Report and Actions would be included on the next agenda. It was therefore agreed to close the action.

I005/25 Chairs Opening Remarks

RH acknowledged that members had met that morning and undertaken two deep dives on Children's ADHD/ASD Services and System Waiting Times and Patient Flow which had been well attended with all present participating in discussion. The key elements of assurance would be incorporated within the Alert, Advise and Assure Report.

System Assurance and Committee Reporting

I006/25 High Level Risk Register

RU presented the report noting that there were five new risks, three ongoing static risks, and two risks with an improved status. Regarding new risk 2513 which related to the walk-in centre at King Street, Wakefield, she acknowledged that this was the second active risk associated with the walk-in centre. Part of the mitigation for both active risks involved actively exploring an alternative location.

MB referenced financial risk 2329. She said that due to unexpected challenge the breakeven position had not been achieved and wanted to document that in anticipation of the next financial report.

MB confirmed that the year end position had closed that day with the financial planning submission assumptions underway. There would be a requirement to consider and include a fair share approach of resources across 2025/26.

DT, in relation to risk 2495, raised that there had also been 30 patient attendances through the front door at South West Yorkshire Partnership



NHS Foundation Trust (SWYPFT) the previous day with four of those patients still being managed whilst awaiting an appropriate care home bed in Wakefield. He therefore called out that the issue was not only linked to MYTT but to other partner organisations and consequently an active risk across all services. PM supported this and said that this had been seen in real time through the quality team.

PM highlighted serious concerns about a care home in the Castleford area under the provider Maria Mallaband Care Group that was further affecting system flow. The concerns had resulted in suspension of funded admissions which was recognised as adding to pressure on the system. As well as the quality team providing support, the CQC were also working with the provider to support improvements. Admissions will be reopened when assured.

PM noted that risk 2507 Court of Protection Deprivation of Liberty Safeguarding was a regional and national risk and not purely attributed to NHS West Yorkshire ICB and Wakefield Place.

It was noted by RU that a workshop to review alternative location solutions for the walk-in centre (2481 and 2513), had taken place and had revisited the options considered a couple of years previous and that NHSPS had presented property that had suitable space in a city centre location to maintain visible presence. The preferred model would be an Urgent Treatment Centre (UTC) with access to the full range of services via pathways if not on site. The available estate options from NHSPS were limited and would require capital investment. National planning guidance indicated capital would be available to develop UTC's co-located on a hospital site.

It was resolved that The Wakefield Integrated Assurance Sub-Committee:

- Had **REVIEWED** the new and existing risks and confirmed no amendments prior to reporting to the Wakefield Health and Care Partnership Committee
- Were **ASSURED** that all new and existing risks were effectively managed and that controls and assurance processes were in place

I007/25 Quarter 4 Quality, Safety and Experience Report

PM took members through the report confirming that it covered assurance on quality, safety and experience from across all alliances. She said the position on temporary escalation beds at MYTT was much improved. Learning was identified following the harm, with increased reporting of pressure ulcers, falls, and the death of patients in escalation beds.

The level of scrutiny had increased with visits from the CQC and NHS England. Beverley Geary, Director of Nursing for the West Yorkshire ICB, had commissioned a rapid quality review at the beginning of March 2025. The outcome had provided a lot of assurance with rapid quality improvement weeks planned to continue. The Trust had embarked on a comprehensive programme of work called 'Improving Together'. The data was showing a significantly improved position. Oversight and governance would continue to be monitored through the MYTT Quality Committee on a monthly basis.

PM recorded emerging concerns about Manor Park Care Home in Castleford. The home was visited by the CQC three weeks previously following which a number of warnings were issued. They included breach of regulations on safety and governance. Admissions had been suspended and the quality team were working closely with the home and the Local Authority to support improvements.

The concerns raised specifically focussed on the dementia unit within the home, particularly regarding nutrition, pressure ulcers and medication management. There had been good response from Community Services and the Local Authority to support improvements with safe and wellbeing checks on all residents undertaken.

PM confirmed that there was a visit planned with the home provider, Maria Mallaband Care Group, where assurance will be sought that continued improvements were being prioritised. LE added that the CQC report for Croft House, the other home by Maria Mallaband Care Group had been published with a rating of requires improvement. The provider would remain under enhanced monitoring processes for both homes.

LE provided the following highlights:

- Within Adult Social Care there was another care home, Westmead in Castleford, which had been rated Inadequate and placed into special



measures after a CQC assessment in July 2024. The CQC had revisited the home in March 2025 confirming a new rating of Good.

- In May 2024 an incident relating to a dental practice where a qualified dentist, registered with the General Dental Council was undertaking NHS services, but was not on the NHS performers list. Updates on the management of the incident and recall programme have been provided at sub-committee throughout 2024/25. The individual is now on the NHS performer's list and all patients who accepted the offer for a review appoint were seen and offered further treatment if required by 31 March 2025. A final stakeholder briefing and report for the recall programme is being produced and would be shared in relevant forums at system and place level.
- Stuart Road Practice in Pontefract has been escalated to enhanced quality 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 has been taken and the quality and primary care teams continue to support the practice and closely monitor progress which to date had been positive and would support the practice when assessed by the CQC from 6 May 2025.
- Crofton and Sharlston Medical Centre was assessed by the CQC as Requires Improvement in 2023 and following re-assessment the rating had improved back to Good.
- A local maternity and neonatal system (LMNS) visit to MYTT took place in February 2025. The visit aimed to gain insight and assurance of safe, effective and responsive maternity and neonatal services and the implementation of the three year delivery plan. The MYTT key headlines were confirmed as, welcoming environment; staff 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.

LE highlighted that it was the Experience of Care Week and said that the Experience of Care Network had recently looked at people's experience of maternity services as an area of high profile nationally and locally with good participation including a showcase from the Maternity and Neonatal Voices Partnership.



DT called out the work that was being undertaken at SWYPFT on the use of restraints in care. He confirmed that alternative practices were being explored with training to support this in the process of roll out. He expressed pride in the progress made in aspects of care, along with the proper agreements and communication with family.

MB was assured by the additional scrutiny from the ICB and NHS England in relation to the flow within hospital and the reduction in the number of escalation beds in use but was curious to understand the reasons for this. PM agreed that the numbers appeared higher across Wakefield but did not see them as an outlier. She gave assurance that everything that could be done to focus on the front door was being progressed with the first 60 minute of decision making now the priority, which was a shift as this had not previously been the focus. There continued to be a number of patients with no reason to reside and flow internally had continued to be the challenge. In comparison other local Trusts had reported improvements in the 'no reason to reside' numbers and flow over the past year and MYTT would now take learning from those successes and embed it in preparation for the next winter period. MB was reassured that work was underway and hoped it would yield the benefits over winter 2025/26.

MB reported her concern about the infection control outbreaks and the continued environmental challenge. She was however pleased to hear that care homes and practices were being supported to make improvements and that support had enabled Crofton and Sharlston Medical Centre to move from Requires Improvement to Good.

In relation to flow across the system, DT recorded that the pressure also continued at SWYPFT. He said that providing care closer to home for out of area patients continued to be challenging with the level of activity impacting staffing. Occupancy rates and acuity of patients was also impacting flow. Historically there had been focus on the financial pressures of out of area placements but that had shifted to a focus on flow issues. MB recognised that had been highlighted at system meetings and acknowledged that the concerns highlighted around dementia care in care settings had impacted discharge of people from SWYPFT. MB asked if this issue on wider flow should be added as an emerging risk on the next risk cycle. DT said that he would reflect and come back to MB which was agreed.

ACTION: DT to consider the inclusion of an emerging risk flow issues in mental health services .

In the interim MB suggested that a deep dive to explore and provide assurance that partners were working together to support a solution and this was agreed. RH supported that, noting it that the committee's consideration of flow issues tended to be dominated by acute hospital services.

ACTION: JH to arrange a deep dive session prior to the next meeting in July 2025 and include within the Alert, Advise and Assure Report.

RH asked what resilience was in place to support the care home sector given the suspension of admissions at Manor Park Care Home and the ongoing scrutiny at Croft House. PM confirmed there were concerns particularly regarding dementia provision which seemed fragile and somewhat unstable. Care homes were generally in a vulnerable position, further affected by significant rate increases that would require efforts to assess the additional care provision in light of these changes. However, there was still work to be done on this. LE agreed noting that there had been a number of beds lost in recent years following home closures or homes opting to change their registration from nursing to residential beds. This was leading to families looking out of the area for care beds.

