# BOARD MEETING OF THE GOVERNING BODY
TO BE HELD ON TUESDAY, 12 NOVEMBER 2019
BOARDROOM, WHITE ROSE HOUSE
AT 1.00 PM

## AGENDA

### PART 1

<table>
<thead>
<tr>
<th>No.</th>
<th>Agenda Item</th>
<th>Lead officer</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Welcome and Chair’s Opening Remarks</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Apologies for Absence – Jo Webster, Hany Lotfallah, Anna Hartley</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Public Questions and Answers</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Declarations of interest</td>
<td>All present</td>
</tr>
<tr>
<td>5.</td>
<td>a. Minutes of the meeting held on 10 September 2019</td>
<td></td>
</tr>
<tr>
<td></td>
<td>b. Action sheet from the meeting held on 10 September 2019</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Matters arising</td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>Chief Officer Briefing</td>
<td>Pat Keane</td>
</tr>
<tr>
<td>8.</td>
<td>Maternity Services: Pontefract Freestanding Midwifery Led Unit</td>
<td>Pat Keane</td>
</tr>
<tr>
<td>9.</td>
<td>Wakefield CCG Approach to Delivery of the NHS Long Term Plan</td>
<td>Ruth Unwin</td>
</tr>
<tr>
<td></td>
<td>a. NHS Bill</td>
<td></td>
</tr>
<tr>
<td></td>
<td>b. Integrated Care System</td>
<td></td>
</tr>
<tr>
<td></td>
<td>c. Integrated Care Partnership</td>
<td></td>
</tr>
<tr>
<td></td>
<td>d. Primary Care Networks</td>
<td></td>
</tr>
<tr>
<td></td>
<td>e. Model Constitution</td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>Governing Body Assurance Framework Update</td>
<td>Ruth Unwin</td>
</tr>
<tr>
<td>11.</td>
<td>Yorkshire and the Humber Collaborative Commissioning – Integrated Urgent &amp; Emergency Care (IUEC)</td>
<td>Pat Keane</td>
</tr>
<tr>
<td>12.</td>
<td>Quarter 1 2019/20 Quality Reports: Patient Safety and</td>
<td>Suzannah Cookson</td>
</tr>
</tbody>
</table>
Outcomes and CQC Inspection Update Reports  
(Governing Body summaries)

13. Performance Report  
 Jonathan Webb

14. Finance Report Month 6  
 Jonathan Webb

15. Receipt of minutes and items for approval

   a  Audit Committee  
      (i) Minutes of meeting held on 25 July 2019

   b  Finance Committee  
      (i) Minutes of meeting held on 15 August 2019
      (ii) Minutes of meeting held on 19 September 2019

   c  Integrated Governance Committee  
      (i) Minutes of meeting held on 15 August 2019

   d  Clinical Cabinet  
      (i) Minutes of meeting held on 22 August 2019
      (ii) Minutes of meeting held on 26 September 2019

   e  Connecting Care Executive  
      (i) Minutes of meeting held on 11 July 2019

   f  Probity Committee  
      (i) Minutes of meeting held on 21 May 2019

   g  Health and Well Being Board  
      (i) Minutes of meeting held on 19 September 2019

   h  West Yorkshire and Harrogate Joint Committee of CCGs  
      (i) Minutes of meeting held on 1 October 2019

   i  Decisions of the Chief Officer – verbal update

16. Any other business

17. The Board is recommended to make the following resolution:
   “That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest” (Section 1 (2) Public Bodies (Admission to Meetings) Act 1970”.

18. Date and time of next Public meeting:

   Tuesday, 14 January 2020 at 1.00 pm in the Boardroom, White Rose House
19/165 Welcome and Chair’s Opening Remarks

Dr Adam Sheppard, Chair of the CCG, welcomed everyone to the meeting.
19/166 Apologies for Absence

Apologies for absence were received from:

Andrew Balchin Corporate Director, Adults, Health & Communities
Stephen Hardy Lay Member
Jo Webster Chief Officer

19/167 Public Questions and Answers

The Chair informed the committee that a question had been received from a member of the public and advised that the CCG would be writing a response in the usual manner.

A further question was also received from a Unison representative stating that there was an ongoing midwifery staffing crisis and confirmed that the union welcomed the recruitment of the twenty plus midwives. However, he felt that he needed to draw the CCGs attention to the fact that the vacancy crisis was down to staff leaving due to the levels of continual bullying and harassment they faced. He further confirmed that there were hotspots of midwifery management and harassment culture and suggested that appointing newly qualified staff would not be a ‘quick fix’. He advised that this issue should be regularly monitored and unless the issues were addressed the mass exodus would continue.

Pat Keane responded by advising that he was confident that Martin Barkley, Chief Executive of Mid Yorkshire Hospitals Trust would want to respond to this question if he was at this meeting.

Dr Adam Sheppard confirmed that the comments would be passed on to the Trust who should have the opportunity to respond and thanked the Union Representative for highlighting the issues with the Governing Body.

Diane Hampshire asked if the response would be brought back to the Governing Body. Pat Keane responded by saying that as it was raised in public it should be brought back to the Governing Body.

Dr Deborah Hallott further confirmed that there were regular discussions with the maternity partnership and staffing was regularly reviewed at those meetings. Dr Hallott further confirmed that there was a national issue around midwifery recruitment and that there was a new programme to support midwives in post.

Dr Adam Sheppard confirmed that feedback should be brought back to the next Governing Body meeting.

19/168 Declarations of Interest

There were no declarations of interest.
19/169 Minutes of the meeting held on 9 July 2019

The minutes of the meeting held on 9 July 2019 were agreed as a correct record.

19/170 Action sheet from the meeting held on 9 July 2019

The action sheet from the meeting held on 9 July 2019 was noted.

19/171 Matters arising

There were no matters arising.

19/172 Project Search

Gordon Smith, a Business Liaison Officer from Mid Yorkshire Hospitals Trust attended along with one of the interns from Project Search which provides students with learning difficulties the opportunity to gain work experience by working in several departments within the Trust. Gordon provided an overview of the project and showed a brief video which included feedback from some of the students who have been involved with the project.

Gordon explained that the Trust is working in partnership with Highfield School, the Local Authority, Wakefield College and HFT Bradford and commented that the project supports the Trust in understanding the reasonable adjustments that an organisation may need to make when considering the requirements of staff and patients with learning difficulties.

Ryan who has taken part in the project was able to provide an overview of what jobs he had undertaken over the year and was pleased to say that he had applied for a post in the Trust and was successful and now working in the Catering Department at the Trust.

Dr Adam Sheppard commented that he was impressed with the progress interns had made through involvement with this project. Dr Anna Hartley was pleased to advise that following a similar presentation at a recent Health and Well Being Board meeting, colleagues from the CCG, Wakefield District Housing and Project Search colleagues lots of ideas have been discussed including training students with learning disabilities to go into Care Homes to provide valuable feedback and information on the facilities available in Care Homes for residents with a learning difficulty.

Dr Adam Sheppard thanked Gordon and Ryan for attending the meeting and presenting the achievements of those involved with Project Search and wished Ryan good luck in his new job.

It was RESOLVED that:

(i) Members noted the presentation
Chief Officer Briefing

Pat Keane presented this paper providing details of ongoing developments and highlighted the following:

- **West Yorkshire and Harrogate Health and Care Partnership** – all health and care partnerships nationally are required to develop their response to the national NHS Long Term Plan. In West Yorkshire the narrative plan has been in development since March 2019 and has been refreshed to ensure it will meet the requirements of the NHS Long Term Plan.

- **Memorandum of Understanding (MOU) to support procurement of 999 and 111 services** – CCGs across the Yorkshire and Humber region have developed a memorandum of understanding for Integrated Urgent Care to support more effective collaborative arrangements for commissioning of 999 and 111 services. The aim of the MOU is to replicate the WY&H approach across Yorkshire and Humber whereby each ICS/STP will agree a collective Yorkshire and Humber position.

- **Publication of revised guidance for implementing the Friends and Family Test** – NHS England is making changes to the way providers are required to carry out the Friends and Family Test. The new guidance is effective from 1 April 2020. This is a useful tool to inform and support care in hospital.

It was RESOLVED that:

(i) members noted the information and supported ongoing developments outlined in the content of the report

NHS Oversight Framework 2019/20

Pat Keane introduced this paper advising of the development of a new approach to oversight, setting out how regional teams review performance and identify support needs across sustainability and transformation partnerships.

Esther Ashman went on to say that this framework summarises how the new approach to oversight will work from 2019/20 and the work that will be done during 2019/20 for a new integrated approach from 2020/21. For the CCG the NHS Oversight Framework will replace the Integrated Assessment Framework.

Changes to oversight will be characterised by several key principles:

- NHS England and NHS Improvement teams speaking with a single voice, setting consistent expectations of systems and their constituent organisations
- A greater emphasis on system performance, alongside the contribution of individual healthcare providers and commissioners to system goals
- Working with and through system leaders, wherever possible, to tackle
problems
• Matching accountability for results with improvement support, as appropriate
• Greater autonomy for systems with evidence capability for collective working and track record of successful delivery of NHS priorities

Metrics introduced in 2020/21, including system metrics, will include the measures described in the NHS Long Term Plan Implementation Framework. The regional team will determine how frequently they will review CCGs and providers support needs and segmentation based on their performance against the metrics in the assessment framework.

A discussion followed acknowledging the work that is already underway and mutual accountability across organisations is welcomed. The Integrated Care Partnership has mutual accountability high on their agenda and they will receive quarterly reports of progress. Esther Ashman commented that the process for sharing data is yet to be clarified.

It was RESOLVED that:

(i) members noted the new Oversight Framework and the associated dataset through which the CCG and wider system will be measured

19/175 Update on Care Quality Commission/Ofsted Special Educational Needs and Disabilities (SEND) Re-visit June 2019

Mel Brown presented this paper advising that in July 2019 Ofsted published on their website the outcome of their last Care Quality Commission/Ofsted Special Educational Needs and Disability (SEND) Revisit to Wakefield which took place in June 2019. The Inspectors concluded that Wakefield had made sufficient progress in relation to the significant weaknesses identified in the previous SEND inspection in 2017.

The positives identified include:

• marked reduction in the number of children and young people waiting for their ASD assessment
• improvement in the waiting time for under 14 ASD pathway from nearly 2 years in June 2017 to 26 weeks in June 2019
• The parent and carer forum in Wakefield has made a strong contribution to improving the local area’s arrangements for ASD diagnostic assessment and positive feedback has been received from parents on the parent sessions that have been in place between November 2018 and June 2019
• Specialist diagnostic assessment of ASD for children aged 0 to 5 has been timely and effective

Mel provided details of a 12 week programme called Engage for families for ASD which has been very successful and a further three more programmes have been commissioned over the next two years. The CCG are also hosting a series of open learning events for areas working through the ASD pathway.
and the second is scheduled for October 2019.

Members acknowledged the significant progress that has been made.

It was **RESOLVED** that:

(i) members noted the attached published report from CQC/Ofsted and the outcome of sufficient progress; and
(ii) noted the progress that has been made in reducing the waiting times for ASD assessment in Wakefield.

**19/176 Emergency Preparedness Resilience and Response Annual Report 2018/19**

Pat Keane introduced this paper advising that it is an NHS England requirement that the CCG presents an Emergency Preparedness Resilience and Response (EPRR) Annual Report at a public governing body meeting.

Sharon Wallis and Andrew Singleton presented the report advising that the EPRR team work across North Kirklees CCG and Wakefield CCG and the report reflects EPRR activity undertaken across both CCGs.

Andrew referred to the training of loggists to record decisions taken in the response to an emergency incident and advised that there are now 17 loggists trained to provide a resource for on call managers should they be needed to support an event.

Both CCGs undertook the annual NHS England EPRR Core Standard self-assessment in October 2018. The Core Standards assess how well prepared the CCGs are for responding to major, critical and business continuing incidents. Both CCGs submitted a rating of ‘substantial’ compliance based on the CCGs complying with 42 of the 43 core standards. The partial compliance relates to Accountable Emergency Officer attendance at the West Yorkshire Local Health Resilience Partnership. All CCGs will continue to send a representative from their own organisation if the Accountable Emergency Officer is unable to attend. The partial compliance on the standard was consistent across other CCGs.

It was **RESOLVED** that:

(i) members noted the content of the annual report

**19/177 EU Exit Operational Readiness Guidance from the Department of Health & Social Care**

Ruth Unwin presented this paper advising that NHS contingency planning is fully focused on planning for a ‘no deal’ exit. The Department of Health and Social Care issued guidance to the health and care system in England on action to be taken to prepare for a no deal exit from the European Union.
The CCG attended a regional workshop hosted by NHS England on 5 September when NHS England shared information about national contingency arrangements and reviewed local arrangements.

The prospect of exiting the EU on 31 October 2019 means that the short and medium term risks may impact on the health and social care system during the winter period, when the system is most stretched.

All teams within the CCG will be asked to refresh their Business Continuity Plans.

A discussion followed regarding the settled status of EU nationals living in the UK and Dr Adam Sheppard advised that there is no need to change any primary care processes.

Dr Adam Sheppard advised that national leaders have highlighted to NHSE that social care also needs to be considered as part of the risk mitigation planning process.

It was RESOLVED that:

(i) members noted the guidance issued by the Department of Health & Social Care and the actions being taken in the local system to prepare for a potential no deal exit from the European Union.

19/178 Wakefield CCG Safeguarding Children and Adults Annual Report 2018/19

Suzannah Cookson introduced this item. Mandy Sheffield and Karen Charlton advised that this is the second combined Safeguarding Annual Report to the Governing Body which covers the three areas of statutory responsibility; Safeguarding children; Safeguarding adults and Prevent.