It was resolved that The Wakefield Integrated Assurance Sub-Committee:

- **NOTED** the current place risks and assurances relating to quality, safety and experience;

Jenny Lingrell left meeting

1008/25 Arrangements for the 2025/26 Quality Impact Assessment (QIA)

LE confirmed that sub-committee had received a similar report a year ago which included guidance for the completion of QIAs across the ICB including individual organisations and Wakefield Place. It also identified areas to strengthen the process to ensure impact assessment was embedded in all work of the ICB.

LE confirmed today's report provided an update on the QIA arrangements for Wakefield Place and the West Yorkshire ICB Board as well as highlighting the national requirements in the 2025/26 planning guidance

and the outline development of a national QIA framework.

There had been an in-depth review of the 2024/25 efficiency schemes with a dedicated share and learn session for colleagues focused on completion of QIA. Impact assessments were also considered as part of the recent investment/disinvestment process. These processes will continue in a similar vein across 2025/26 with updates to be made to the governance flowchart to reflect strengthened quality input into the alliances and the Wakefield Transformation and Delivery Collaborative Meeting.

LE confirmed the intention to request information from MYTT and SWYPFT on their quality impact assessment of internal cost reduction and efficiency schemes for 2025/26 during the first quarter. The report then provided an update from a West Yorkshire perspective which included the establishment of an Impact Assessment Quality Oversight Group with representation from quality teams across each Place.

LE noted that there had been a delay in receipt of guidance from the national quality board which would set out good practice principles and guidance for undertaking QIAs as part of the decision-making process for planning, approving and implementing changes to or commissioning new health and care services. Once that guidance was available it would be shared at the relevant forums at system and place level.

It was resolved that the Wakefield Integrated Assurance Sub-Committee:

- **NOTED** the contents of the paper
- **APPROVED** the proposed next steps

I009/25 Performance Exception Report

MB presented the report providing the following headlines:

- There had been an increase of 8.5% in calls to NHS 999 in 2024/25 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 above 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 health checks for people with learning disability and serious mental illness was expected to increase in quarter 4 following the usual yearly trends.

Jenny Davies left the meeting – the meeting became inquorate

RH referenced the deep dive on planned care and flow held that morning noting it had been a good reminder of the extensive plans in place to support improvement across 2025/26 which included the referral to treatment (RTT) position. One key takeaway from that discussion was that it was important to maintain a focus on the patient journey rather than focusing solely on targets.

RU noted that a number of issues had been highlighted where mental health and learning disability services did not get the same prominence as acute and asked whether the performance report was sufficiently reflective of this. DT agreed that the report did not necessarily reflect that but this was no different to the other Places where SWYPFT operated. He would reflect on how that could be captured more prominently in future.

It was resolved that the Wakefield Integrated Assurance Sub-Committee:

- **NOTED** the latest performance and the indicators where performance is below target from the report

Governance and Performance

I010/25 End of Year Committee Effectiveness Review

RU confirmed the report showed good attendance from some members but that it was less consistent from colleagues across social care and MYTT. Representation at the sub-committee was key to support rich discussion. Attendance across 2025/26 was therefore encouraged from all members.



RU highlighted good feedback on the sub-committee chair and the governance support.

Generally, the terms of reference had been fulfilled but there had been some duplication in reporting identified that had been addressed as part of the work plan review.

RU confirmed that a suggestion had been made through the survey to facilitate more in depth discussions on various topics. This had been addressed through deep dives, where rich and informative conversations took place and this approach would be maintained throughout the year.

The terms of reference were confirmed. It was noted that some functions may be absorbed by the Provider Alliance as that developed.

The survey provided assurance that the sub-committee had functioned well in a complex environment.

DT requested additional clarity regarding the statement about functions. RU confirmed while the functions of the ICB had not yet been defined, it was known that work was already underway to develop provider alliance for Wakefield district. That may impact the work of the sub-committee.

MB highlighted the feedback that not all members had felt comfortable to contribute to discussions. She asked if there was anything that could be done to support colleagues, or changes to the meeting format for example in support. RU confirmed that the morning deep dive session had proven a good environment with everyone in attendance contributing. She said that the risk register would be used to identify key areas of focus for future deep dives throughout the year. RH agreed and said that the session had been good and he was pleased to see everyone contributing. He felt it was important to cover everything required of the sub-committee but it was equally important to support member involvement.

LE highlighted an item on the work plan for removal. She confirmed that the Quality Assurance Framework for Adult Social Care was not required annually.

It was resolved that The Wakefield Integrated Assurance Sub-Committee:

- **RECEIVED** the report and noted its contents as assurance that the committee fulfilled its remit during 2024/25
- **RECEIVED** the results of the 2024/25 committee effectiveness survey
- **REVIEWED** and **AGREED** the recommendations for development across 2025/26
- **APPROVED** the 2025/26 Work Plan for submission to the Wakefield District Health and Care Partnership Committee for final ratification
- **APPROVED** the revised Terms of Reference for submission to the Wakefield District Health and Care Partnership Committee for final ratification

Final Items and Closing

I011/25 Matters to escalate to the Wakefield District Health and Care Partnership Committee

The following areas would be highlighted to the Wakefield District Health and Care Partnership Committee via the Alert, Advise and Assure Report:

- Finance report postponed due to end of year processes however the committee were advised that the year had ended in a definite position
- The current position and improvements in relation to temporary escalation beds at MYTT
- Emerging concerns related to Manor Park Care Home in Castleford
- Assured in relation to the quarterly risk register review and in particular risk 2501 and 2495
- Assured by the Arrangements for the 2025/26 Quality Impact Assessment

I012/25 Any Other Business

There were no additional items of business to cover.

I013/25 Reflection on the Sub-Committee

RH thanked everyone for their attendance and contribution to the meeting and the deep dives undertaken that morning. He felt the day had been informative and had given many areas of assurance and this was supported.

I014/25 Date and Time of the Next Meeting

The next meeting of the Wakefield Integrated Assurance Sub-Committee is scheduled to take place on Tuesday 22 July 2025 from 2.00pm via Microsoft Teams.

Proud to be part of West Yorkshire Health and Care Partnership

APPROVED - 22.7.2025

ITEM 23a

Wakefield District Health & Care Partnership – Minutes

People Panel

06 February 2025, 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), Maurice Burrows (MB), Emma Boxall (EB), Hilary Rowbottom (HR), Meinir Smith (MS), Glenys Harrap (GH), Emma Boxall (EB)

Kate Trevelyan (minute taker), Items 5 & 6 Dáša Farmer (DF), Item 7 Fiona Forbes, Sarah Hudson and Adam Heseldene, Item 8 Laura Elliott (LE), Item 9 Ruth Unwin (RU), Item 10 Sarah Mackenzie-Cooper (SMc)

Apologies:

Stuart Green, Michelle Poucher, Lucy O'Lone

Agenda no	Item	Actions
1	Welcome and apologies	
	SH welcomed everyone to the meeting and apologies were noted as above.	
2	Declarations of interest	
	SH asked the Panel for any declarations of interest. SC advised interest as a Trustee of the Prince of Wales Hospice in respect of Item 8 Experience of Care.	
3	Minutes of meeting held on 12 December 2024	
	The minutes of the meeting held 12 December 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, actions would remain on the action log, until they were allocated to future agendas.	
5	Birth Choices in Wakefield District – update on consultation	
	Dáša Farmer (DF) presented the update on the preparations for a public consultation around not reinstating the birthing facility at Pontefract Hospital but continuing to provide and offer the same antenatal and postnatal care. The consultation would start in mid-February and run for 12 weeks. Highlights included: • Consultation to launch on Monday 10 February and briefing documents prepared to support the work. Mailouts to libraries, community centres/hubs and MPs among others together with briefing documents to help colleagues to publicise the consultation on our behalf. • Community venues have been mapped to hold drop-in sessions. Online events will also take place. The venues have been chosen to capture the full district, include our more deprived areas and include settings with activities relevant to the consultation, e.g. stay and play groups. • Alternative formats also available. • DF shared the outline of the consultation document and poster created for the consultation. • All information will be available in the public domain with links to 'how to have your say'. The consultation document will also be available in community settings e.g. pharmacies, GP practices and libraries.	