Safeguarding continues to be embedded in services commissioned by the CCG and by other NHS and public health commissioners. Performance has continued to improve across the NHS in the last 12 months. The CCG continues to meet its statutory obligations to safeguard children and adults at risk.

The report also detailed the plans and developments for 2019/20 including:

- Establish the Safeguarding Assurance Group as a support to the new Multi-Agency Safeguarding (Children) Partnership
- Gain assurance all action plans are completed following launch of the GP safeguarding standards
- Produce a quarterly GP newsletter containing up to date and relevant safeguarding issues
- Ensure that any legal changes, such as the Liberty Protection Safeguards (LPS) as change to MCA/DoLS are planned for and fulfilled
- Ensure safeguarding is integral to the new models of
commissioning/provider organisations
- Support the Local Authority in preparation for Joint Targets Area Inspection
- Maintain state of readiness for Children Looked after and Safeguarding Inspection (Care Quality Commission)

A discussion followed regarding the use of different systems when collating data. Mandy Sheffield advised that MYHT will be requested to provide a report detailing the assurance received when collating information from several data systems.

It was **RESOLVED** that:

(i) members noted the content of the report; and  
(ii) approved the recommendations.

**19/179 Health of Children in Care Annual Report 2018/19**

Mandy Sheffield presented this annual report providing an update on the current health of ‘Children in Care and Young People’.

Mandy advised that the purpose of the report is to review the work undertaken by the Children in Care Health Team, including the challenges and gaps in service provision and details of the plans in place to redress this.

The report includes recommendations for improvements for future care delivery as recommended by the Statutory Guidance on “Promoting the Health and Well Being of Looked after Children”, Department of Health 2015.

In regard to adoption, the CCG is to develop a children in care specification for the service required from MYHT to ensure that the Trust can fulfil the requirements of their contract.

It was **RESOLVED** that:

(i) members noted the content of this annual report; and  
(ii) noted the recommendations.

**19/180 Wakefield and District Safeguarding Adults Annual Report 2018/19**

Diane Hampshire as interim Chair of the Wakefield and District Safeguarding Adults Board presented this annual report for 2018/19 commenting that this was a stable well functioning Board and has made “Making Safeguarding Personal” a strategic priority for all partners and a recent survey of board members confirmed that all members felt that the board was committed to this work and well on the road to embedding the changes in practice across all the agencies.

It was noted that the membership and role of the Board will continue to be reviewed to broaden the area of prevention to seek further assurance of appropriate processes in place.
It was RESOLVED that:

(i) members noted the content of the report

19/181  Wakefield and District Safeguarding Children Board Annual Report 2018/19

Suzannah Cookson presented this report advising that this is the final report to be submitted to the CCG as the Safeguarding Children Board has been replaced by the Safeguarding Partnership Arrangements.

From September 2019 the three key partners, Local Authority, Police and the CCG will share responsibility for the safeguarding arrangements following a transitional period from June 2019.

The new arrangements in Wakefield have been developed through consideration of the revised national guidance ‘Working Together 2018’. The guidance includes a requirement for Independent Scrutiny and the three key partners in Wakefield have decided to appoint an Independent Scrutineer from September 2019.

Wakefield will continue to contribute to longstanding West Yorkshire wide arrangements including Safeguarding Week, shared multi-agency policies and procedures and through a number of other specific events.

It was RESOLVED that:

(i) members noted the content of this annual report

19/182  Progress on Developing Wakefield’s Integrated Care Partnership

Mel Brown presented this report providing an update on the work underway for the implementation of the NHS Long Term Plan’s focus on the integration of Community and Primary Care.

To take this work forward it has been agreed across the system to rebrand the New Models of Care Board to Wakefield’s Integrated Care Partnership (ICP) and to revise the terms of reference for our integrated care partnership forum. As part of the revision of the terms of reference it was agreed to refresh the Wakefield Integrated Business Rules which were adopted in 2014. Through a number of partner discussions Wakefield Principles Ways of Working document was developed and to date most health and care partners have signed this document. Wakefield CCG is asked to agree that the Chief Officer on behalf of the CCG can sign this document.

Ruth Unwin advised that she had met with legal advisors to look at the ways commissioners and providers can work together on decision making. The proposed districtwide integrated care model is about creating a new system of care delivery, supported by an effective and robust financial and business
model. The partnership will develop an approach to share system level quality, performance and finance updates at the Integrated Care Partnership.

A discussion followed and Richard Hindley queried how lay representation will be fed into the process. Some form of shadow ICP/Health and Well Being Board patient involvement group was one suggestion.

It was RESOLVED that:

(i) members noted the content of this report;
(ii) approved that Wakefield Clinical Commissioning Group can sign the Principles of Ways of Working document; and
(iii) approved the terms of reference for the Wakefield Integrated Care Partnership.

19/183 Experience of Care Report

Suzanne Cookson introduced this report which identifies good practice and where areas for improvement need to be considered to support and improve patient experience.

Laura Elliott advised this report provides an overview of emerging themes and trends for Quarter 4 2018/19 noting that the full report was discussed in detail at the Integrated Governance Committee in July 2019.

The future of the Friends and Family Test has been under consultation over the past year and recommendations are waiting finalisation from NHS England. The main proposals are around the wording of the standard question and the mandatory timing requirements in some settings. NHS England/Improvement intend to run a series of workshops and webinars about the new requirements and colleagues from the Quality Team will be engaging in the webinars when they are available.

A discussion followed regarding the soft intelligence and how any relevant issues are fed back to primary care. Laura advised that they receive feedback as part of the annual quality assurance visit or directly where appropriate.

It was RESOLVED that:

(i) members noted the current trends against indicators in the experience of care dashboard;
(ii) noted the themes relating to experience of care; and
(iii) noted the full report has been discussed in detail at the Integrated Governance Committee.

19/184 Care Quality Commission (CQC) Inspection Update

Laura Elliott presented this update providing an overview of the latest CQC inspection ratings that have been published for providers within the Wakefield
Laura advised that after a recent inspection in May and June 2019, South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) has been rated as Good by the CQC following a previous rating as ‘Requires Improvement’ in July 2018. The report and improvement plan will be discussed at the next SWYPFT Quality Board meeting on 27 September and a more detailed presentation will be given to a future Integrated Governance Committee.

Laura referred to the CQC inspection of Bradford District Care NHS Foundation Trust who has received a Requires Improvement rating. The trust deliver community health services for children and young people registered with NHS Wakefield CCG practices. The contract for 0-19 services is managed by Wakefield Local Authority who has responsibility for commissioning this service. Anna Hartley confirmed that the funding from Wakefield CCG is used solely for the Wakefield population and there is no cross over of funding. A discussion followed and it was agreed that an update will be included in a future Chief Officer Governing Body briefing following further discussions regarding the CQC report taking place at the Integrated Care Partnership.

It was RESOLVED that:

(i) members noted the outcome of recent CQC inspections; and
(ii) the actions being taken to support providers rated as Requires Improvement.

19/185 Performance Report

Jonathan Webb introduced the report which includes performance against the Improvement and Assessment Framework (IAF) for 2018/19 Q4 and CCG performance against the constitutional standards and Yorkshire Ambulance Response Times Dashboard as at June 2019.

Natalie Tolson referred to the 58 IAF indicators and advised that at the end of 2018/19 Q4, 30 indicators were refreshed with latest published data. Of the refreshed indicators, 10 reported a performance improvement, 11 reported a performance reduction, six reported no change and three were unable to be calculated.

Natalie gave an update on the Constitutional Performance highlighting the following:

- Five of the nine cancer waiting time standards achieved the assigned target.
- The two week wait cancer measure for ‘breast’ reports below the 93% standard but has improved significantly by 44% to report at 75.8% for June. Provision data for July reports achievement of the national standard.
- For June, the referral to treatment 18 week standard has deteriorated slightly. The incomplete waiting list has decreased by 382 pathways in
June to 27,131. The waiting list position reports 12% above the March 2018 position.

A discussion followed noting that the Planned Care Improvement Group (PCIG) closely monitors the planned care performance and this information is fed back to the Executive Programme Board. Pat Keane advised that an increased length of stay has an impact on patient flow and discussions are continuing at PCIG to consider a different approach regarding follow up out-patient appointments.

It was noted that winter planning preparation is ongoing.

It was **RESOLVED** that:

(i) members noted the current CCG performance against NHS Constitutional standards; and

(ii) noted those indicators where performance is below target and the exception reports provided.

**19/186 Finance Report Month 4 2019/20**

Jonathan Webb presented this report advising that the year to date position and year-end forecast are both in line with the planned full-year surplus of £2m noting that further to an assessment of financial risks and potential mitigations, a net nil risk has been reported to NHS England/Improvement.

The CCG is forecasting delivery of £10.1m of efficiency against the target of £12.2m. The adverse impact of this is being managed through the contingency reserve of £3.0m which remains unspent. Based on the current forecast, the CCG underlying surplus is £0.9m which will form the starting point of the 2020/21 financial plans.

The 2019/20 Risks and Mitigations table was discussed noting that the progress of the pipeline efficiency schemes and identification of additional flexibility will be reported through the Finance Committee on a monthly basis.

It was **RESOLVED** that:

(i) members noted the content of this report

**19/187 Audit Committee**

The minutes of the Audit Committee were presented.

It was **RESOLVED** that:

(i) Members noted the minutes of the Audit Committee meeting held on 23 May 2019
Minutes of Finance Committee

The minutes from the Finance Committee were presented.

It was RESOLVED that:

(i) Members noted the minutes of the Finance Committee meetings held on 20 June and 18 July 2019

Minutes of Integrated Governance Committee

The minutes from the Integrated Governance Committee were presented.

It was RESOLVED that:

(i) Members noted the minutes of the Integrated Governance Committee meetings held on 20 June and 18 July 2019

Minutes of Clinical Cabinet

The minutes from Clinical Cabinet were presented.

It was RESOLVED that:

(i) Members noted the minutes of the Clinical Cabinet meetings held on 27 June and 25 July 2019

Minutes of Connecting Care Executive

The minutes from Connecting Care Executive were presented.

It was RESOLVED that:

(i) Members noted the minutes of the Connecting Care Executive meeting held on 9 May 2019

Minutes of Health and Wellbeing Board

The minutes from Health and Wellbeing Board were presented.

It was RESOLVED that:

(i) Members noted the minutes of the Health and Wellbeing Board meetings held on 21 March and 18 July 2019

Minutes of West Yorkshire & Harrogate Joint Committee

The minutes from West Yorkshire & Harrogate Joint Committee were presented.
It was **RESOLVED** that:

(i) Members noted the minutes of the West Yorkshire & Harrogate Joint Committee meeting held on 2 July 2019

19/194 **Decisions of the Chief Officer**

There were no additional decisions by the Chief Officer.

19/195 **Any other business**

None

19/196 **Date of next meeting**

Tuesday, 12 November 2019, Boardroom, White Rose House.
<table>
<thead>
<tr>
<th>Minute No</th>
<th>Topic</th>
<th>Action Required</th>
<th>Who</th>
<th>Date for Completion</th>
<th>Progress</th>
</tr>
</thead>
</table>
| 19/134    | Public Health Update on Sexual Health Services    |  • Consider what support could be provided through Primary Care Home  

  • Consider how to progress integrating commissioned services including the sharing of data | Anna Hartley/ Dr Deborah Hallott/ Joanne Hinchcliffe | November 2019          | Provider engagement sessions to be held in the New Year, which we will encourage PCH to participate in, to inform our future sexual health procurement model  
Meeting set up with Dr Deborah Hallott for 5/12/19. Also looking to involve relevant CCG commissioning leads. |
<p>| 19/137    | Pontefract Freestanding MLU Case for Change       |  • Present proposed options following deliberative event in September 2019                                                      | Pat Keane                 | November 2019       | Agenda item 8                                                                                                                            |</p>
<table>
<thead>
<tr>
<th>Minute No</th>
<th>Topic</th>
<th>Action Required</th>
<th>Who</th>
<th>Date for Completion</th>
<th>Progress</th>
</tr>
</thead>
</table>
| 19/167    | Public Questions | • Public question  
  • Question from Unison representative | Pat Keane   | November 2019      | Public Question response attached at Appendix 1 to the action sheet.  
Unison representative question, response included in Agenda item 8 |
| 19/182    | Progress on Developing Wakefield’s ICP | • Clarify how lay representation will be sought | Mel Brown   | January 2020       | ICP development session taking place on 6 November 2019. Feedback will be provided after this event if lay representation is required for ICP. |
| 19/184    | CQC Inspection Update | • Provide update as part of future Chief Officer briefing following discussion of the report at Integrated Care Partnership | Ruth Unwin/Laura Elliott | November 2020      | Update in the Chief Officer Report – Agenda item 7 |
Redacted response to a question received from a member of the public

I write in response to your correspondence about the cost to the NHS when patients do not attend for appointments, referred to as DNAs. This is something which both GPs and hospital services monitor and there are a number of initiatives in place to remind people to contact services if they are unable to keep an appointment.

The remainder of the response related to a personal matter and is not shared.
<table>
<thead>
<tr>
<th>Title of meeting:</th>
<th>Governing Body</th>
<th>Agenda Item:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Meeting:</td>
<td>12 November 2019</td>
<td>7</td>
</tr>
<tr>
<td>Paper Title:</td>
<td>Chief Officer Briefing</td>
<td></td>
</tr>
<tr>
<td>Purpose (this paper is for):</td>
<td>Decision</td>
<td>Discussion</td>
</tr>
<tr>
<td>Report Author and Job Title:</td>
<td>Ruth Unwin, Director of Corporate Affairs</td>
<td></td>
</tr>
<tr>
<td>Responsible Clinical Lead:</td>
<td>Not applicable</td>
<td></td>
</tr>
<tr>
<td>Responsible Governing Board Executive Lead:</td>
<td>Jo Webster, Chief Officer</td>
<td></td>
</tr>
</tbody>
</table>

Recommendation:

- To note the content for information and support on-going developments outlined in the content of the report.