Agenda no	Item	Actions
	• The ICB will present mid-point overview to the Overview and Scrutiny Committee on 20 March. • A further update will be brought back to the People Panel in April. People Panel comments noted: • The consultation document is comprehensive but might be little wordy for some. • What other ways of sharing views are there for those who don't use internet. DF informed on a telephone number and dedicated email address. The consultation document, various versions of the poster and smaller leaflets would be available in community settings including antenatal and day unit clinics. • DF also commented on previous feedback from OSC which has been reflected in preparations around the materials. Also noted was the work on the Equality Impact Assessment and the support provided by SMC towards an accessible summary of the consultation document. Requests in respect of language and interpretation would be accommodated. • Suggestion was made to add telephone number to the poster. SH thanked DF for the update.	
6	Engagement update	
	Dasa Farmer (DF) provided an update on the 10-year Plan consultation: • Reference to the last People Panel and useful comments received on the NHS 10-year plan. The information was	

Agenda no	Item	Actions
	being added to the submission to the national portal, together with information from the Quality Team, Quality Intelligence Group, Healthwatch report and the conversation held in Middlestown PPG. Emma Boxall updated on joint working with Healthwatch on capturing feedback from Young People. The national timescale was considered tight and there was concern about available time to produce suitable materials. The data will be added to the portal. SH asked about the deadline and DF responded that it was 14 February for organisational responses and responses to the national picture, but West Yorkshire were extending the engagement to end of May. DF agreed that the deadlines set were challenging, but there was a need for meaningful conversations and reflecting feedback in local planning process. There were no comments noted from the People Panel. SH thanked DF for the update provided.	
7	Integrated Quality Assurance Processes for Adult Social Care Providers	
	Fiona Forbes (FF), Sarah Hudson (SH) and Adam Heseldene (AH) attended to present an overview of the quality oversight process for care homes: • 96 care homes in the district including residential, nursing and complex health needs. • Quality assurance programme helps to oversee for improvements.	

Agenda no	Item	Actions
	• The Quality Intelligence groups provide intelligence from our organisation, nursing, GPs which feeds into the safeguarding quality assurance where information is gathered. We also work with the CQC and cover quality visits with managers. The care plans are reviewed, a report produced and a meeting with partners set up if there are any issues to discuss. • There was a need to ensure that all care was safe and of the highest quality supported by good systems and process in written format in a quality assurance framework for integrated social care. • Escalation process and review every 6 weeks, meetings with stakeholders to review any concerns to achieve improvement. • Unannounced care home walkabouts to identify any problems. • Community into the care homes - animal visits, veterans café were highlighted as examples. • Support from agency staff to provide extra care (getting out of chair, meals, personal care). • Training/ageing suit, valuable, particularly for young staff to understand what it is like to be a certain age. Staff wellbeing support. • Hospital discharge, recovery plans, support of MY Therapy, appropriate package of care and care plans to support discharge to home. • Wellbeing improvements due to activities such as gardening, social activities, singing. Panel comments:	

Agenda no	Item	Actions
	• Health & Safety concerns around animals being taken into care homes. • How many people do not get the help they need because they do not want to divulge their bank details. It is an intrusion of privacy. Cannot have more than a certain amount but you need to keep a certain amount e.g property maintenance. • Communication between appointments and NHS. Feels that there is just a great disconnect. • The care process and action needed comes down to good practice in care homes, but also making communication better. Patients go into hospital, then move to a care home. How can we make the communication process better between different system and organisations. There is disconnect between different departments in the Council and the NHS. LE highlighted the valid comments, around communication about a clear referral pathway criteria, and the process of recording so that every service point could access a shared health care record (at national and local levels) immediately, which could be something to feed into the 10-year Plan. • Importance of a telephone call to speed up communication between agencies. • AH shared the improvement work done at Flanshaw Care Home and the significant changes that were achieved, which have resulted in improved experience and feedback from residents and families. The improvement in CQC rating was also shared, which was the result of significant work done by the care home manager and the team.	

Agenda no	Item	Actions
	LE explained the visits of Healthwatch volunteers which captured resident experience and the reasons for visits being made. LE also informed on the Council's Adult Social Care undergoing CQC assessment in March. SH thanked FF, SHd and AH for the information.	
8	Quarter 3 Experience of Care update	
	Laura Elliott (LE) gave an overview of the Quarter 3 Experience of Care update key themes from Q3 Quality Intelligence Group meetings: - Highlights from the 2024 National Urgent and Emergency Care Experience Survey. - Local maternity system and choice of where to give birth. - Feedback on GP appointments. - Care home vaccinations, collective impact and review of side effects. - CQC ratings, surveys published and experiences in ED/Urgent Care Centre around waiting times, environment in respect of food and drink, privacy when discussing details with receptionist. - Experience of Care Network met in October, good session which showed the correlation between staff experience and how people experience services. - Work of Quality Intelligence Group and its focus in December on waiting times for autism assessment for children and young people. - Next Experience of Care Network will take place on 15 February with focus on maternity services. People Panel comments:	

Agenda no	Item	Actions
	SH reflected on the autism 2-5 year waiting times for a diagnosis and queried who was driving change and emotional support for children. LE explained the support for children and families. SH commented on the previous additional money to support plans such as out of district referrals to create capacity. People Panel comments: - Want to endorse what is being said about waiting times on autism. Could a deep dive be scheduled onto the agenda to provide People Panel with an overview of services. DF informed on the work Healthwatch were doing and that the new Chief Executive would be attending the next meeting. Action: Autism support on next meeting agenda. - It is a bigger problem down to capacity and resources which impact on education and care plans. SMc commented on the increased awareness and support available for adults and children. Evidence showed that ADHD was linked to an increase in early age criminality and aggressive incidents compared to those without ADHD. SMc also informed on the work happening in West Yorkshire in respect of ASD and ADHD assessment services to increase access and reduce waits. https://www.adhdfoundation.org.uk/wpfrom this document is hard to read - red background! content/uploads/2022/06/Takeda ADHD-in-the-CJS-Roundtable-Report_Final.pdf	

Agenda no	Item	Actions
	- It was noted that in magistrate courts, an assessment before sentencing is needed and the issue was currently more prevalent particularly as diagnosis of ADHD and autism takes so long. - EB reflected that people with learning disability, ADHD and autism were more vulnerable to crime. Behavioural issues can be manipulated or exploited by criminal gangs. People mask symptoms to fit into what society expects. SH reflected that all the autism services concerns to be shared at the next meeting. SH thanked LE for the update.	
9	Integrated Care Board update – commissioning decisions	
	Ruth Unwin (RU) reported on the background around the Integrated Care Board around operational planning guidance and commissioning decisions which highlighted: - Every year from December to end of January, the ICB have a plan to complete to provide additional access to capital. - The place focus is on prevention to divert people away from hospital. - Consideration in light of financial constraints include reviewing areas to provide opportunities to do things once across one site as opposed to three, aligning commissioning policies but also potential reconfiguration and delivering services at a centre of excellence. - DF involved in the QEIA process with colleagues and Impact Assessments with be brought to the Panel.	

Agenda no	Item	Actions
	- Investment decisions will be made at Place and West Yorkshire to deliver NHS efficiencies and how we can support each other. - Item was brought to Panel's attention now and an update will be given at a future meeting. People Panel comments: - Pontefract taking on more patients every year and there is no capacity and no money. Several new builds but no additional support for the local system. RU commented on access to capital to support capacity issues including Primary Care. - The GP Practices cannot support the extra services. First hospitals were run by matrons and now there is a matron in every department which is expensive. RU described the difference in matrons' roles. SH thanked RU for the update provided.	
10	Equality, Diversity and Inclusion update	
	Sarah Mackenzie-Cooper attended to present an update around equality, diversity and inclusion: - The ICB legal duties and compliance for EDI. Document illustrates progress of the EDI work in the Wakefield District and will be shared post meeting. - Gap analysis produced by the ICB. - EDI Strategy objectives will be reviewed in conjunction with the EDI steering group and aligned to focus on what is important across Wakefield district. - EDS event in December looked at early diagnosis of cancer, staff wellbeing and other issues	

Agenda no	Item	Actions
	- Support provided on work around maternity consultation and hospital transport. SMc also informed on the work done in conjunction with the Quality Team around efficiency schemes to support decision making. People Panel Comments: - Are we going to be learning from best practice to move forward in respect of the strategy. SH thanked SMc for the update.	
11	Any Other Business	
	No items noted. SH thanked the People Panel for attendance and contribution to the meeting.	
	Date of the next meeting Thursday, 10 April 2025 – 10.00 – 12.00 noon DF informed: - Table of future meeting dates had been circulated for noting in diaries. The meeting will continue in the hybrid format online and in person at White Rose House. - Details of access to the Citizen Coin QR code was given.	

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	Ongoing
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	Actioned
12.12.2024	8 – 10-year Plan	Mental Health vehicle project future agenda item	Future agenda item	Carried forward
06.02.2025	8 – Experience of Care update	Autism Services update to next meeting	On agenda for 10 April 2025	CLOSE ACTION
06.02.2025	9 - Integrated Care Board update	Updates to future meetings	On agenda for 10 April 2025	Carried forward

Proud to be part of West Yorkshire Health and Care Partnership

ITEM 23b

Wakefield District Health & Care Partnership – Minutes

People Panel

10 April 2025, 10am – 12noon, via MS Teams/White Rose House

Attendees: Dáša Farmer (DF), Stephen Hardy (SH), Paulette Huntington (PH), Ross Grant (RG), John Nye (JN), Sandra Cheseldine (SC), Sarah Mackenzie-Cooper (SMc), Lewis Smith-Connell (LSC), Safeen Rehman (SR), Stuart Green (SG), Sharon Nobbs (SN), Glenys Harrap (GH), Hilary Rowbottom (HR), Lucy O'Lone (LO).

Kate Trevelyan (minute taker), Item 5 Amrit Reyat (AR), Item 6 Jo Rooney (JR).

Apologies:

- Ruth Unwin (RU), Laura Elliott (LE)

Agenda no	Item	Actions
1	Welcome and apologies	
	SH welcomed everyone to the meeting and apologies were noted. SH shared the sad news that Simon Walters had passed away and condolences had been given to his family. Simon was an active member of the PPG Network and he will be very much missed.	
2	Declarations of interest	
	SH asked the Panel for any declarations of interest and non were noted.	
3	Minutes of meeting held on 06 February 2025	
	The minutes of the meeting held 06 February were agreed as a true and accurate record of the meeting.	
4	Matters arising	

Agenda no	Item	Actions
	There were no matters arising from previous meetings to discuss that were not covered on the agenda. The action log was reviewed, actions would remain on the action log, until they were allocated to future agendas.	
5	Accelerator Work Update	
	Amrit Reyat (AR) presented the update on the Wakefield ICB economy accelerator programme which was a complex and fast-paced work to understand how we can work together to give connectivity and a voice to the programme. It was a government ask to get people back into work including those with work-limiting health conditions. Some key points of the presentation included: • Consensus that health and economy strongly related. • A need to build an evidence base which supports people to be healthy. • Work with accelerators across the country to create the evidence base. • Provide health support joined up with other services. NHSE and government to develop robust plan in respect of health interventions. • Health checks within workplaces to provide pro-active health monitoring, wellness champions, and charter to help employers to support individuals to remain in work. • Employment support offer added to mental health support app. • Risks around this work have been raised with DWP. • Joint working and involvement of partners. People Panel comments:	

Agenda no	Item	Actions
	• Query about links into the new Saviour's programme where health workers visit people in their own homes to make sure they are in as best health as possible. • There have been numerous cases across the country that have been identified as fit for work and within a couple of days have died. So there will need to be careful monitoring of this. Also need to appreciate that there are generations of people and families who have never worked. • At a time of increased costs in businesses, who are going to be able to employ these people and how much is it going to cost to support them back into work. • Visual and hearing impairment, we need to fix the system as it does not work now. Need to look at the various issues of getting people back into work but also support them whilst in the employment. At the moment, all we are doing is perpetuating the problem because people are not getting the support they need in their work. AR commented on the interventions which had been developed and asked for a conversation outside the meeting to go through the layers around the need for parity of access which we have not been able to consider. It was acknowledged that none of the interventions are supporting around sensory impairment. • Community health and well-being champions already in place in London and Cornwall. • Health population approach connected with workplace. We need to build the infrastructure to support.	

Agenda no	Item	Actions
	SR highlighted planned Healthwatch involvement activity and informed the group about the mental health panel of people with lived experience. AR welcomed Healthwatch representation and to have a conversation outside of the meeting. DF noted previous ICB engagement work and links to workplace healthchecks and queried if these had been used to build links. DF also noted the engagement and insight work to date that could be used as part of evaluation, appreciating that the timescales do not allow for new insight gathering at this stage. However, insight would be beneficial in supporting the evaluation work. It was suggested that the Impact Assessment be presented to the People Panel. DF also asked about the plan after 31 March 2026. AR stated that this will be evidence based and may be looking at 2-3 years with providers involvement. SH highlighted that the organisation has a history of projects (some successful) but the issue is when funding ends and the impact on vulnerable people, then what have we achieved? SH asked for this comment to be taken back. AR advised that NHSE were very clear about exit strategy. JR highlighted the digital offer for young people around anxiety through the Brain in Hand initiative, which supports people on a case-by-case basis, using social prescribing to evaluate and work with people for 6/7 months to give confidence to support themselves. JR queried if funding for	

Agenda no	Item	Actions
	this could be considered as part of the digital workstream of the accelerator. DF queried to the funding and allocation of accelerator sites. SH thanked AR for the information shared.	
6	Autism Spectrum Conditions (ASC)	
	Jo Rooney (JR) provided an update on the autism spectrum conditions services including the background to the waiting lists position, 2019 investment and redesign of services to build in growth: • During 2020 Pandemic, some work was done virtually in the hope to maintain pathway referral to diagnosis, but the growth of referrals increased. • NICE guidance and diagnosis delays. • Investment for pathway improvement. • We are in the process of developing parent workshops to provide understanding of child development and sensory needs communication. • Our current position - a decrease in time to first appointment, down to 38 weeks. • Working with parents and families over child behaviour and 10-week programme for families to support the child. • Worked with number of schools to identify children who are showing autistic traits. People Panel comments noted:	

Agenda no	Item	Actions
	• Are we just diagnosing people now for the sake of diagnosing? Everybody seems to need to have a diagnosis these days. JR commented on existing research and considerations that high use of social media and not enough interaction can play a role. The work in family hubs was highlighted. Challenges that the pandemic posed on children was also recognised. • A closer link between the diagnosis pathway and SEND offer would have with waiting list. There is an important relationship between the two as children may have different disability. • A child needs support and does not always need a diagnosis. The diagnosis doesn't always help to get an education, health and care plan. • Schools and education - how you report the different strategies. Schools have 55 minutes long lessons, but no one under 18 years can concentrate over 20 minutes, which makes it challenging. • Worked closely with a school and with children with emotional behaviour problems. Totally different service, but most of the problems were down to parent issues that parents really struggled to cope with. JR informed on a programme to support children who are home educated, supporting around child anxiety, and with parents' pathway of working together. In context parents need support as well as the child, often before the child. JR advised that when child is not in school there is help available for parents to complete paperwork and informed on	

Agenda no	Item	Actions
	the national service contract for autism assessment for child and adult. Family input can provide additional information. There is no treatment support strategy for ADHD but medication can be useful in conjunction with a diagnosis. SH commented on assessment and schools willing to engage whether or not autism issues being addressed. How is this picked up? JR informed on the close work with the Local Authority and the parent carer forum has been valuable. JR noted that some schools were taking action to support and providing reasonable adjustments but without visible general communications to parents. SR noted previous involvement of Young Healthwatch and how positive it is to see the changes that have been done over the last few years. SR also asked about equality monitoring of the referrals that are coming in and subsequent diagnosis/outcome. JR highlighted the involvement of Healthwatch as well as the Parent Carer Forum. SR informed on the meetings with young people and families to support after diagnosis of autism which can be a very difficult time. LSC sought assurance about those who are not in schools and right to choose. JR responded on the help in place to support parents and that Wakefield were part of the neurodiversity steering group. The right is to choose any provider with an NHS contract.	