Executive Summary:

The report covers:

- West Yorkshire and Harrogate Health and Care Partnership
- West Yorkshire and Harrogate Lung Cancer programme
- Wakefield Health and Wellbeing Board
- New leader appointed to Wakefield Council
- Assurance on 0-19 services following CQC report on Bradford Care Trust
- Yorkshire Ambulance Service CQC rating
- Stroke rehabilitation services
- Health facilities for City Fields development
- Every Mind Matters national campaign
- Preparations for EU Exit
- Data sharing agreement between West Yorkshire and Harrogate CCGs

Link to overarching principles from the strategic plan:

| Reduction in hospital admissions where appropriate leading to reinvesting in prevention | ✓ |
| New Accountable Care Systems to deliver new models of care | ✓ |
| Collective prevention resource across the health and social care sector and wider social determinant partners | ✓ |
| Expanded Health and Wellbeing board membership to represent wider determinants | ✓ |
| A strong ambitious co-owned strategy for ensuring safe and healthy futures for children | ✓ |
| Outcome of Impact Assessments completed (e.g. Quality IA or Equality IA) | Not applicable |
| Outline public engagement – clinical, stakeholder and public/patient: | Not applicable |
| Assurance departments/ organisations who will be affected have been consulted: | CCG Leadership Team |
| Previously presented at committee / governing body: | A Chief Officer Report is presented at every Governing Body meeting. |
| Reference document(s) / enclosures: |  |
| Risk Assessment: | Not applicable |
| Finance/ resource implications: | Not applicable |
West Yorkshire and Harrogate Health and Care Partnership

The draft Five Year Plan for West Yorkshire and Harrogate Health and Care Partnership will be discussed at the next public meeting of the Partnership Board on 3 December.

The draft plan builds on local plans that have been developed in each of the six areas that make up the partnership, supplemented with additional improvements that it has been agreed can best take place at a West Yorkshire and Harrogate level. The draft plan has been developed considerably to reflect comments received since it was published at the end of August.

Alongside the publication of the draft Five Year Plan, there will be a summary – this will further set out the uniqueness and strengths of the six places, and the richness and diversity of the communities which make up West Yorkshire and Harrogate, as well as identifying ten top priority ambitions that partners will work on together.

These include:

- Reducing the gap in healthy life expectancy for West Yorkshire and Harrogate versus England, and within that closing the gap between the poorest 10% and the rest.
- Halting the rise in childhood obesity for all children and significantly reducing the gap for children living in the households with the lowest incomes.
- A reduction in the gap in life expectancy for adults and children with mental health, learning disabilities and autism compared with the wider population.
- Increasing our early diagnosis rates for cancer, offering an additional 1000 people the chance of curative treatment.
- Taking a zero suicide approach.
- Working together to tackle climate change.
- Supporting local labour markets and fair growth in employment and opportunities for all.

The Joint Committee of CCGs met on 5 November 2019. Key issues under discussion were development of a common approach to knee surgery across all partner CCGs and to screening of patients being treated with hydroxychloroquine, which is increasingly used to treat autoimmune diseases and in dermatology and rheumatology and emerging treatments in oncology because it can have better outcomes than other treatments, but can affect vision when taken over a long period of time.

The Joint Committee also discussed governance arrangements and work that is currently underway to review voting arrangements and the Memorandum of Understanding that underpins the partnership’s approach to joint working and decision making.

The full set of papers can be found here.
**West Yorkshire and Harrogate Lung Cancer programme**

As part of the WY&H ICS Cancer programme, Wakefield is one of two areas to be identified as a pilot for tackling Lung Cancer. The purpose of the programme is to introduce a system wide focus on the early identification of Lung Cancer. Taking a systemic approach four interventions are being deployed:

- Optimising Smoking Cessation Support
- Push & Pull Symptom Awareness Campaigns and Community Engagement
- Risk Identification in Primary Care with direct to Low Dose CT scanning (based on largely on the Manchester model)
- Optimising the Lung Cancer Pathway

The pilot has initially been implemented with lung health checks at two primary care practices, Dr Diggle & Phillips and Dr Singh & Partners in the South East of the district although the ICS are exploring how this can be extended further across the district. In addition Ultra Low Dose CT has been delivered from a mobile LDCT in the car park at Church View Health Centre. A smoking cessation offer has also been included in to this offer.

To date 2224 invitations to patients have been sent out with 954 health checks booked and 875 already completed. 350 patients have been identified as having a raised lung cancer risk and 21% of current smokers have accepted a referral to YSF. Two cases of lung cancer have been detected in the first scanning session and are potentially treatable. The aim is that overall 68 lives will be saved in the pilot area as a result of this work.

**Wakefield Health and Wellbeing Board**

The next meeting of the Health and Wellbeing Board is due to take place on 14 November 2019 at St Catherine’s Community Centre. The focused discussion for this month will be around the priority ‘Giving Every Child the Best Start in Life’ and will in particular centre on the mental health and wellbeing of our children and young people.

**New Leader Appointed to Wakefield Council**

Councillor Denise Jeffery appointed as leader for Wakefield Council, following the resignation of Councillor Peter Box. Councillor Jeffery will take up post from 1 December.

**Bradford District Care NHS Foundation Trust CQC Inspection report**

Following the report to Governing Body in September that community health services for children and young people provided by Bradford District Care NHS Foundation Trust (BDCT) had moved from Good to Requires Improvement following a recent CQC inspection, the CCG has received assurance from Wakefield Council which commissions 0-19 services for Wakefield from the Trust.
The report was based on inspections that took place in April 2019, which involved visits to different locations where service teams are based and deliver services for both Bradford and Wakefield Local Authority Areas.

The report did not take into account that Bradford District Care NHS Foundation Trust 0-19 services in Bradford and Wakefield are delivered under separate contracts with different specifications, separate staff teams and resource allocations.

Public Health, as commissioner for the Wakefield 0-19 service, has developed an assurance framework with BDCT to understand what concerns of the report relate to Wakefield and provide assurances on Wakefield 0-19 Services, which has been shared with CCG colleagues. In addition it has been agreed that the 0-19 Service will report and review areas through the quarterly contract management meetings e.g. sickness levels, caseload numbers. Work is ongoing with partners to review the ‘health’ contribution to child protection meetings and strategy discussions to alleviate the pressure on the Wakefield 0-19 services.

Wakefield Council has confirmed it is assured that BDCT is delivering a high quality service to the public. The most recent annual report shows that key performance indicators for the district are higher than the England average.

**Yorkshire Ambulance Service rated ‘Good’**

The Care Quality Commission (CQC) reviewed some of the services provided by Yorkshire Ambulance Service NHS Trust (YAS) in May and July. The review included an unannounced inspection of the emergency call handling centres in Wakefield and York and YAS's patient transport service (PTS)

CQC inspections focus in five key questions: are services safe, effective, caring, responsive and well-led. YAS was rated ‘Good’ in all of the five key questions.

Inspectors found outstanding practice when it came to the speed of operators answering 999 calls from the public. The call centre handles 2,700 emergency calls every day and found to be one of the quickest in the country.

**Stroke Rehabilitation Service**

Mid Yorkshire Hospitals NHS Trust has reassured the public that there has been no change to stroke services following publicity about a reduction in the number of beds in use at Pontefract Hospital.

People who require emergency treatment following a stroke are taken to the specialist unit at Pinderfields Hospital. This is in keeping with national best practice as Pinderfields is one of a number of specialist centres in the region offering hyper-acute stroke care.

The Trust has temporarily taken 12 beds out of use on the medical ward at Pontefract. 30 beds are still in use on the ward, which is mainly used for rehabilitation and step-down care for stroke patients and people requiring post-
operative care. Improvements in the care of people following a stroke means patients are able to be discharged home sooner, resulting in less beds being needed at Pontefract for these patients. This allows staff to be deployed elsewhere in the Trust where demand is greater.

City Fields

The developer of the City Fields estate in Wakefield, has secured planning permission for a health facility as part of a retail and leisure complex. The CCG is working with the developer to explore the possibility of the site being used to provide GP and primary care services. Discussions are at an early stage and any proposals will be subject to involvement and dialogue with local people.

Every Mind Matters

Public health England launched a campaign on 7 October 2019 to support everyone to feel more confident in taking action to look after their mental health and wellbeing by promoting a range of self-care actions.

Preparations for EU Exit

The CCG has continued to engage with NHS England in preparation for exit from the European Union. This has included undertaking assessment and mitigation of any risks across the system and participation in scenario planning exercises. The requirement to submit situation reports has been suspended following the decision to delay the date for exiting the EU to January 2020.

Information Governance – Data Sharing Agreements in the current landscape.

The WY&H CCG BI Working Group are currently in the process of preparing a shared NHS Digital Data Sharing Agreement for commissioning data to allow collaborative working across CCG’s. The DSA will allow CCGs to work efficiently and will support ICS level reporting which is required and will become more of the norm as we move to a more integrated way of working.
### Title of meeting:
Governing Body

### Date of Meeting:
12 November 2019

### Paper Title:
Maternity Services: Pontefract Freestanding Midwifery Led Unit

### Purpose (this paper is for):
<table>
<thead>
<tr>
<th>Decision</th>
<th>Discussion</th>
<th>Assurance</th>
<th>Information</th>
</tr>
</thead>
</table>

### Report Author and Job Title:
Tracy Morton: Service Delivery and Transformation Manager. Women’s, Maternity and Children’s Services

### Responsible Clinical Lead:
- Suzannah Cookson: Chief Nurse WCCG
- Dr Debbie Hallott: GP Clinical Lead Maternity and Children’s Services

### Responsible Governing Board Executive Lead:
Pat Keane: Chief Operating Officer

### Recommendation:
It is recommended that the Governing Body:

i) Notes the current situation in relation to the Midwife Led Unit at Pontefract and the decision by the Mid Yorkshire Hospitals NHS Trust to temporarily suspend the birthing service to maintain safety across the maternity service.

ii) Notes the full process that is being undertaken to secure a long term solution for maternity services in the Wakefield district, including the future provision of maternity services at Pontefract.

### Executive Summary:
This paper is in two parts: the first part provides an update to the Governing Body on the decision by the Mid Yorkshire Hospitals NHS Trust to temporarily suspend the birthing service at the Pontefract freestanding midwife led unit (FMLU) to maintain safety across the whole maternity service.

The second part describes the process being led by the CCG to secure a long term solution for maternity services, including considering the future provision of maternity services at Pontefract.

- The November 2018 Governing Body discussed the request from MYHT to enter into a formal process regarding the future provision of midwife led births at Pontefract Hospital. This was discussed again at the January 2019 Governing Body which provided the case for change with the option of ceasing to offer women the facility to give birth at the Pontefract FMLU while retaining the antenatal and postnatal services.
• The case for change described how the FMLU at Pontefract Hospital has been under-utilised since it opened despite efforts to promote and increase awareness and demand for the service. The birthing unit had been subject to short term closures on a number of occasions.

• The case for change was taken through the NHSE formal change assurance process with full public engagement during the course of 2019 and engagement with the Overview and Scrutiny Committee, MPs and local councillors, as well as local media and social media coverage. The purpose of this phase of engagement was to help to inform the development of potential solutions.

• The process has been closely supported and advised by the Yorkshire and Humber Clinical Senate, an independent, non-statutory clinical advisory group hosted by NHSE and made up of experts in the field who have provided clinical expertise and impartial advice.

• During this period maternity services in Wakefield district have been under increased pressure in particular with staffing and capacity issues.

• Wakefield is currently under scrutiny from NHSE/I on relation to delivery of Continuity of Carer which is a key commitment outlined in the NHS Long Term Plan.

• As a result of local pressures in the maternity system a partial on-demand service was implemented in the Pontefract FMLU from 29 July 2019. This means that the service is open 7am to 7pm weekdays and then “on-demand” during evenings and weekends. Staffing pressures have led to the decision announced by MYHT on 30 October to temporarily suspend births at the Pontefract Midwife Led Unit from 8 November 2019.

• Staffing pressures in the maternity system are not restricted to Wakefield: the West Yorkshire and Harrogate Local Maternity System (WY&H LMS) has highlighted maternity staff shortages to be a regional and national issue.

• The feedback from the Clinical Senate was they agreed that, given the low number of births and staffing pressures, it was not a realistic solution to retain Pontefract MLU as a unit staffed 24/7 by a resident midwife and a healthcare assistant. Changing this to an on-demand birthing service was considered an innovative way to retain the option of a freestanding midwifery led unit in Pontefract. However the Senate felt that some points areas needed further development, in particular to describe workforce capacity and service sustainability. The Senate also advised that proposals for the FMLU needed to be considered in the context of the wider vision for maternity services.

• The recommendations made in the Clinical Senate final report around scoping in more detail the on-demand model will be taken forward.

• Maternity services will be under the spotlight locally during the next 12 months starting with a local Task Force being established. Continuity of Carer is being monitored by WY&H LMS with NHSE/I input with a meeting planned for 11 November. Maternity services will be discussed at the Wakefield CCG Integrated Governance Committee (IGC) on 21 November.