Agenda no	Item	Actions
	SH thanked JR for the update provided. Really interesting and it will support this item at governance committee meeting.	
7	Engagement	
	Dáša Farmer (DF) presented an update Birth Choices Consultation DF informed that the consultation was at the halfway point in the process with online events, drop-in sessions talking to parents in the Family Hubs, and community sessions. The final event prior to the end of the consultation will be Baby Fayre at Farmer Copley's on 17 May. - In terms of the responses received and profile of those presenting, we will continue to work with the Polish Centre in Wakefield, family hubs and others to diversify who we hear from. - Also want to hear from those who are located on the borders with South and North Yorkshire and have contacted colleagues in those ICB areas. Information has also been sent out to children's centres along the borders with these areas to make sure we promote the consultation. - Healthwatch colleagues have also been sharing the consultation information at various events. - Evening online event has been added and supported by social media posts and a press release to encourage participation. - Feedback gathered will inform the impact assessments. - The business case will also be updated with evidence. SR queried engagement with young people which DF confirmed.	

Agenda no	Item	Actions
	People Panel comment: - There was no information on display in the Knottingley community centre. DF confirmed that posters have been displayed during a visit to the centre. JN also noted that information had been shared with the centre manager. This would be double checked at next visit by HR. LSC emphasised that the work was a Herculean effort. Noted that an enormous amount has been done and within the context of the ICB and the incredible challenges that it is under, how would anything like that happen if we didn't have a really robust place or if we were in a provider collaborative model? Demonstrates that place [Wakefield in the context of West Yorkshire] is really important. NHS 10-year plan National deadline of 14 February 2026 but across West Yorkshire, we have continued to gather the views of local people. Action: DF to share NHS 10-year plan engagement information with SR. CQC Visit SH commented on the CQC visit to Adult Social Care which representatives from the People Panel attended. The visit went very well and was supported by colleagues. Questions around adult social care were specific and CQC were impressed with the work of the People Panel and the level of commitment.	

Agenda no	Item	Actions
	• Transformation and Delivery Collaborative (TDC) PH commented on the intensive content of the meeting and advised that it could be useful for someone from that committee to speak to People Panel. Question was posed about representation of the VCSE sector and PH informed that Paula Bee, Chief Executive of Age UK was a member of the TDC meeting. SH and DF thanked PH for attending the meeting. SH highlighted the restructure and abolishment of NHSE reflecting whether there will be a Place Committee in the future, how it will work and what the landscape will look like. DF informed that the national model proposal should be available by end of April and more information on local working by end of May. One of the main themes for next meeting on the 22 May 2025 would be an update from Ruth Unwin on the TDC/future arrangement for involvement under the proposed reorganisation. Panel comments: • No further comments noted. SH thanked DF for the information shared.	
8	Any Other Business	
	No items noted. SH thanked the People Panel for attendance and contribution to the meeting.	
	Date of the next meeting	

Agenda no	Item	Actions
	Thursday, 22 May 2025 – 10.00 – 12.00 noon JN extended his apologies due to surgery. SH acknowledged and hoped everything would go well.	

APPROVED

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	Carried forward
12.12.2024	8 – 10 year Plan	Mental Health vehicle project future agenda item	Future agenda item	Carried forward
06.02.2025	9 - Integrated Care Board update – commissioning decisions	Updates to future meetings	On agenda for 10 April 2025	Carried forward

Proud to be part of West Yorkshire Health and Care Partnership

ITEM 23c

Wakefield District Health & Care Partnership – Minutes

People Panel

22 May 2025, 10am – 12noon, via MS Teams/White Rose House

Attendees: Dáša Farmer (DF), Stephen Hardy (SH), Paulette Huntington (PH), Ruth Unwin (RU), Laura Elliott (LE), Lucy O’Lone (LO), Ross Grant (RG), Sandra Cheseldine (SC), John Nye (JN), Hilary Rowbottom (HR), Lewis Smith-Connell (LSC), Michelle Poucher (MP), Stuart Green (SG), Glenys Harrap (GH), Natalie Tolson (NT)

Kate Trevelyan (minute taker),

Apologies:

- Safeen Rehman (SR), Sarah Mackenzie-Cooper (SMC)

Agenda no	Item	Actions
1	Welcome and apologies	
	SH welcomed everyone to the meeting and apologies were noted as above.	
2	Declarations of interest	
	SH asked the Panel for any declarations of interest and no declarations were noted.	
3	Minutes of meeting held on 10 April 2025	
	The minutes of the meeting held 10 April 2025 were agreed as a true and accurate record of the meeting. Noted that Hilary Rowbottom and Lucy O’Lone had been omitted from list of attendees and their names should be added to the final approved version. Agreed for attendees also with a speaking role not to be named twice.	
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,	

Agenda no	Item	Actions
	actions would remain on the action log, until they were allocated to future agendas. The matter of Knottingley community shop and the MLU notice was raised by HR. DF advised that it had been displayed in March on the main display area of the community venue.	
5	Using data to shape services	
	Natalie Tolson presented this item and advised on her role as Joint Service Lead for Business Intelligence at Wakefield Place and working across Mid Yorks. The aim of the agenda item was to inform the People Panel of the work the ICB Business Intelligence Team(s) are doing to support population health management. Some key points included: • Improving the way we use data to tackle health inequalities and improve people's lives. • How we are working as a Partnership to collect and share de-identified data to support joined up decision making • An opt out was available if patients do not want their data to be shared. • Population health management to optimise health outcomes. • Proactive work to reduce risk of hospitalisation and reduce health inequalities • Patient data anonymised • Population Health Management uses both healthcare and non-healthcare data from various sources. Current data sources available in the linked data model. • Planned data sets that are subject to information governance approval from NHS England • Sharing of de-identified data with partners through approved sub-licensing agreements • This work is key to integrated work. People Panel comments noted: • How does this work link into the statistics we get on the population of Wakefield district. For the area I live in it reflects high levels of heart disease and cancer. How does this research influence screening and screening in the right	

Agenda no	Item	Actions
	places. NT advised on the neighbourhood practice level work which informs Public Health and GP practice work to reflect priorities in the area towards the integrated model. The data determines the needs of the population. • How accurate is the data and Joint Strategic Needs Assessment information, has any been used to influence the data you are collecting? NT responded that the data was updated on a regular basis with daily, weekly and monthly availability so was up to date. The JNSA is little different as considers the picture over a longer period of time. The JSNA would be looked at but the population health data from different organisations is more live and up to date to drive decisions. For some aspects, data needs to be considered across a longer period of time to allow for outcomes and impacts to be seen. • Concern about pulling data sets from many organisations, like to know more about how the anonymisation process works, and reassurance over cyber security in light of recent events. NT advised information governance and protocols were robust with data provided through NHS England being subject to their governance protocols. Data processing was described. There was no name, address in the data that is extracted at NHS number. It is sent into a secure environment, so ICB only receive pseudonymised data with no trace back. The information governance approval process has taken two years, which demonstrates the level of scrutiny. The Health Research Authority have given an approval which we have had for a number of years, with annual review to confirm adherence to the government protocols. One of the asks is around how we engage and communicate with partners and the public around how we use data. • Query on the pseudonymised level of data and re-identification. Primarily when people give their data to health services, their expectation might be that it is directly for their care. The data that we are looking at are wider to include housing etc. No issue with it and it is important but it's crucial that the public have faith and part of this is about what they understand the process is. NT responded that the	

Agenda no	Item	Actions
	reidentification process was for direct care intervention only and all requests would need Caldicott Guardian approval. No re-identification would be done without a formal approval. Lot of work ongoing with NHS England around the national opt out and this has been applied as the data is used for commissioning purposes and secondary care. • When I was promoting the NHS app, there was a lot of suspicion around access and confidentiality. • It is great that population health approach helps us to target NHS and social care resources, but how does the information we glean help to improve schooling, housing conditions and high levels of crime? Unless all the partners are tied into this information and do something about it, it's just the NHS acting alone. RU responded that this was a key theme in the current Health and Wellbeing Board strategy and what is currently being developed is a district wide plan. The health and wellbeing element of the plan will be informed by the data discussed today. In addition, other parts of the system are working and contributing to this plan on aspects like economy, which is about better employment opportunities, as well as work around climate change. This is a holistic approach. DF commented on the wider involvement work around the data and the Panel were asked if they were interested in commenting on the public information developed to support this work. This would include the full and summary versions of the privacy notice. SH thanked NT for the information provided.	
6	Experience of Care	
	Lucy O'Lone (LO) presented the update on Experience of Care and explained the key themes which included: • Key themes arising from Quality Intelligence group during quarter 4 of 2024/2025	

Agenda no	Item	Actions
	• Review of Quality Intelligence Group topics that saw speakers give updates on community pharmacy, vaccinations in care homes and maternity services patient experience survey. • Update on Patient and Resident Safety Walkabouts, visits to healthcare settings and care homes. • Summary of CQC ratings of care homes and GP practices • 2024 maternity services patient experience survey, a national survey published by CQC. • Summary from Experience of Care Network that took place in February 2024 and focussed on experience of maternity services. People Panel comments noted: • Query around expectant mums being asked where they want to go to have their baby - concern around potential impact of the proposal (birth choices consultation) on Pinderfields and Dewsbury. • Question about PLACE audits and these taking place. Also highlighted place results which restarted last year. LE commented on PLACE audits and action was agreed to follow up with MYTT and Healthwatch – completed. SH thanked LO for the update provided.	
7	Birth choices across Wakefield District – update on consultation	
	Dáša Farmer (DF) presented an update on the Birth Choices consultation, which closed on Sunday 18 May 2025. The proposal was not to reinstate birth facilities at Pontefract but to provide antenatal and postnatal care there and in the community. DF summarised the aspects that the public and stakeholders were asked to comment on. There had been over 400 responses via the survey alone and the consultation ran across the district for everyone to have an opportunity to have their say and included reaching out across borders (Barnsley, Leeds, Selby) to capture the views of those who	

Agenda no	Item	Actions
	may be using / could use services in Wakefield district. The work also aimed to capture voices from across our communities. The data was being analysed and the responses will inform the Business Case which will support the decision-making process. The aim is for a decision to be made at the Heath & Care Partnership Committee in September. There will also be engagement with our stakeholders including attendance at the Overview and Scrutiny Committee. We have also received a submission from the MP for Pontefract, Castleford, Knottingley and Altofts, and RU will co-ordinate a response. Information will be shared when finalised, and this item will continue to remain on the agenda until the conclusion. DF expressed thanks to People Panel, Healthwatch and MNVP for their support. Panel comments: • No comments noted. SH thanked DF for the update.	
8	NHS Reforms and public involvement	
	SH introduced this item referring to the Government NHS reduction by 50% and abolishment of NHSE. RU provided an overview of the position which will result in 45% reduction in running costs of the organisation, which will primarily be taken out of staff costs. Key points: • Government announced ICB running costs to reduce by 50% and for NHSE to be abolished. • Rationale - more streamlined, less duplicative arrangements will be needed to deliver the 10-year plan. • Blueprint out in two weeks, with talks about what ICBs will be required to do. Information will be used to develop long term plans. • Performance monitoring functions undertaken by ICB will be done by Regional Health team of the Department of Health.	

Agenda no	Item	Actions
	• Merger of some ICBs across the country and reduction from 42 to about 25 to be capable of providing service or covering the work with less people. • ICB roles will include using data and public insight to understand what drives peoples' choices for modelling • Working with partners and clinicians to inform the development of care pathway. Working with providers will be about a co-production approach around new services. • ICBs will also stop doing some roles emergency preparedness; workforce strategy, which includes overseas recruitment, planning, training (all will be done by Department of Health). • R&D, digital, infection control, safeguarding, Medicines Optimisation are likely to transfer to a provider organisation. • We do not have Neighbourhood providers yet so ICB will retain functions until an alternative model is put in place. • Query around where CHC will sit in the future (likely to be provider organisation). • Provider alliance development (provider alliance will take on delegated functions from the ICB). • NHS England changes/merger with Department of Health will require legislation and be implemented over a longer period. • Next steps – timeline for implementation is quarter three of this year so the reductions in functions and staff will be seen by end of this calendar year. Level of delay is expected in terms of transfer of functions. Consultation with staff once staffing structures are available followed by opportunities for people to apply for roles in the new organisation. People Panel comments included: • Who is going to have responsibility for the provider oversight. RU commented that the Department of Health will have regional outposts with responsibility for performance oversight. Currently the ICB work with providers to agree a plan for performance management but in the future, this will be agreed directly with the Department of Health. • Sounds like we are going back to the old Regional Authority (reinventing the wheel again!).	

Agenda no	Item	Actions
	- What are the implications for Wakefield Place and the District Partnership in terms of governance and local accountability. RU informed that this will eventually move into a provider alliance with ICB providing functionality support. The delegated budget will be managed through the provider alliance. - It's a conflict of interest then? RU commented that some of those providers are already part to the WDHCP. - Provider alliance almost feels like we will end up with some of this work. Going to take more community to come forward. Oversight of contract management, there must be a proper mechanism. RU advised on the work around the provider alliance to provide a strong voice in the decisions of where money was being spent, including VCSE voice, with money coming out of acute hospital services as population health data is telling us that more investment in community services and particularly grassroots community services have the biggest impact in terms of managing demand on hospital services. more investment in community services has biggest impact around management of hospital services for future benefit. The ICB will still have leverage through contract management. - How do we keep patients reassured that all the changes are not going to significantly impact healthcare. How do we communicate. RU commented that locally the focus will be to reassure people about what the services will look like for the Wakefield population. - How is it going to cost any less? Just moving one team to another team, which is still going to cost the same amount of money (comment about previous organisational changes). There's something radically wrong. The government is relocating money from the ICB to outside organisation. RU advised that the exercise was to reduce duplication and costs due to 'bloated bureaucracy' in the NHS. There is a definite amount of money allowed for ICBs in terms of running costs. DF added that for any functions being	

Agenda no	Item	Actions
	transferred out, reductions will be made before transfer takes place so it is not a simple shift of costs. SH reflected on power of the new provider structure with no direct local oversight. There may or may not be a place committee as the governance was still to be decided (whether there will be any independent, lay or patient input). It may be seen as a symphony of private interests where there will be limited transparency and no accountability except maybe through a few regional officials. West Yorkshire ICB was built on the basis that the five districts took local decisions. Under the new structure districts may play a marginal role and providers a higher level of decision making. RU commented that the ICB will still exist at West Yorkshire level. There will be people who have control over the investment and through delegation to those provider alliances. ICB will have leverage through contract management if providers are not delivering. RU informed that the consultation was direct with staff only about their future employment, and the jobs which are available. People Panel would be kept involved and updated on the developments and the Chair will be part of the Committee discussions as they take place. There was a need to make sure that the voice of the People Panel was being fed back into that process for the future of delegated functions.	
9	Engagement Updates	
	Dementia engagement MP attended to provide information on dementia engagement work (part of a wider piece of work). MP updated on the transformation work with specific engagement involving different charities (Age UK, Prince of Wales, Wakefield Hospice and others). With conversations around experiences like diagnosis, support for carers, respite care and end of life care and how adult social care could support in the future.	

Agenda no	Item	Actions
	MP highlighted the development of an action plan to support the work. People Panel would be kept informed as the work progressed and report of this work will be shared with the Panel. SH thanked MP for the information shared. DF reported on other engagement updates: • PPG Network meeting taking place on the 4 June 2025 which will be in Patient Participation week, the agenda included various updates and speakers with a focus on celebrating our PPGs and sharing best practice across the district. • Self-management in West Yorkshire – link to be shared. • Children receiving complex care packages to provide more independence between parents and families – planned engagement. • RG updated on interpretation services and focus on BSL in response to feedback over many years of challenges for people for same day, face to face, or pre-booked GP appointments. The new language contract for GP practices involves remote/online support for a deaf patient using BSL with an interpreter. The Contract had commenced, and training of GP practices was being undertaken on a gradual basis to support learning. • Integrated Neighbourhood Health Teams update on the People Panel agenda for 19 June 2025.	
10	Any Other Business	
	Patient Transport Services: SH reminded the meeting of JN's involvement in discussions around Non-Emergency Patient Transport following a presentation to People Panel last year as the committee asked for JN's involvement in the project.	