<p>| Link to overarching principles from the strategic plan: | Reduction in hospital admissions where appropriate leading to reinvesting in prevention |
| | New Accountable Care Systems to deliver new models of care |
| | Collective prevention resource across the health and social care sector and wider |</p>
<table>
<thead>
<tr>
<th>social determinant partners</th>
<th>Expanded Health and Wellbeing board membership to represent wider determinants</th>
</tr>
</thead>
<tbody>
<tr>
<td>A strong ambitious co-owned strategy for ensuring safe and healthy futures for children</td>
<td>✓</td>
</tr>
<tr>
<td>A shift towards allocation of resources based upon primary and secondary prevention and social determinants of ill health</td>
<td>✓</td>
</tr>
<tr>
<td>Transforming to become a sustainable financial economy</td>
<td>✓</td>
</tr>
<tr>
<td>Organising ourselves to deliver for our patients</td>
<td>✓</td>
</tr>
</tbody>
</table>

**Outcome of Impact Assessments completed (e.g. Quality IA or Equality IA)**

A full Integrated Impact Assessment has been drafted for the Pontefract FMLU Case for Change and will continue to be developed as necessary.

**Outline public engagement – clinical, stakeholder and public/patient:**

Full public and staff engagement undertaken by WCCG during Jan 2019 and March 2019. Independent report published.  

NHSE formal change assurance process followed  

Yorkshire and Humber Clinical Senate fully engaged  

Deliberative Clinical Event 13 June 2019 involving full range of local clinicians  

Public Engagement event 12 September 2019  

Discussion at Overview and Scrutiny Committee:  


Updates and discussion at Public Involvement and Patient Experience Committee (PIPEC) March and June 2019  

Update to WCCG Clinical Cabinet September 2019.  

Updates to Wakefield Maternity Voices Partnership (MVP) January 2019 and October 2019.

**Assurance departments/organisations who will be affected have been consulted:**

CCG Senior Leadership Team  
Mid Yorkshire Executive team  
Clinical Cabinet  
Mid Yorkshire Hospitals clinicians  
NHS England  
Clinical Senate  
Health and Wellbeing Board
<table>
<thead>
<tr>
<th>Overview and Scrutiny Committee</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Previously presented at committee / governing body:</strong></td>
</tr>
<tr>
<td>November 2018</td>
</tr>
<tr>
<td>January 2019</td>
</tr>
<tr>
<td><strong>Reference document(s) / enclosures:</strong></td>
</tr>
<tr>
<td>• January 2019 Governing Body Paper with original Case for change</td>
</tr>
<tr>
<td>• The final public and staff engagement report</td>
</tr>
<tr>
<td><strong>Risk Assessment:</strong></td>
</tr>
<tr>
<td>There are two risks relating to maternity on the CCG risk register. They are:</td>
</tr>
<tr>
<td>Delivery of NHS Long Term Plan commitments:</td>
</tr>
<tr>
<td>• Continuity of carer target of 20% of women on a continuity of care pathway by March 2020</td>
</tr>
<tr>
<td>• Saving Babies Lives Care Bundle 2</td>
</tr>
<tr>
<td><strong>Finance/ resource implications:</strong></td>
</tr>
<tr>
<td>No financial savings are anticipated as a result of any service change. The objective is to ensure optimum use of current resources.</td>
</tr>
</tbody>
</table>
PART 1

1. Current situation regarding midwife led births at Pontefract Hospital

The purpose of this paper is to set out the current situation at Pontefract Hospital with regard to the decision taken by the Mid Yorkshire Hospitals NHS Trust to temporarily consolidate midwife led births at the Pinderfields birth centre.

NHS Wakefield CCG has been informed by the Trust that it cannot currently maintain maternity services across three sites and in the community due to the fact that they did not recruit as many midwives as they hoped to in September. The situation is compounded by nine midwives being on maternity leave and 6% sick leave level.

NHS Wakefield CCG is aware of the challenges experienced by the Mid Yorkshire Hospitals NHS Trust running hospital services across three sites. This presents operational difficulties and workforce pressures, particularly in specialties where there is a shortage of trained staff.

2. Previous work undertaken

A lot of work has been done in recent years to address these difficulties, including reorganisation of services to make the best use of staff and minimise the need for people to travel for care and treatment that they need regularly.

The maternity service run by Mid Yorkshire Hospitals NHS Trust is exceptional in that it is one of only a handful of Trusts in the country to offer a such a wide choice of home birth, two freestanding midwife led units, an alongside midwife led unit and a consultant led obstetric ward At the same time the Trust provides comprehensive community ante-natal and post-natal care. The difficulties this poses have been known for some time. In summer 2018, the Trust took the decision to temporarily close the MLU at Pontefract for a six week period due to concerns about being able to safely sustain services because of staff shortages.

The Trust stood by its commitment to reopen the service in November 2018 and since then has been working very hard to keep all the maternity services operating safely – including putting in place a new staffing model to reduce the impact on other services.

Alongside this, the CCG has been working with the Trust to try to identify a long term solution. Our aspiration was to be able to maintain 24/7 access to midwife led births at Pontefract Hospital until this work was concluded. Feedback from public engagement carried out to help inform a decision on the long term solution tells us people want services to be local where possible but most importantly, they want services to be safe.
The CCG agrees safe services must be the top priority and it is, therefore accepted that, where a choice has to be made about which services should be withdrawn to maintain safety, priority must be given to those services where there is the greatest risk due to the number or acuity of patients.

Consolidation of the birthing element of the Pontefract service temporarily will mean staff can be deployed to support women and babies in the other hospitals. This decision also means that the Trust is able to continue to provide comprehensive midwifery support to women and babies throughout pregnancy and after the birth in their local community.

There will be no change to ante-natal and post-natal services provided at Pontefract Midwife Led Unit or in the community.

3. **Review and monitoring**

This temporary measure is an operational decision which is rightly taken by the Trust and the CCG has been given assurances that there is no alternative. This position will be kept under review. In particular, the CCG will be monitoring how the temporary withdrawal of the option women have of giving birth at Pontefract is impacting on the care of women and babies across the whole maternity service.

Whilst is regrettable that this decision has had to be taken before a long term solution can be found, there remains a commitment to find a long term solution which ensures sustainability of the whole maternity service. No decision has been made on the long term position and work will continue to support that process.

**Part 2: Change Assurance Process to Secure Long Term Solution for Maternity Services**

4. **Case for change rationale**

A case for change for the Pontefract Free Standing Midwifery Led Unit (FMLU) was presented to and discussed with Governing Body in November 2018 and again in January 2019. The case for change outlined that the unit was being under-utilised and was set in the context of local pressures across the whole maternity system and the national and regional maternity policy.

The paper presented to Governing Body in January 2019 outlined the formal NHSE change assurance process that the case for change would need to be taken through and the associated timescale. This involved comprehensive engagement with the public, and key stakeholders including the Overview and Scrutiny Committee, MPs, local councillors as well as local media and social media coverage.
5. Case for Change Process and Engagement

The CCG engagement plan has been informed by advice from the independent Consultation Institute. During the course of the year the process has involved a range of engagement activities which are summarised below. The more detailed engagement with Clinical Senate is detailed in this paper.

<table>
<thead>
<tr>
<th>Date 2019</th>
<th>Activity</th>
</tr>
</thead>
</table>
| January   | Public and staff engagement  
Initial engagement with Yorkshire and Humber Clinical Senate  
Presentation to OSC  
Presentation to CCG Governing Body |
| February  | Public and staff engagement with parallel running Clinical Senate engagement |
| March     | Conclusion of public engagement  
Meeting with Clinical Senate to discuss potential solutions  
Presentation at OSC  
Presentation at PIPEC |
| April     | Draft public engagement report received |
| May       | Potential solutions provided to Clinical Senate  
Clinical Senate first report and recommendations received |
| June      | Deliberative Clinical Event  
Presentation at OSC  
Presentation at PIPEC |
| July      | Outcome from the clinical event with potential solutions submitted to Clinical Senate |
| August    | Further detailed discussions with Clinical Senate  
Presentation to OSC |
| September | Formal feedback received from Clinical Senate  
Public Deliberative Event |

6. Public and Staff Engagement

The public and staff engagement process undertaken between January and March 2019 provided an opportunity to further explore the issues raised by stakeholders. The focus has been on obtaining a deeper understanding of women’s choices about giving birth and the likely impact if the service were to change. The priority, therefore, has been to engage directly with people who have recently had a baby or are likely to be impacted in the future by any change to the maternity service, in particular women and prospective parents living in the East of the district.

The outputs of this process were analysed independently by The Campaign Company and their report was considered along with feedback from the
Yorkshire and Humber Clinical Senate and any additional evidence put forward by or requested from the Mid Yorkshire Hospitals NHS Trust. The final engagement report can be found on our website.

6.1 Responses to Public Engagement

There were 900 responses to the public engagement in various formats. These were predominantly quantitative feedback with qualitative feedback given through open questions in the survey and at engagement sessions. Respondents were self-selecting. 80% were in the target group of current or prospective users of the services.

6.2 Public and staff views

Below is a summary of key findings from the engagement.

- Of those who responded to the engagement survey 47% had given or were about to give birth at Pinderfields Obstetric Unit because they needed access to consultants.

- 40% of people living in the East of the Wakefield District said they would prefer to give birth in Pontefract FMLU compared to 6% in the West of Wakefield.

- Being able to give birth in a place that was easily accessible was the most important factor that influenced where they chose to give birth.

- 48% of respondents said they would use Pinderfields MLU as an alternative to Pontefract if the birth centre were to close. The main concerns about the impact of closure were:
  - further to travel to give birth during a stressful time;
  - choice would be reduced;
  - the potential increased burden on other services and impacts on quality of care.

- In terms of staff concerns if the birth centre were to close:
  - 48% thought there would be an impact on other maternity services;
  - choice would be reduced;
  - would not meet the needs of the growing population in the area,

- There was broad consensus that access to safe and high quality staffing and care close to home were important factors for future planning.

- In moving forward for planning services both staff and the public thought appropriately skilled staff was a key consideration. The public wanted access to high quality care closer to home and choice to be key considerations. Staff were concerned with having the right skills and staff
available through the whole of the pregnancy and post-natal period and that women and families were listened to so that their needs are met.

- The services and staff at Pontefract Midwife Led Unit are valued by service users.

7. Yorkshire and Humber Clinical Senate Engagement

NHS Wakefield CCG and Mid-Yorkshire Hospitals NHS Trust have engaged with NHS England on the formal service change assurance process to ensure all due process has been followed. The engagement with NHSE started in October 2018 with guidance and advice and the start of the formal process. The CCG also engaged with the Y&H Clinical Senate, an independent, non-statutory clinical advisory group hosted by NHSE and made up of experts in the field who have provided clinical expertise and impartial advice. Clinical Senate reviews are designed to ensure that proposals for large scale change and reconfiguration are sound and evidence-based, in the best interest of patients and will improve the quality, safety and sustainability of care.

The process for involvement of the Clinical Senate is very structured with set timescales, activities and deadlines, culminating in a final report with recommendations. The Clinical Senate provides an in-depth review of all of the information provided in the original case for change and the outcome of public and stakeholder engagement, probing deeper for further information as required. The Clinical Senate has worked with the CCG and Mid-Yorkshire to explore all of the potential solutions that may be available in going forward. The feedback and final report from the Clinical Senate can be found at:


The detailed steps taken and outcomes from the Clinical Senate Engagement are shown below:

**Clinical Senate Engagement Summary**

<table>
<thead>
<tr>
<th>Date</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oct/Nov 2018</td>
<td>Discussions with NHSE on case for change process.</td>
</tr>
<tr>
<td></td>
<td>Agreement on need for taking this through appropriate elements of change assurance process and to involve support from Y&amp;H Clinical Senate.</td>
</tr>
<tr>
<td></td>
<td>Discussion with Clinical Senate agreeing scope, remit and timescales for review.</td>
</tr>
<tr>
<td>January 2019</td>
<td>Case for change and supporting documentation provided to Clinical Senate</td>
</tr>
<tr>
<td>February 2019</td>
<td>Terms of reference of Clinical Senate agreed</td>
</tr>
<tr>
<td></td>
<td>Clinical Senate expert panel shared comments on the case for change by email and supplemented this with several internal clinical discussions by teleconference. Detailed information sent to Clinical Senate at their request</td>
</tr>
</tbody>
</table>
following their review of the case for change

<table>
<thead>
<tr>
<th>Month</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 2019</td>
<td>Meeting with Clinical Senate, CCG and MYHT representatives and other key stakeholder partners for robust clinical discussion. Further detailed information provided to Clinical Senate following the meeting.</td>
</tr>
<tr>
<td>April 2019</td>
<td>First draft report from Clinical Senate</td>
</tr>
<tr>
<td>May 2019</td>
<td>Clinical Senate first report received. <strong>The report recommended that commissioners need to:</strong> Prioritise both consideration of the staffing pressures and maintenance of staff skills and the longer-term capacity in the system to manage growing demand across the MYHT maternity services, before determining the possible solutions for the service. The capacity analysis needs to take into account the housing growth, birth rate and complexity of the women giving birth to clearly assess the ability of the workforce and estate to manage the demand. Undertake further analysis of the results from patient and staff engagement to understand the factors that influence patient choice and how best to support staff as services develop. Develop a vision for the whole local maternity system and reflect engagement with the Local Maternity System (LMS) to show how the regional opportunities for the MLU have been taken into account. Explore opportunities for this service in the future which can include, but are not limited to, a limited hours’ service (on-demand), continuity of carer hub and expansion of community services.</td>
</tr>
<tr>
<td>13 June 2019</td>
<td><strong>Deliberative Clinical Event</strong> looking at potential future solutions taking into account the May Clinical Senate report recommendations. The outcomes of this were detailed in a paper to Clinical Senate on 12 July (see below).</td>
</tr>
</tbody>
</table>
| 12 July 2019 | **Deliberative Clinical Event outcome paper sent to Clinical Senate**   Clinical Senate were asked specifically for feedback on “whether the proposal for the future of the Midwifery Led Unit at Pontefract Hospital balances the requirements for safety and quality, choice and midwifery workforce.” Key outcomes and recommendations from the Clinical event sent to Clinical Senate summarised below:  
  1. Pontefract FMLU should be retained as an on-demand unit for women giving birth. |
2. The on-demand unit should be developed as part of the district-wide midwifery model incorporating continuity of carer and the re-organisation and training of staff to deliver this.