Agenda no	Item	Actions
	JN gave an overview of his recent experience where he had need of transport to get to Leeds by 7am for an operation, however, was told the services was not contracted to support this. SH commented on the patient transport service (PTS) and asked for PTS representative(s) to attend the next meeting so that contract services could be discussed. People Panel comments: • The other solution would be to go night before but that would incur hotel costs. • Cancer appointment at St James's and had to rely on friends' support. JN added that sometimes, patients need support with their journeys to hospital appointments. Action: Patient transport services to be added to June agenda	
	Date of the next meeting Thursday, 19 June 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	Closed
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.	Closed
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	Ongoing
12.12.2024	4 – Matters Arising	MP to present Adult Health and Social Care update	Future agenda item	Ongoing
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	Actioned
12.12.2024	8 – 10 year Plan	Mental Health vehicle project future agenda item	Future agenda item	Carried forward
06.02.2025	9 - Integrated Care Board update – commissioning decisions	Updates to future meetings	On agenda for 10 April 2025	Closed
22.05.2025	5 – Using data to shape services	Privacy notice and summary versions to be shared with Panel for comments	Circulated with papers for 19 June meeting	Closed
22.05.2025	10 – Any Other Business	PST Contracted services to be		Closed

		added to 19 June agenda		
22.05.2025	Any other business	LE to ask MYTT and Healthwatch about members of the public supporting PLACE audits	GH and HR contacted with details for MYTT	Closed

Proud to be part of West Yorkshire Health and Care Partnership

Approved

ITEM 23d

Wakefield District Health & Care Partnership – Minutes

People Panel

19 June 2025, 10am – 12noon, via MS Teams/White Rose House

Attendees: Stephen Hardy (SH), Paulette Huntington (PH), Dáša Farmer (DF), Laura Elliott (LE), Ross Grant (RG), Sandra Cheseldine (SC), John Nye (JN), Hilary Rowbottom (HR), Lewis Smith-Connell (LSC), Michelle Poucher (MP), Glenys Harrap (GH), Simon Rowe (SR), Colin Hurst (CH), Maurice Burrows (MB), Safeen Rehman (SR), Kate Trevelyan (minute taker)

Apologies:

- Sarah Mackenzie-Cooper (SMC), Ruth Unwin (RU), Stuart Green (SG), Lucy O'Lone (LO)

Agenda no	Item	Actions
1	Welcome and apologies	
	SH welcomed everyone to the meeting and apologies were noted as above.	
2	Declarations of interest	
	SH asked the Panel for any declarations of interest and no declarations were noted.	
3	Minutes of meeting held on 22 May 2025	
	The minutes of the meeting held on 22 May 2025 were agreed as a true and accurate record of the meeting. Noted that there was a repeated bullet point under Item 8 and it was agreed that this should be removed before finalisation of the minutes.	
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, actions would remain on the action log, until they were allocated to future agendas.	

Agenda no	Item	Actions
	DF updated that one of the actions from the last meeting related to LE contacting MYTT on the current position of the PLACE audit. This action had been completed, and comments fed back. Also noted that the population health management data privacy notices had been circulated for comments and non-emergency patient transport item was on the agenda for the meeting.	
5	Non-emergency Patient Transport Service (PTS)	
	Simon Rowe (SR) and Colin Hurst (CH) joined to update PP members on the Patient Transport services (PTS) contract. SR asked the group for the items they wished to be covered. SH informed on the previous presentation and that JN was the panel member with lived experience to represent the committee at the programme/project group. JN gave overview of his lived experience of PTS, including the issue that there was no transport before 7.00 am in the morning for a hospital appointment at 7.00 am in Leeds. MP asked whether the criteria had changed for people who use the transport regularly for hospital appointments as a patient was told they do not now fit the criteria due to having a car (this was an issue as wife who is the carer works full time). Comment noted about early radiotherapy appointment at St James and use of friends to transport. SR provided an overview of the main themes which included: • PTS contract between the ICB and YAS expires 30 September 2025. New contract awarded for 18-month period in line with South and North Yorkshire areas. • Core activity which is managed as a block contract held by the ICB and includes the hours and sites the service includes. • Non-core relates to extra journeys which may incur additional money. From a patient's point of view, there should be no difference in whether the hours or site are within 'core' and there shouldn't be obstacles for those who qualify for the service.	

Agenda no	Item	Actions
	• There is a performance indicator of calls being answered within 60 seconds and processes are being looked at to improve access, e.g. online booking. • National review of PTS (SR to share link) came to a conclusion that PTS, in the current form, was unsustainable and there were postcode lottery. Recommendations made in 2022 that there should be standard eligibility through national criteria with an overarching principle that there should be independent travel if safe to do so. • PTS breakdown into 2 categories, specialised vehicles and patient transport, noting safeguarding issues for particular medical issues. • National criteria from national review to be consistent across the country. SH asked why a comms exercise was not undertaken. SR explained the issue around the patient cohort and data underpinning this work, wanting to start with an understanding of who this would impact to ensure targeted communication. Quality of data was also discussed. SH asked for the EIA to be shared, noting that the committee wants to see more rigour in impact assessments. SH trying to understand the challenges but where does it sit with those decisions, narrow or broader interpretation, and how are you tackling people with health conditions. SR advised about governance, the WY Project Group, chaired by Rob Webster, CEO which went live in April 2025. The criteria section is at local discretion, and although not clear cut, transport for chemo and dialysis will automatically be provided. The YAS service needs to be sustainable. CH referred to the previous general travel questionnaire and this second stage of involvement which is due to be launched soon. This will also be done via a survey and shared across West Yorkshire area. SR commented on the criteria and a consistent approach across West Yorkshire for taxis and public transport. SH agreed that it was a huge project and the requirement for a comms campaign to let people know about the changes which is worked through. SR advised that they were trying to get to a position to align	

Agenda no	Item	Actions
	to NHS, social care, the ambulance service and pool with other schemes to achieve a better sustainable service which addresses the challenges around the eligibility criteria. Working towards two offers – one for those who need it and then all other journeys. People Panel comments included: • Reflection back to 2005 when a patient was not allowed to drive themselves due to the type of treatment they were receiving and had to use T1 transport which was organised but didn't work due to the driver coming in a small car which was not suitable for a wheelchair user. • The PTS contract ends on 30 September this year. That is only 3 months away to negotiate and agree contracts. Is there any involvement overview, are you going to procurement or is it just a renewal with YAS. Would like to see overview of feedback and plan for involvement. SR advised that there was a plan, new legislation came in which did not oblige us to go through procurement anymore. There is a challenge about PTS around the country not just West Yorkshire. SH requested appropriate procurement documents should be shared in the strictest confidence. • There should be a general mandate for operation from the morning. SR agreed and reflected on the progress over the last few years. • You do not want to use the transport at 10 am in the morning as it could be 10 pm before you get home. • What are the percentages of patients who go to hospital and ask for patient transport. • Improvement of access to service. SR advised that JN would be welcome to come to the contract meeting to help shape the eligibility criteria, monitor the impact of the eligibility criteria and look at mandate. SR to share relevant documents in confidence. Actions for SR: • Share procurement information that is appropriate - in confidence.	

Agenda no	Item	Actions
	• Share equality impact assessment • invite JN to future contract meetings to help shape the eligibility criteria, monitor the impact of the eligibility criteria and look at that mandate. • Pick up with YAS core and non-core journeys in light of feedback shared. SH thanked both SR and CH for the information provided.	
6	Integrated Neighbourhood Health Update	
	Rebecca Barwick (RB), Associate Director of Partnerships, attended and provided a brief overview of the Integrated Neighbourhood Health work. • Complex programme and neighbourhood health is going to be one of the central themes of the 10-year plan to reflect where we have come from and where we are going. • New neighbourhood health guidance out with six components including population health management, standardising community health services, integrated intermediate care and modern general practice. Multi-disciplinary teams jointly responsible for people with complex needs. • Big change for future of NHS mainly specific to get into a good position across the 6 components. • Poor service user experience and demand for complex needs not set up trying to solve these issues. • People diagnosed with COPD, dementia and end of life care via multidisciplinary teams to better support and reduce non elective activity. People Panel comments noted: • What is the plan to reconfigure. RB advised better quality care, more efficient and ways of working to avoid duplications of work to create capacity. Theory is to save resources and create efficiencies. • How is the VCSE sector involved in this work? It seems that there would be greater reliance on the VCSE sector to	

Agenda no	Item	Actions
	support this. RB responded that they are involved at the design level and at Neighbourhoods. • LSC always problems in respect of PPG representation, how could they best be involved in this. • SH queried how the People Panel can best be involved in terms of involvement. SH commented on the involvement of the PCNs and VCSE, it would be good to get the citizen voice at the neighbourhood level. DF advised on the work to reflect patient engagement at West Yorkshire with local level opportunities and starting to develop an approach. LE informed that one of the key principles in the Embedding Quality and Involving People programme was starting with what we know and the Quality and Involvement teams have worked on supporting the Neighbourhood MDT programme with insight on the three cohorts identified - COPD, dementia and end of life. SH commented that the Panel may wish to have this item on a future agenda to ensure involvement is reflected in future structures.	
7	Birth choices across Wakefield District – update on consultation	
	Dáša Farmer (DF) presented an update on the Birth Choices consultation, which closed on Sunday 18 May 2025. The proposal was not to reinstate birth facilities at Pontefract but to provide antenatal and postnatal care there and in the community. DF summarised the aspects that the public and stakeholders were asked to comment on. • Since consultation closed, we have been analysing the surveys. Looking through data on conversations we engaged with 762 people, including on-line and paper surveys. • Good to see majority of people as current or past service users, although wanted to hear from everyone across the district.	