3. The site should be developed into a midwifery community hub with a realistic roll out plan and timescale.

4. These plans would include the potential development of the Dewsbury FMLU as a community hub.

<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>17 July 2019</td>
<td>Clinical Senate requested more detail on the proposed on-demand model of care, as well as a description of how the staff and patient feedback had and would continue to be used to develop the proposed model.</td>
</tr>
<tr>
<td>29 July 2019</td>
<td>Mid-Yorkshire implement a partial on-demand service at Pontefract FMLU due to operational pressures. The partial on-demand service opens from 7am until 7pm on weekdays and then open ‘on demand’ during evening and weekends.</td>
</tr>
<tr>
<td>30 July - 1 Aug 2019</td>
<td>CCG provided Clinical Senate with further detail on the operational detail of the on-demand model (supplied by MYHT) as requested by the Senate.</td>
</tr>
<tr>
<td>August &amp; September</td>
<td>Further information on the operational detail of the on-demand unit (provided by MYHT) sent by the CCG to Clinical Senate</td>
</tr>
<tr>
<td>10 September</td>
<td><strong>Draft final report from Clinical Senate received.</strong> Clinical Senate agreed that with the low number of births and the staffing pressures it was not a realistic solution to retain Pontefract MLU as a unit staffed 24/7 by a resident midwife and a healthcare assistant. Changing this to an on-demand service was considered an innovative way to retain the option of a freestanding midwifery led unit in Pontefract. However the Senate said more evidence was needed about the on-demand model to establish whether this was sustainable and was the most appropriate strategic solution. Overall, the Senate was supportive of the proposals for the community hub and the continuity of carer pathways, The Clinical Senate final report and feedback was published on 25 September 2019.</td>
</tr>
<tr>
<td></td>
<td><strong>The report recommendations were:</strong> To further analyse the pressures on the staffing of maternity services for the whole population served by Mid Yorkshire Hospitals NHS Trust, and the maintenance of staff skills, to ensure these are addressed in the future model of service.</td>
</tr>
</tbody>
</table>
To work with the Local Maternity System to comprehensively analyse the capacity across the Mid Yorkshire Hospitals NHS Trust maternity service, taking into account housing expansion, birth rate and acuity, to demonstrate the ability to manage the future demand in maternity services.

To explain the position of Dewsbury MLU more clearly within the future presentation of Mid Yorkshire NHS Hospitals HS Trust maternity services, and to reflect engagement with the Local Maternity System to show how the regional opportunities for the MLU has been taken into account.

To analyse the finalised patient and staff engagement to fully understand the factors that influence patient choice and to help to support staff in the service changes.

<table>
<thead>
<tr>
<th>12September</th>
<th>Public Engagement Event.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Headline feedback from the Clinical Senate was shared with attendees.</td>
<td></td>
</tr>
<tr>
<td>Attended by members of the public, local councillors, press and MPs. The engagement event focused on the issues that had emerged during the public engagement and how maternity services might look in the future. The event was well received and helpful in particular in attendees having a better understanding of the pressures on local maternity services and the need to consider all possible solutions.</td>
<td></td>
</tr>
<tr>
<td>The outcomes from the public engagement event were:</td>
<td></td>
</tr>
<tr>
<td>Antenatal care:</td>
<td></td>
</tr>
<tr>
<td>• Antenatal care would benefit from closer working between the NHS and community groups, increased availability and consistency of messages as well as reach across the community.</td>
<td></td>
</tr>
<tr>
<td>• Antenatal education was seen as helpful in enabling women to make a choice of where to give birth. The access to antenatal education should reach everyone and information should be available to women on clinics, classes and groups that are available. Suggestion was made to consider bringing mums of similar needs to the same antenatal classes, e.g. language/cultural support or same gestation stage.</td>
<td></td>
</tr>
<tr>
<td>• Women should be given a clear message that they can change their mind about where to give birth and they should have a say in where to give birth as opposed to being told. This should include their view of their own risk.</td>
<td></td>
</tr>
<tr>
<td>Birth:</td>
<td></td>
</tr>
<tr>
<td>• Home birth could be a better option for some women, considering their personal circumstances.</td>
<td></td>
</tr>
<tr>
<td>• Need to consider how women are reassured about different places of birth and the on-demand model.</td>
<td></td>
</tr>
</tbody>
</table>
| • Changes and uncertainty around the service may impact on the messages that are given to women by staff. Need to consider the
messages that are given to women about the options available to them of where to birth.

- Care should include smaller aspects, such as clean environment as these add to the overall experience.
- Informed consent is needed as opposed to scaremongering.
- High risk pathways need to be developed further.
- Raising awareness – show women what birth experience should look like so that they are more aware of what to expect. Provide appropriate information at the appropriate time and by the right person. Raise awareness of the choices of where to give birth available to women be it via information or attendance. Being transferred is a concern for many women. Some opt for hospital birth just in case assistance was needed.
- Pain relief choices need to be discussed well to make women, their partners and families aware of the options. More information is needed on what pain relief is available at a MLU to ease worries about giving birth there.

Continuity of carer, on demand model and hubs:

- Continuity of Carer could have positive impact on staff to re-engage them with why they came into the profession in the first place. This could have a positive effect on the decisions made, which could lead to lesser likelihood of a transfer.
- Develop wider hub services and consider who would lead this, e.g. third sector, children’s service, public health. Hubs need to be easily accessible and offer varied services including pelvic floor care, breastfeeding advice and support, mental health support, reduction in smoking, alcohol and weight. Also include social care and social services. Services being in one place would be a positive and helpful move. Hub could be very beneficial for women with learning disabilities as it would provide continuity and familiarity with people and location. Drop-in aspects would be beneficial in making the hubs accessible.
- The on demand model was seen as positive in respect of the role that Midwife Support Workers would play both in terms of the choice of birth, birth itself and wider support for the woman and her family. Time needed for Midwife Support Workers to familiarise with new cases when on call was noted.

Workforce:

- Need to consider the workforce – recruitment, the changing age profile, skill mix and roles. Training should be in place to ensure staff can support physical health as well as wellbeing of the mother. Workforce profile should reflect our population.

Access to services:

- Access to services should be the same for all, regardless where they live. Services to be patient centred, taking into consideration the needs of the woman; good experience leads to less
interventions

- The first priority is safety and this should include physical as well as emotional safety (wellbeing).
- When considering families on low income and no private transport, the cost of a taxi from Pontefract to Pinderfields MLU will be a one off cost during labour, but should consider this for antenatal and postnatal care. This should be delivered locally.
- Discussions took place around the engagement with service users from ethnic minorities, different cultures and those who may not have English as their first language as well as seldom heard groups in general. The cultural differences in expectations of maternity services and care were also discussed. English not being the first language can be a barrier to engagement, care in general as well as triage telephone system.
- Consider profile of the community and the difference amongst communities within it.
- Care for vulnerable women needs to be reviewed throughout pregnancy to understand women’s needs. Consideration to be given to women with learning disabilities to provide continuity of care across midwifery, LD support and health visiting. This should include preparations for birth and going home.
- Signposting to other services to support families with e.g. finances, father’s health, continence as well as those provided within hubs.
- Partners and families to be involved as they play an important role

<table>
<thead>
<tr>
<th>October 2019</th>
<th><strong>Current Pressures in the Maternity System</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A stocktake was undertaken by WCCG on the current quality and safety of the maternity service across Wakefield.</td>
</tr>
<tr>
<td></td>
<td>Data on the implementation of the Continuity of Carer model across CCGs in West Yorkshire and Harrogate has also been assessed and shared by the LMS.</td>
</tr>
<tr>
<td></td>
<td>Continuity of Carer means that women receive the same midwife or team of midwives throughout their whole pregnancy including birth and perinatal period. This requires a significant redesign of the maternity workforce with training needs. This and a number of other national drivers for transformational change of maternity services have added to the pressures on the Wakefield maternity system.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>November 2019</th>
<th><strong>MYHT advise that the birthing service at Friarwood Birth Centre will be suspended temporarily to ensure safety to be maintained across the whole maternity service.</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Local councillors and MPs briefed.</td>
</tr>
</tbody>
</table>
8. **Other key controls**

Other key monitoring controls include the CCG and MYHT established a monthly Pontefract FMLU Task and Finish Group which has clinical and managerial representatives from WCCG, MYHT and the WY&H LMS. NHSE more broadly have been kept informed through regular updates to the regional lead.

9. **Next Steps**

The CCG will continue to work with the Trust to seek a long term solution that ensures the maternity service for everyone in the Wakefield district is safe and sustainable. This will take account of the views reflected in the public engagement and the feedback we have received from the Clinical Senate. This process will be led by the CCG, which has the responsibility for planning services for the population.

The proposed next steps for maternity services in the Wakefield District are:

- Mid-Yorkshire maternity leads and LMS to meet with NHSE/I on 11 November to discuss detail of roll out of national commitment of Continuity of Carer.
- A local Maternity Transformation Board is being established to assess quality and safety across the service, with a plan to be put in place to address any immediate and long term issues. The plans will be in the context of the national maternity strategy (including roll out of Continuity of Carer) and commitments made in the NHS Long Term Plan. The WY&H LMS will be involved in this work.
- The review of the future service model will be progressed, taking account of the recommendations made by Clinical Senate in particular obtaining and providing more detailed information on the sustainability of the on-demand model in the context of the whole maternity service. The service review will also take into account of feedback from public engagement and any further issues or plans resulting from the work of the Maternity Transformation Board.
- Local committees and stakeholder groups will be provided with regular updates. The WY&H LMS will be fully involved in developments in going forward.
- There will be continued efforts to recruit additional staff to the maternity service and the temporary suspension of birthing services at Pontefract FMLU will be kept under continuous review. This will include review of the impact on other services.

If a long term solution is proposed that would mean a significant change to the way people access services, this would be subject to the NHS England service change assurance process and the CCG would work with the OSC to agree appropriate and proportionate engagement with the public.
Title of meeting: Governing Body Agenda Item: 9

Date of Meeting: 12 November 2019

Paper Title: Approach to delivery of the NHS Long Term Plan

Purpose (this paper is for):  
<table>
<thead>
<tr>
<th>Decision</th>
<th>Discussion</th>
<th>Assurance</th>
<th>Information</th>
</tr>
</thead>
</table>

Report Author and Job Title: Ruth Unwin, Director of Corporate Affairs

Responsible Clinical Lead: Dr Adam Sheppard, Chair and Clinical Leader

Responsible Governing Board Executive Lead: Jo Webster, Chief Officer

Recommendation:

It is recommended that the Governing Body:

i) Consider the proposed changes to the Constitution in the context of the changing commissioning landscape and the anticipated NHS Bill; and

ii) Agree that the revised draft Constitution should be put to the CCG membership for approval.

Executive Summary:

The attached paper sets out work that is being undertaken by the CCG to equip the organisation to deliver the long term plan for the NHS.

This includes proposed changes to the constitution, to bring it into line with the new model constitution set by NHS England.

These changes are set in the context of the changing commissioning landscape as a result of the advent of integrated care partnerships serving wider geographical footprints, integration within local places and the development of primary care networks.

The paper provides the contextual backdrop to the changes and a summary of the changes that are currently proposed. The draft constitution is available here.

In line with the current Constitution and Standing Orders, changes to the Constitution require formal approval by the GP membership. The draft constitution will be disseminated to the membership for them to confirm their support by Written Resolution following consideration by the Governing Body.
The outcome of the formal process will be presented back to the Governing Body in January 2020.

**Link to overarching principles from the strategic plan:**

| Reduction in hospital admissions where appropriate leading to reinvesting in prevention | ✓ |
| New Accountable Care Systems to deliver new models of care | |
| Collective prevention resource across the health and social care sector and wider social determinant partners | |
| Expanded Health and Wellbeing board membership to represent wider determinants | |
| A strong ambitious co-owned strategy for ensuring safe and healthy futures for children | |
| A shift towards allocation of resources based upon primary and secondary prevention and social determinants of ill health | |
| Transforming to become a sustainable financial economy | |
| Organising ourselves to deliver for our patients | |

**Outcome of Integrated Impact Assessment completed (IIA)**: Not applicable

**Management of Conflicts of Interest:** The proposed legislation and the changes to the Constitution are designed to manage conflicts of interest

**Assurance departments/organisations who will be affected have been consulted:** The proposed changes have been discussed with the LMC and will be subject to formal approval by the whole CCG membership.

**Previously presented at committee / governing body:** The proposed changes have been discussed at Development Sessions

**Reference document(s) / enclosures:** Not applicable

**Risk Assessment:** Not applicable

**Finance/ resource implications:** None
Approach to delivery of the NHS Long Term Plan

1. Context

The proposed changes to the Constitution reflect the new national Model Constitution developed by NHS England and the expectation that CCGs will continue to hold responsibility for commissioning at local level within the context of new arrangements for development of services within primary care networks, partnership working within Wakefield district place and across the wider geographical footprint of West Yorkshire and Harrogate Health and Care Partnership.

The constitution is designed to enable the CCG membership to retain control over key decisions that affect the make-up and philosophy of the CCG and ensure strong clinical representation whilst reducing burdensome governance arrangements.

The changes recognise that the CCG is on a journey towards greater integration and are designed to ensure continuity and stability of the organisation as partnerships are developing that will require new arrangements to be put in place to enable the CCG to deliver the functions for which it is accountable through delegated arrangements.

1.1 NHS Long Term Plan and proposed legislative change

The NHS Long Term Plan sets out NHS England’s strategic vision for the NHS and makes a commitment to deliver Integrated Care Systems (ICS) by April 2021. This means more collaborative system working between GP practices, health partners, social care, voluntary sector and local authorities. The purpose of an ICS is to build capability in the system and improve services at three levels:

- System (West Yorkshire and Harrogate Integrated Care System)
- Place (Wakefield Integrated Care Partnership)
- Neighbourhood (locality/network level)

Subject to the outcome of the general election, it is proposed that an NHS Bill will be introduced in the next session of Parliament to enable different parts of the NHS to work together and with partners more easily to speed up implementation of the NHS Long Term Plan.

An engagement exercise undertaken earlier this year into proposed legislative changes concluded that whilst there is no evidence that current legislation is preventing community collaboration, there could be a greater focus on the benefits of collaboration in the NHS Constitution.
The proposed Bill contains 23 recommendations in total. This includes a recommendation that all parts of the health and care system should work towards a new ‘triple aim’ of better health for the whole population, better quality care for all patients and financially sustainable services for the taxpayer.

If the Bill is approved, it would remove the automatic requirement for procurement of services with a lifetime value over £615k. However, patients would still have a right to choice.

The Bill would not go as far as creating Integrated Care Systems as statutory organisations but would, for the first time since the commissioning and provision functions were separated, allow NHS commissioners and providers to form joint decision-making committees on a voluntary basis.

This would pave the way for the CCG to further develop its approach to integrated working which is currently driven through the Health and Wellbeing Board and Integrated Care Partnership with formal decision making authority delegated to the Connecting Care Executive.

1.2 Integrated Care System

There are 42 Integrated Care Systems (ICS) – previously referred to as Sustainability and Transformation Partnerships - across the country serving populations of varying size.

Wakefield is one of six places that make up the West Yorkshire and Harrogate Health and Care Partnership. The total population served is xx

The Partnership has well established arrangements for decision making through a Joint Committee of CCGs, which has authority delegated to it by the constituent CCGs within the scope of a defined work plan. Decisions that fall outside this scope are referred back to the constituent CCGs for decision making.

The Memorandum of Understanding that underpins the Partnership’s governance arrangements and the work plan are currently going through a process of refresh, which will require formal approval by the GP membership.

1.3 Integrated Care Partnership

The health and social care partnership in Wakefield district is made up of the CCG and local authority as commissioners and the main providers of services that deliver health care or play a key role in contributing to the wider determinants of health. This mirrors the membership of the Health and Wellbeing Board, which has responsibility for setting the strategic direction for health and care services for the district.

The partnership has recently taken a decision to evolve from New Models of Care Board to the Integrated Care Partnership.
Authority is delegated by the CCG Governing Body to the Connecting Care Executive (made up of CCG and local authority representatives) to make decisions within a defined scope, which is set out in its terms of reference. Under current legislation, the CCG cannot delegate responsibility for commissioning functions to a committee that includes commissioners and providers. Therefore, no change is currently proposed to delegation arrangements to the CCE.

1.4 Primary Care Networks (Primary Care Home)

Primary care networks will become the basis for neighbourhoods, defined populations and geographies, around which integrated care between local hospitals and local authorities, primary care, community health and the third sector, can be planned and delivered.

A Primary Care Network is a group of GP practices that agree to work together with other practices in their local area to provide the care patients need, in better ways. By working together, it is expected they will be able to make resources go further and care for patients more creatively.

Primary Care Home is one delivery model of primary care networks, developed by the National Association for primary care and currently operates in over 200 sites across England. The delivery model adopted by the Wakefield Integrated Care Partnership will have the four key characteristics of primary care home:

- An integrated workforce, which cuts across primary, secondary and social care
- A focus on personalisation and improving population health outcomes
- Alignment of clinical and financial drivers
- Provision of care to a defined, registered population of between 30,000 and 50,000.

All seven primary care networks in Wakefield are currently operating under the Primary Care Network model and are now affiliated to the national association for primary care as Primary Care Network model, which brings access to well-developed case studies, implementation and evaluation tools alongside leadership support.

Patients will continue to be registered at their existing GP practice, which will be the main point of contact for their care. A much wider team of health professionals is increasingly becoming involved in patients’ care in GP practices. Through Primary Care Networks there will be more clinical pharmacists, physiotherapists, physician associates, community paramedics and social prescribing link workers.
Primary care networks will be expected to play a significant role at all levels of the ICS:

- Primary care networks will deliver integrated services to people in ‘neighbourhoods’, as the foundation of an effective health system;

- In ‘places’ (Wakefield District), primary care will interact with hospitals, third sector and local authorities, working together to meet the population’s needs (Wakefield’s Integrated Care Partnership will hold oversight at the ‘place’ level to support primary care networks);

- At the system level, (West Yorkshire and Harrogate), primary care as a provider will increasingly participate in system decision making. Networks create an opportunity for primary care to have a greater voice in both the design and delivery of ‘place’ based care with hospitals and local authorities, than may have been feasible historically in arrangement of individual separate practices.

The Clinical Directors and leadership teams of Wakefield’s primary care networks will play a critical role in shaping and supporting the West Yorkshire Integrated Care System, Wakefield Integrated Care Partnership and ensuring GP practices are fully engaged in implementing the Long Term Plan. Through primary care networks, practices will play an even greater part in the wider system than they have previously. These arrangements will be complementary to the arrangements for GP representation through the GPs who are elected to the Governing Body in line with the Constitution.

2. **Proposed changes to the NHS Wakefield CCG Constitution**

**Background**

In autumn 2018 NHS England published a suggested new model Constitution for CCGs. It is not mandatory for CCGs to adopt but each CCG has been asked to consider whether it would be appropriate to recommend to their Member Practices to update their CCG’s Constitution.

NHS Wakefield CCG adopted the initial model Constitution as recommended by NHS England as part of its authorisation and has continued to maintain and update this document.

In July 2019 the Remuneration Committee Terms of Reference were amended in line with the guidance provided by NHS England and legal advice, which advised that the governing body was responsible for determining the remuneration, fees and other allowances payable to employees or other persons providing services to the CCG. No other amendments were required immediately and none of those changes had any impact on the CCG continuing to carry out its business but were more “tidying up” in nature and hence as we were aware of the publication of a new model
Constitution, we held these pending its publication and our review as to whether it would be appropriate to adopt.

It is clear from the guidance that accompanies the new model Constitution, that in order to remain compliant with the new guidance we need to make some additional more important changes and we are required to include some Committee Terms of Reference as a minimum within the Constitution again.

The 2012 version of the Constitution was prepared at the time of CCGs being established. Since then a number of changes to the health and social care landscape have taken place including:

- A Legislative Reform Order has been passed, introducing amendments to the 2006 Act to permit CCGs to establish joint committees
- Development of new models of care, particularly integrated care systems
- Refined guidance issued by NHSE with regard to a number of key issues
- Maturity of CCGs as commissioning bodies has informed the way governance structures have developed

The new model Constitution looks to the future and facilities a greater degree of flexibility, whilst maintaining high levels of transparency and accountability. It has been prepared by NHS England nationally in conjunction with legal advice from Browne Jacobson who then delivered webinars to highlight key changes and issues for consideration by CCGs. The aim is to provide more flexibility, supporting collaboration and commissioning across larger footprints and different types of organisations and new models of care, particularly integrated care systems. One of the key objectives throughout the national review process was to ensure that the new version supported CCGs in developing integrated or collaborative working arrangements and the new model enables this by:

- Recognising the speed of change associated with integration, as well as the fact that arrangements evolve over time. Model wording has been included for various joint and collaborative working arrangements.
- With the agreement of Member practices, CCGs can agree certain aspects of the Constitution that are not 'material' and which can be revised without Member Practice approval being required, thus avoiding the current administratively burdensome processes for some minor wording updates.

Governing Body agreed in principle to adopt the new model Constitution, appending a full suite of Committee Terms of Reference together with the Standing Orders (SOs) and the delegated limits for financial commitments on behalf of the CCG.

The draft Model Constitution has being brought to this meeting of the governing body as it is important to have an up to date Constitution approved by our Member Practices and by NHS England. We are required to have fully approved Terms of Reference for each of our statutory committees of Governing Body and we need a Constitution which is “fit for purpose” as the CCG evolves its working with other partners.
It is possible that the Constitution may need further changes during 2019/20 as the role of the CCG evolves but this paper does not seek to identify what these changes might be as this requires reference to any future legislative changes.

Key Issues and Changes

The link for the proposed new Constitution with all its appendices has been provided to members of Governing Body as part of their information packs for this meeting.

It is important to highlight that this is not a radically new Constitution. In most cases the changes made are “tidying up” of existing documents. As a result, to make it easier for members to follow the documentation, it is not presented with tracked changes; NHS England who has confirmed that tracked changes are not required. The documentation should be read as a new set. This paper highlights any significant changes made which Governing Body and then our Member practices need to consider.

A) Main Body of Constitution

This has been produced with the starting point being the new model Constitution produced by NHS England with its lawyers. To this we have added in various sections from the CCG’s current Constitution including the membership of the Clinical Commissioning Group.

The main proposed change to the Constitution in terms of substance is the inclusion of section 1.4.2 which allows for Governing Body to agree changes that are determined as “not material” without needing to seek GP Membership approval as currently has to occur for all changes. This would seem a sensible and pragmatic way forward with the safeguard built in that if a majority of Governing Body members believe the issue is sufficiently important it can be deemed “material” and referred to our membership for consideration.

For ease of reference the section is as follows:

“The Accountable Officer may periodically propose amendments to the Constitution which shall be considered and approved by the Governing Body unless:

- Changes are thought to have a material impact
- Changes are proposed to the reserved powers of the members
- At least half (50%) of all the voting Governing Body Members formally request that the amendments be put before the membership for approval.

Changes considered to have a material impact will include, but are not limited to:

- A change in the number of GPs on Governing Body as voting members
- A Change in the procedure followed for decision making
- Changes relating to the role of the Chair/ Clinical Leader “
In addition as referred to above, in line with the national recommendations, a new section 5.10 to 5.13 has been included in the Constitution which expands the existing ability of the CCG to work collaboratively with other partners, in particular our Local Authority, other CCGs and NHS England.

B) Standing Orders (SOs)

No new national model SOs have been produced and so we have reviewed the CCG’s existing ones. The review suggests that some changes are required:

a) in relation to two of the roles on the governing body no longer being required:
   i) role of the Chief Operating Officer
   ii) role of the Assistant Clinical Leader

The removal of these two roles is intended to streamline the board membership, recognising that increasingly the CCG as wider relationships with Primary Care Home (PCH) directors evolves.

   i) in line with guidance provided by NHS England the terms of office for relevant board members has been amended to cover a maximum term of office of no more than a six to ten year tenure to maintain external perspective.

The further changes we have made relate to the issue of a quorum for Governing Body for decisions on Remuneration Committee proposals. As Governing Body members may recall, the legal advice issued with the new Constitution based on the 2012 NHS Act, is that CCG Remuneration Committees are not permitted to approve the remuneration of Governing Body members, such committees can only make recommendations to Governing Bodies. There is a clear conflict of interest for all Governing Body voting members as clearly they are unable able to vote on their own remuneration. As our quoracy is constituted, Governing Body could never be quorate if we exclude GP members. Thus it is proposed that we include separate clauses to allow quoracy without GPs being present / able to vote on the issue of their remuneration only. A further quoracy arrangement will also be required when the remuneration for Executive/Very Senior Manager members of the board is required to be approved/ voted. The following quoracy arrangements are therefore proposed. These are all set out in section 4.6 of the Standing Orders and are as follows:

“No business shall be transacted at a meeting of the Governing Body unless the following are present:

i) The Chair or Deputy Chair
ii) 2 other GPs as elected by the membership (i.e. not including the Clinical Chair)
iii) 1 lay member
iv) Either the Chief Officer or the Chief Finance Officer/Deputy Chief Officer
Alternative Quoracy Arrangements:

Where a standard quorum cannot be convened from the membership of the Governing Body, owing to the arrangements for managing conflicts of interest or potential conflicts of interests, alternative quoracy arrangements may be applied. In such circumstances, the Governing Body will be quorate with the presence of at least five of the remaining members of the Governing Body, to include:

i) Either the Registered Nurse or the Secondary Care Specialist and;
ii) Either the Chief Officer or the Chief Finance Officer/Deputy Chief Officer

Alternative Quoracy Arrangements:

Where neither a standard quorum nor alternative quorum can be convened due to an actual or potential conflict of interest for both the Chief Officer and the Chief Finance Officer/Deputy Chief Officer; for example when decisions are required regarding the remuneration and/or terms of service for the Chief Officer and/or Chief Finance Officer/Deputy Chief Officer, the Governing Body may be considered quorate with the presence of at least the following members of the Governing Body:

i) Either the Chair or Deputy Chair
ii) 3 other GPs as elected by the membership
iii) 1 lay member
iv) Either the Registered Nurse or the Secondary Care Specialist

These arrangements must be recorded in the minutes.

C) Delegated Authority Limits for Financial Commitment

Under the new model Constitution, CCGs are required to incorporate the “Delegated Authority Limits for financial commitment” are now mandated to be included as an appendix to the Constitution.

CCGs when established were set up to have Prime Financial Policies (which many other organisations call Standing Financial Instructions.) The new model Constitution suggests that CCG’s have Prime Financial Policies which set out the arrangements for managing the CCG’s financial affairs and have SFIs which set out the delegated limits for financial commitments on behalf of the CCG.