Agenda no	Item	Actions
	- On-line events were held as well as sessions going into clinics, community centres, and via newsletters and social media. - Posters and documents shared in community settings which was also an ask from People Panel and OSC. - DF outlined the key findings and the groups that responded, e.g. comments from local MP and Councillors. - Next steps include presentation at the Mid Yorkshire Teaching Trust Board meeting on 10 July, OSC meeting on 24 July and MP meeting on 25 July as well as information to NHS England. - All impact assessments, including equality and transport, will be reviewed in light of the feedback we have received during the consultation. - The feedback will be reflected in the decision making business case. The Wakefield District Health and Care Partnership Committee, on behalf of WYICB, aims to make a final decision in September 2025. Panel comments: - No comments noted. SH thanked DF for the update and asked for DF to provide updates to keep the committee informed ahead of September.	
8	Engagement update:	
	DF reported on engagement updates: - Children with complex needs discussion groups with parents are going to take place in July. - Equality Strategy (information document and slides to be shared). DF to include as a standalone agenda item. Action: DF to circulate equality strategy document and slides. People Panel comments: - No comments noted.	

Agenda no	Item	Actions
	SH thanked DF for the update.	
9	Any Other Business	
	No other items were discussed.	
	Date of the next meeting Thursday, 24 July 2025 – 10.00 – 12.00 noon Seminar Room.	

Approved

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	Closed
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.	Closed
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	Ongoing
12.12.2024	4 – Matters Arising	MP to present Adult Health and Social Care update	Future agenda item	Ongoing
12.12.2024	8 – 10 year Plan	Mental Health vehicle project future agenda item	Future agenda item	Carried forward
19.06.2025	5 – Patient Transport Service	SR to: • Share link to the 120-page procurement document in confidence. • Share impact assessment. • invite JN to future contract meetings to help shape the eligibility criteria, monitor the impact of the eligibility criteria	24.07.2025	

		and look at that mandate.		
19.06.2025	8 – Engagement update	DF to share Equality Strategy information and slides	24.07.2025	

Proud to be part of West Yorkshire Health and Care Partnership

Approved

ITEM 24

Committee Escalation and Assurance Report – Alert, Advise, Assure

Report from: Wakefield District Health and Care Partnership Committee (WDHCP)

Date of meeting: 3 June 2025

Report to: NHS West Yorkshire ICB Board

Report completed by: Jemma Harris, Governance Manager on behalf of Ann Carroll (chair) and Mel Brown (Accountable Officer Wakefield Place of the WY ICB)

Date: 9 June 2025

Key escalation and discussion points from the meeting	
Alert:	
N/A	
Advise:	
• Provider Alliance Development: Work is progressing on the development of the Wakefield Provider Alliance, a key step towards the creation of a local neighbourhood health model. (BAF 1.3) • Local facilities: The first patients were welcomed to the new Mid Yorkshire Teaching NHS Trust (MYTT) Surgical Hub at Dewsbury Hospital at the end of April 2025. The new unit is providing additional capacity for elective surgery and outpatient services. The Wakefield Community Diagnostic Centre (CDC) recently has celebrated its first birthday. More than 70,000 tests and scans have been delivered at the Centre since it opened in 2024. The committee noted the strong local feedback around accessibility and quality of care. (BAF 2.4) • New appointment: Rachel Bowes has been appointed as the new, permanent Corporate Director, Adults and Health (DASS) at Wakefield Council. Rachel will join the WDHCP Committee when she starts her role from 1 July 2025. • Note the operational and financial plan for 2025/26 were submitted on 27th March 2025.	
Assure:	
• Following extensive work with partners, the Wakefield District Plan is progressing toward publication. The plan will provide a joint vision for improving outcomes for all who live, work or study in Wakefield. The Plan is built around six key themes: Health, happy children; Living Healthy Lives; Thriving, safe communities; An economy that works for everyone; Tackling climate change, and Targeted and collaborative support	

for people with complex lives. The 'Living Healthy Lives' chapter of the plan will double as the new Health and Wellbeing Strategy for the District. The final plan is due to be presented for approval by Wakefield Council on 16 July 2025. (BAF 1.3 & 2.4)

- **Birth Choices – consultation now closed:** more than 700 people shared their views on birth choices in Wakefield District as part of a public consultation. The 14-week consultation closed on Sunday 18 May and focussed on the future of birth services at Pontefract Hospital, which have been temporarily suspended since 2019. All consultation responses are now being reviewed and analysed ahead of a recommendation to the Wakefield District Health and Care Partnership Committee in September. (BAF 2.1)
- The **2024/25 Annual Report for Wakefield District Health and Care Partnership** highlighted achievements against the three strategic priorities; Equal Health for All; Building Community Support; and Managing Service Demand. It described the proactive work against each priority and included specific service highlights from across our programmes and alliances which served as examples of how the Partnership is making a positive difference to the lives of the people of Wakefield District. This narrative report is complemented by an accessible animation to be shared with staff and the public. (BAF 1.1 & 1.3)
- The **Place Committee Annual Report 2024/25** reflected strong governance through the year, with increased focus on financial and quality assurance, including development sessions on: the strategic plan; Older People Mental Health Inpatient Service; Wakefield Leadership Review; future system architecture for the mental health alliance; and the neighbourhood health workstreams.
- **Wakefield assurance:**
 - the Wakefield District Committee noted recommended changes to the Transformation and Delivery Committee to support the transition to the **Provider Alliance from October 2025**, including a focus on the development and implementation of our neighbourhood health programme. (BAF 1.3)
 - **Financial pressures** across health and care remain significant. Oversight through Place finance groups continues, and risks associated with workforce costs and system inflation were noted. The Place Risk Register continues to evolve, supporting system-wide transparency and assurance. (BAF 3.1 & 3.2)
 - **Quality, Safety and Experience** report provided an overview of the district's health and care services' performance and improvements during the final quarter of 2024/25. There continues to be intensive focus on several care homes under enhanced quality oversight, with tailored support in place. Good levels of assurance were received at a Rapid Quality Review with Mid-Yorkshire Teaching Hospitals NHS FT (MYTT) around urgent care performance, which is part of a national process. (BAF 2.1)

- Wakefield Council reports from OFSTED and the CQC are expected shortly following recent **inspections of the Local Authority Children's Services (ILACs)** and an assessment of **Adult Social Care**, respectively. MYTT received positive feedback following a Local Maternity and Neonatal System (LMNS) assurance visit, and in February 2025 Donna Ockenden was invited to tour MYTT maternity unit and spoke positively to staff about what she observed. Improvements were noted in care delivery and outcomes, as well as in positive changes in response to feedback from local families. (BAF 2.2)
- The Committee gained assurance from the **Performance Report**, which focused on operational plan themed areas: 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); and Community (virtual ward, bed occupancy and community services waiting list) (BAF 1.2 & 2.3)
- The **Wakefield Integrated Assurance Sub-Committee** conducted a deep dive into System Waiting Times and Patient Flow, and Children's ASD and ADHD Services. Both demonstrated a strong commitment to oversight and service improvement to further strengthen assurance processes. (BAF 2.2)
- The committee approved the refreshed **Wakefield District Health and Care Partnership Agreement**. (BAF 2.2 & 2.3)
- The committee noted **Wakefield Place Committee Annual Report 2024/25**, received the revised terms of reference and work plan for 2025/26; and recommends the Place Committee's **Terms of Reference** to the West Yorkshire ICB Board for approval.
- The committee also received the end of year **Annual Reports** highlighting developments and achievements from 2024/25 and revised terms of reference and work plans for the following sub-committees:
 - Wakefield Integrated Assurance Sub-Committee; and
 - Wakefield Transformation and Delivery Collaborative Meeting.