For Wakefield CCG the suggested way forward is for us to combine the Prime Financial Policies and Standing Financial Instructions as these currently stand as two separate documents. It would therefore be appropriate and append the table which describes the Delegated Authority Limits to the constitution as mandated. As part of this review, some amendments have been proposed:

- Combine PFPs and SFIs;
- Remove section on IT as not concerning finance matters;
- Remove detail re Tendering and Contract Procedure and replace by reference to
new detailed financial policy, Procurement Policy;
• Update on section on Bank Accounts to reflect use of Government Banking Service;
• Remove section on Risk Management and Insurance as needs to be in SOs
• Expansion of Payroll section to include payroll expenditure including IR35 rules
• Remove section on Retention of records as needs to be in SOs
• Amendments to financial limits regarding health care and non-health care Spend

D)  Scheme of Reservation and Delegation (SoRD).

Under the new Constitution arrangements, CCGs are still required to have a SoRD. The current version has been fully reviewed so that it cross references to the revised Constitution, SOs and delegated limits and PFPs.

No significant changes have been made to the powers reserved to the CCG’s Membership or to the powers reserved to the CCG’s Governing Body.

The SoRD will be included with in a Governance Handbook as per NHS England guidance. Any minor amendments can be proposed by the Chief Officer for the governing body to approve.

E)  Committees’ Terms of Reference (ToR)

As part of this review, the terms of reference for the committees of the CCG Governing Body have been reviewed. Changes to the statutory committee terms of reference for i) Audit, ii) Remuneration Committee and iii) Primary Care Commissioning Committee (currently known as Probity Committee) have been reviewed initially as they are required to be included within the Constitution. The other Committee Terms of Reference will also be reviewed so that they fully align with the new Constitution in terms of cross referencing and will be presented to the Governing Body for approval at the next meeting.

It will remain the responsibility of each Committee of the governing body to review their ToR at least once a year and to recommend any changes to Governing Body for approval.

Next Steps

Assuming Governing Body approves the new Constitution the next steps would be:

During November:

• Member practices consulted on / vote on proposed changes (allowing 21 days for written resolution on a one practice-one vote basis as set out in the current standing orders)
During December / January:

- Governing Body to consider any issues emerging from Member practices.
- NHS England asked to approve new Constitution
- New Constitution published on CCG website and all staff made aware.

Approval of Changes in the Future

If the attached new Constitution is approved by Governing Body, Member practices and NHS England then going forward the approvals would be as follows:

**By Governing Body**

All changes to the Constitution including all appendices.

**Also by the CCG’s Member Practices**

Proposed changes would be presented to the GP membership in the following circumstances:

- Changes to the powers reserved to the CCG’s Membership (i.e. Member practices) as set out in the SoRD and section 3 of the Constitution
- Changes that are deemed material by Governing Body (as outlined in section 1.4.2 of the new Constitution)
- Where at least 50% of Governing Body voting members request that the membership should be consulted.

This considerably reduces the time consuming current bureaucracy of asking the CCG’s Membership to approve all changes but at the same time, importantly ensures that any material changes still go to our Membership for approval.

**Also by NHS England**

There are only three documents as set out in sections 1.4 of the Constitution (i.e. the main body of the Constitution, the Standing Orders and the Delegated Authority Limits) which require NHS England approval.

This change helpfully allows changes to be made in particular to the terms of reference of the CCG Governing Body’s Committees which are always reviewed at least annually without these also having to go to NHS England for approval.

**Recommendations**

i) Consider the proposed changes to the Constitution in the context of the changing commissioning landscape and the anticipated NHS Bill; and

ii) Agree that the revised draft Constitution should be put to the CCG membership for approval.
Title of meeting: Governing Body  
Agenda Item: 10

Date of Meeting: 12 November 2019  
Public/Private Section:  
Public ✔  
Private  
N/A

Paper Title: NHS Wakefield CCG Governing Body Assurance Framework  
Purpose (this paper is for):  
Decision ✔  
Discussion  
Assurance  
Information

Report Authors and Job Titles: Pam Vaines, Governance Officer

Responsible Clinical Lead: Not Applicable

Responsible Governing Board Executive Lead: Jo Webster, Chief Officer  
Ruth Unwin, Director of Corporate Affairs

Recommendation:

It is recommended that members of the committee:

i) Approve the Autumn 2019/20 Governing Body Assurance Framework for NHS Wakefield Clinical Commissioning Group

Executive Summary:

The previous version of the Governing Body Assurance Framework (GBAF) was approved at Governing Body on 14 May 2019.

This version of the GBAF will be shared at Integrated Governance Committee on 21 November 2019 for information and at Audit Committee on 5 December 2019 for assurance.

An internal audit undertaken is the summer identified two errors in the entries on the GBAF that was received by the Governing Body in May. These were minor reporting errors as opposed to errors within the GBAF itself and have been corrected for the September/October overview report.

The summary showed entry 5 having a previous score of 12 and a current score of 8 but the GBAF shows a previous score of 12 and a current score of 12. The also summary showed entry 11 having a previous score of 16 and a current score of 20 but the GBAF shows a previous score of 20 and a current score of 16.

The GBAF was refreshed in September/October 2019. Each entry was reviewed by the Lead Manager, Lead Director and Lead Clinician allocated to that entry.

During the review cycle ten entries maintained a static risk score and none have increased in score. Two scores reduced, including Entry 7, Specialised Commissioning, which has been identified for closure. This area has been led by NHS England for a considerable amount of
time and as there are no associated risks on the Risk Register it is suggested that this entry is closed.

Entry 8, NHS Constitutional targets, remains the most challenging entry with a maintained score of 20. This reflects the fundamental challenge of demand verses capacity with systemic resource limitations constrains our risk appetite.

All the key strategic objectives have robust controls mechanisms and arrangements for providing assurance to the Board. However, gaps in controls have been identified in relation to ten objectives and gaps in assurance have been identified in relation to seven objectives. The gaps in control and assurance that have been identified demonstrate the need to ensure robust control and assurance mechanisms where objectives are being delivered through partnership arrangements.

The gaps in controls or assurance and actions to address this are summarised in appendix 1.

A summary of the gaps in control or assurance is attached at Appendix 1 and the full GBAF can be accessed link

Gaps in assurance and/or controls are linked to associated risks on the Risk Register which are highlighted. The rationale for the scores is detailed in each entry.

| Link to overarching principles from the strategic plan: | Reduction in hospital admissions where appropriate leading to reinvesting in prevention | ✔ |
| | New Accountable Care Systems to deliver new models of care | ✔ |
| | Collective prevention resource across the health and social care sector and wider social determinant partners | ✔ |
| | Expanded Health and Wellbeing board membership to represent wider determinants | ✔ |
| | A strong ambitious co-owned strategy for ensuring safe and healthy futures for children | ✔ |
| | A shift towards allocation of resources based upon primary and secondary prevention and social determinants of ill health | ✔ |
| | Transforming to become a sustainable financial economy | ✔ |
| | Organising ourselves to deliver for our patients | ✔ |

Outcome of Integrated Impact Assessment completed (IIA): The relevant equality impact assessment was carried out as part of the Integrated Risk Management Framework.

Outline public engagement – clinical, stakeholder and public/patient: Not applicable

Management of Conflicts of Interest: None identified

Assurance departments/organisations who will be affected have been consulted: Each risk has a nominated Lead Governing Body Member, Lead Director and Lead Manager who have provided the information to populate the assurance framework.
<table>
<thead>
<tr>
<th>Previously presented at committee / governing body:</th>
<th>The Assurance Framework was last reviewed by the Governing Body in May 2019.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reference document(s) / enclosures:</td>
<td>Appendix 1 – Summary of gaps in control or assurance and actions to close the gaps</td>
</tr>
<tr>
<td></td>
<td>GBAF Summary Dashboard and the Full GBAF: Link</td>
</tr>
<tr>
<td>Risk Assessment:</td>
<td>This is an aspect of the risk assessment mechanism for NHS Wakefield CCG and each entry references any associated risks contained within Wakefield CCG Risk Register.</td>
</tr>
<tr>
<td>Finance/ resource implications:</td>
<td>None identified</td>
</tr>
</tbody>
</table>
Appendix 1 - Summary of actions to address gaps in control or assurance

<table>
<thead>
<tr>
<th>Objective</th>
<th>Score &amp; movement</th>
<th>Control/assurance gap</th>
<th>Action</th>
</tr>
</thead>
</table>
| There is a strategic risk of non-achievement of a cohesive, joined up approach to responding to the changing needs of children and young people in Wakefield. This is due to conflicting demands, limited funding, lack of a skilled workforce in all partner organisations and increasing need. This could result in children and young people not having adequate access to all services and their physical, safety, emotional and wellbeing needs remaining unmet. | Static (9) | Control: Appropriate governance arrangements need to be developed for CAMHS transformation programme  
Control: Paediatric Quality Partnership Group needs establishing with MYHT to consider key quality data, drive service improvements and ensures waiting time standards are adhered to.  
Assurance: A review of JSNA for maternity, children’s and mental health is required which CCG will contribute to. | ASD strategy in development to be considered at Clinical Cabinet. The plan is to launch the strategy in Q4.  
Work in train to establish the Paediatric Quality Partnership Group. |
| There is a risk that we fail to increase the focus on prevention and early intervention of mental health support to improve the wellbeing of our population. Due to the conflicting priorities across the district and the | Static (12) | Control: oversight and assurance role of the Mental Health Alliance Control needs to be clarified  
Control: Requires increased focus on the outcomes delivered for individuals and the system – mental health outcome framework to be developed by Q3  
Assurance: Reporting progress into the Mid Yorkshire Improvement Groups. | Mental Health performance dashboard being developed alongside the outcome framework to support the mental health alliance in developing its assurance approach.  
(December 2019)  
Operational meeting to in October to agree reporting approach |
<table>
<thead>
<tr>
<th>Objective</th>
<th>Score &amp; movement</th>
<th>Control/assurance gap</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>resource available to deliver them. Resulting in the continued demand for primary and secondary care services which is unsustainable in the long term.</td>
<td>Static (12)</td>
<td>Control: CCG does not have a formal Long Term Conditions Strategy or single dashboard that defines the scope and priorities for the population that builds upon work undertaken in specific teams for specific conditions.</td>
<td>Plans to be developed for each work stream including economic evaluation.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Control: There is a lack of integrated structural oversight within the CCG for LTC</td>
<td>Discuss availability of relevant data with Public Health.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Assurance: Reports should be received for oversight by the NMOC Board</td>
<td>Sense check of plans against overarching objectives.</td>
</tr>
<tr>
<td>There is a risk that the CCG is not maximising the impact of current resources and initiatives to manage health inequalities. Due to the current lack of a co-ordinated approach to long term conditions. Resulting in acute admissions, higher than necessary prescribing costs and inconstancies in the management of long term conditions.</td>
<td>Static (12)</td>
<td>Management resource to be identified to pull all schemes into a coherent strategy to be reviewed if this is identified as a priority in the 2020/21 programme</td>
<td>Governance and management of long term conditions within the CCG to be reviewed to implement Governing Body intentions as a priority.</td>
</tr>
<tr>
<td>There is a risk of deterioration of quality of services to elderly and frail people in the Wakefield district. Due to failure to deliver the</td>
<td>Static (8)</td>
<td>Control: A level of fragmentation between the providers developing services which support elderly and frail patients</td>
<td>Governance review of the system is underway.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Assurance: No established mechanism for Governing Body to routinely see the minutes of</td>
<td>Consolidate the existing frail and elderly groups which exist in voluntary sector, CCGs, Local</td>
</tr>
<tr>
<td>Objective</td>
<td>Score &amp; movement</td>
<td>Control/assurance gap</td>
<td>Action</td>
</tr>
<tr>
<td>-----------</td>
<td>-----------------</td>
<td>-----------------------</td>
<td>--------</td>
</tr>
<tr>
<td>programme of work under Integrated Care Partnership for elderly care and frailty. Resulting in a reduction in the sustainability of the health and social care system.</td>
<td></td>
<td>the Integrated Care Partnership</td>
<td>Authority and MYHT establish a consistent approach. Review NHS North Kirklees frailty strategy to identify potential of merging strategies. Ensure the Connecting Care Programme and the PCH programmes are aligned. Role of Integrated Care Partnership is currently being reviewed, which includes its relationship with the Governing Body.</td>
</tr>
<tr>
<td>There is a strategic risk of the CCG not meeting its cancer objectives due to delays in diagnosis and system sustainability resulting in the national cancer strategy not being fully implemented.</td>
<td>Static (12)</td>
<td>Control: Improved engagement with and support for GP practices/Primary Care Networks (PCN). Assurance: assurance has not been provided on readiness for MYHT to implement 28 day rapid diagnosis standard. Assurance: Performance report highlights challenges in meeting the delivery of the 62 day referral first definitive treatment.</td>
<td>Ongoing discussion and engagement with West Yorkshire and Harrogate Cancer Alliance colleagues regarding optimal pathways and living with and beyond cancer programmes. Working with Mid Yorkshire Hospitals NHS Trust to improve diagnostic capacity and prepare for the 28 day rapid diagnostic standard which goes live 1 April 2020. Engagement with CCG and PCNs</td>
</tr>
<tr>
<td>Objective</td>
<td>Score &amp; movement</td>
<td>Control/assurance gap</td>
<td>Action</td>
</tr>
<tr>
<td>-----------</td>
<td>-----------------</td>
<td>-----------------------</td>
<td>--------</td>
</tr>
<tr>
<td>There is a risk of not achieving the NHS constitutional targets due to an imbalance between current capacity and rising demand resulting in poor patient experience and outcome.</td>
<td>Static (20)</td>
<td>Control: National shortage of workforce. Control: Shared care pathways with LTHT can be challenging (Cancer). Control: 52 week waits in particular for trauma and orthopaedics at Leeds Control: 35 week waits at Mid Yorkshire Hospitals NHS Trust could cause an increased risk of 52 week breach. This relates specifically to ENT and Gynaecology. Control: Shortage of diagnostic capacity. Control: Despite building in outpatient growth, it is not assumed that the 92% achievement target will be reached. Control: A&amp;E demand growth</td>
<td>including CCG target event for GP and Advanced Nurse Practitioners with a focus on Cancer on 16 October 2019 Develop plan for supporting Primary Care Networks. To work with cancer alliance to understand readiness of MYHT to implement the 28 day RDS Clinical summits have taken place for partnership agreements for priority specialties and actions continue to be overseen and developed by PCIG NHS England workforce strategy to be shared Primary Care Home to help facilitate key performance targets in relation to Integrated Care Partnership Cancer Alliance to develop programme of improvement of diagnostics for cancer and ultrasound and training of endoscopy specialists Clinical collaboration to be optimised</td>
</tr>
<tr>
<td>Objective</td>
<td>Score &amp; movement</td>
<td>Control/assurance gap</td>
<td>Action</td>
</tr>
<tr>
<td>-----------</td>
<td>-----------------</td>
<td>----------------------</td>
<td>--------</td>
</tr>
<tr>
<td>Control: Outstanding pathway development across primary and secondary care.</td>
<td>Control: New screening programmes and campaigns (whilst a good thing in themselves) increase pressure on referral rates and capacity.</td>
<td>Control: Constraints within providers limit transformational opportunities.</td>
<td>across primary and secondary care ICS to review capacity and pathways for 52 week waits across West Yorkshire and Harrogate.</td>
</tr>
<tr>
<td>Control: Mid Yorkshire Hospitals NHS Trust is taking part in the pilot of the new Urgent Care Performance standard and therefore A&amp;E waiting time performance is not monitored.</td>
<td></td>
<td></td>
<td>A&amp;E demand growth is being overseen through JUCIG. Separate workshops have taken place for Wakefield and North Kirklees</td>
</tr>
<tr>
<td>There is a strategic risk of not being able to commission <strong>safe, high quality care</strong> due to our health and care system’s ability to maintain quality while balancing financial, demand and capacity pressures resulting in poorer outcomes for our patients and negative patient experience</td>
<td>Static (12)</td>
<td>Control: Limited interface with lead commissioners of other providers outside West Yorkshire and Harrogate area regarding quality assurance for services where Wakefield CCG do not hold the contract</td>
<td>Strengthening the interface with lead commissioners in other organisations for 2 acute providers in South Yorkshire.</td>
</tr>
<tr>
<td>Control: Governance of Integrated Care Partnership (ICP) quality to be developed further (as identified from Wakefield Health &amp; Care Peer Review )</td>
<td></td>
<td>Control: Adopt West Yorkshire &amp; Harrogate Quality and Equality Impact Assessment (QEIA) tool</td>
<td>Continued development of system quality assurance process for ICP (March 2020) Replace and update IIA Policy and adopt QEIA tool and guidance (December 2019)</td>
</tr>
<tr>
<td>Control: Targeted support sought for primary care estates and workforce.</td>
<td>Static (12)</td>
<td></td>
<td>Development of a workforce plan within each Primary Care Network.</td>
</tr>
<tr>
<td>There is a risk that <strong>General Practice</strong> in</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Objective</td>
<td>Score &amp; movement</td>
<td>Control/assurance gap</td>
<td>Action</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>------------------</td>
<td>---------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Wakefield does not deliver the Wakefield General Practice Strategy due to practice resilience and sustainability resulting in failure meaning negative impact on patient experience, failure to deliver statutory duties and delivering the CCG objectives. | Static (16)      | Control: Extend the use of digital technology to make use of the workforce in a more effective manner.  
Assurance: Internal assurance on workforce planning  
Assurance: Engagement with workforce planning at ICS level                                                                 | Further support to Primary Care Home Leadership teams to ensure effective use of resources across the system  
Further engagement with the ICS Digital Team and CCG IT/Primary Care staff in implementing the Digital scheme set out in the 5 year Framework for General Practice  
Develop internal assurance process on workforce planning                                                                 |
| There is a risk that the CCG is limited in its ability to commission innovative and high quality services for the population of Wakefield. Due to the requirement to pay back historic deficits, the allocation settlement for Primary Care Co-commissioning and the current model of service delivery in Wakefield which is relatively acute hospital based. Resulting in the CCG and local | Static (16)      | Control: Lack of fully quantified and costed impact of the transformation initiatives being undertaken via PCIG and UCIG. (November 2019)  
Control: Current financial plan for 2019/20 includes unidentified efficiency schemes of £2.3m  
Control: Lack of system financial plan and the required oversight from the Integrated Care Partnership Board. (December 2019)  
Control: Lack of progress on identifying West Yorkshire and Harrogate wide schemes | Continue to focus via the Planned Care Improvement Group and the Urgent Care Improvement Group on the financial impact of system transformation schemes  
Continued discussion at Executive Level on financial recovery and impact on the system as a whole versus individual organisations; including identification areas for future review.  
Renewed focus through team and individual objectives on working across the West Yorkshire and |
<table>
<thead>
<tr>
<th>Objective</th>
<th>Score &amp; movement</th>
<th>Control/assurance gap</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>providers breaching their statutory financial duties, a lack of financial flexibility for pump-priming new service models with the consequence potential detrimental impact on service quality and access</td>
<td></td>
<td></td>
<td>Harrogate ICS.</td>
</tr>
</tbody>
</table>
| There is a risk of organisational strategic objective to be a **high performing employer** not being fully achieved due to workforce processes not being fully developed or embedded within the organisation resulting in an inability to recruit and retain appropriately skilled staff, low productivity and deterioration in performance. | Static (8)       | Control: People strategy requires refresh  
Assurance: Quarterly workforce report shows compliance with PDR and MAST is not 100%1. | People strategy to be refreshed in Q3  
Heads of service progress chase compliance with MAST relevant to their teams and their areas of responsibility  
Staff survey results due winter 2019 |
<table>
<thead>
<tr>
<th>Title of meeting:</th>
<th>Governing Body</th>
<th>Agenda Item: 11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Meeting:</td>
<td>12 November 2019</td>
<td></td>
</tr>
<tr>
<td>Paper Title:</td>
<td>Yorkshire and the Humber Collaborative Commissioning – Integrated Urgent &amp; Emergency Care</td>
<td></td>
</tr>
<tr>
<td>Public/Private Section:</td>
<td>Public ✓</td>
<td></td>
</tr>
<tr>
<td>Purpose (this paper is for):</td>
<td>Decision ✓</td>
<td>Discussion</td>
</tr>
<tr>
<td>Report Author and Job Title:</td>
<td>Amrit Reyat, Governance &amp; Board Secretary</td>
<td></td>
</tr>
<tr>
<td>Responsible Clinical Lead:</td>
<td>Dr Adam Sheppard, Chair and Clinical Leader</td>
<td></td>
</tr>
<tr>
<td>Responsible Governing Board Executive Lead:</td>
<td>Jo Webster, Chief Officer</td>
<td></td>
</tr>
</tbody>
</table>

**Recommendation**

It is recommended that the Governing Body:

i) Note the progress made to date on developing the needs of IUEC across Y&H
ii) Approve the 2019/21 Ambulance partnership framework
iii) Approve the Y&H IUEC collaborative commissioning MOU
iv) Support the plans to drive forward the strategic intentions and timeline

In the spring of 2016, Yorkshire and the Humber CCGs each approved a Governing Body paper setting out the then ambulance commissioning strategy and the associated collaborative commissioning agreements (Memorandum of Understanding (MOU)).

The strategy and MOUs have been updated taking into account changes to the evolving commissioning geographies and the journey towards integration captured under the umbrella of Integrated Urgent and Emergency Care (IUEC).

This paper and appendices explain the rationale for revising the IUEC commissioning arrangement for Yorkshire and the Humber (Y&H) and seeks to gain approval from each place.

**Link to overarching principles from the strategic plan:**

<p>| Reduction in hospital admissions where appropriate leading to reinvesting in prevention |
| New Accountable Care Systems to deliver new models of care |
| Collective prevention resource across the health and social care sector and wider social determinant |</p>
<table>
<thead>
<tr>
<th>partners</th>
<th>Expanded Health and Wellbeing board membership to represent wider determinants</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A strong ambitious co-owned strategy for ensuring safe and healthy futures for children</td>
</tr>
<tr>
<td></td>
<td>A shift towards allocation of resources based upon primary and secondary prevention and social determinants of ill health</td>
</tr>
<tr>
<td></td>
<td>Transforming to become a sustainable financial economy</td>
</tr>
<tr>
<td></td>
<td>Organising ourselves to deliver for our patients ✓</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outcome of Integrated Impact Assessment completed (IIA)</th>
<th>Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outline public engagement – clinical, stakeholder and public/patient:</td>
<td>A strategic approach to engagement will take place.</td>
</tr>
<tr>
<td>Management of Conflicts of Interest:</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Assurance departments/organisations who will be affected have been consulted:</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Previously presented at committee / governing body:</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Reference document(s) / enclosures:</td>
<td>Appendices can be accessed: <a href="#">here</a></td>
</tr>
<tr>
<td></td>
<td>Appendix 1: Y&amp;H IUEC strategic partnership framework 2019-21</td>
</tr>
<tr>
<td></td>
<td>Appendix 2: Y&amp;H IUEC collaborative commissioning MOU</td>
</tr>
<tr>
<td></td>
<td>Appendix 3: Y&amp;H IUEC governance structure</td>
</tr>
<tr>
<td></td>
<td>Appendix 4: JSPB work programme 2019/20</td>
</tr>
<tr>
<td>Risk Assessment:</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Finance/ resource implications:</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>
Yorkshire and the Humber Collaborative Commissioning –
Integrated Urgent & Emergency Care (IUEC)

Governing Body
12 November 2019

1  Purpose

The purpose of this paper is to:

- Explain the rationale for revising the Integrated Urgent & Emergency Care (IUEC) commissioning arrangements for Y&H.
- Gain approval from each of the Yorkshire & the Humber (Y&H) Clinical Commissioning Groups (CCGs) commissioning the Yorkshire Ambulance Service (YAS) to provide 999 ambulance and/or Integrated Urgent Care (IUC) services to a revised partnership framework and collaborative commissioning agreement.
- Set out how the IUEC commissioning intentions will be enacted in the context of the revised approach.

2.  Background

In the spring of 2016, Y&H CCGs each approved a Governing Body paper setting out the then ambulance commissioning strategy and the associated collaborative commissioning agreements (Memoranda of Understanding (MOU)). The strategy and MOUs have been updated taking into account changes to the evolving commissioning geographies and the journey towards integration captured under the umbrella of Integrated Urgent and Emergency Care (IUEC).

3.  What is the scope of integrated urgent and emergency care in Y&H?

IUEC encompasses a wide range of services beyond those directly provided by YAS. A key feature is that no matter whether someone seeking help has done this via 999 or 111 or through NHS 111 on line, the pathway of care should be seamless whether the clinical end point is a service within a primary care network, a GP out of hours service, an acute trust service, a mental health service or some other service. The scope is set out in the partnership framework at Appendix 1.

To ensure this happens changes are being made to back office processes for example, improved access to patient records, improved access to clinical support, the ability to book immediately into appointment slots and access to a wide range of local clinical and social care services on a 24/7 basis.

4.  What has been achieved since 2016?

Notable progress has been made in the past three years in respect of ambulance commissioning across Y&H:
a) YAS was rated by the Care Quality Commission (CQC) as ‘requires improvement’ in 2015 and has since been rated as ‘good’.
b) The NHS 111 service in Y&H was launched in 2013 as a stand-alone clinical service for those needing urgent help fast. The service, provided by YAS and commissioned across all Y&H CCGs had become (until the service ceased in March 2019) one of the better performing NHS 111 services in England.
c) Y&H CCGs have, from April 2019, replaced the NHS 111 services with an Integrated Urgent Care (IUC) service. This, in line with national guidance, includes a NHS 111 call handling and clinical advice service (CAS). YAS provide a ‘core’ CAS within the context of a Y&H wide CAS made up of different providers across Y&H (all of whom are expected to work collaboratively). The service reflects our belief that it isn’t about what number has been dialled but what sits behind the entry point.
d) A NHS 111 on line service, which provides an alternative into IUEC without necessarily making a call, is fully available across Y&H.
e) Further investment has been made into YAS 999 services. Y&H CCGs invested £180.2m in 2015/16 into YAS 999 services and this had increased to £211.6m in 2019/20.
f) A Joint Partnership Panel (JPP) was established to coordinate the renegotiation of the 999 contract with YAS. For 2020/21 it will be expanded to cover both the 999 and IUC contracts for 2020/21.
g) The YAS 999 service has evolved in line with the national direction of travel and is fast becoming one of the best performing trusts in England against the new (Ambulance Response Programme (ARP)) national quality indicators. YAS are contracted to provide a service on a Y&H footprint. YAS met all national performance standards in March 2019 with the exception of category 4 (low acuity) where it was 9 seconds off.
h) Y&H commissioners established a Joint Strategic Commissioning Board (JSCB) to oversee the strategic commissioning of IUEC services on a Y&H footprint. This has evolved to become a Joint Strategic Partnership Board (JSPB).
i) Y&H commissioners have established an IUEC Clinical Assurance Group (CAG) in line with national guidance looking along IUEC pathways of care.
j) Y&H CCGs have agreed a revised decision making process for YAS IUEC matters and this is included in a revised collaborative commissioning agreement (Appendix 2) covering YAS 999 and IUC services commissioned from YAS.

5. Rationale for revising our commissioning arrangements

The current ambulance commissioning strategy for Y&H was developed in 2016 (extant until April 2019) alongside a MOU for YAS 999 and 111 collaborative commissioning. Together, these frameworks set the broad strategic direction for NHS 111 and 999 commissioning and the associated scheme of delegation for coordinating commissioners and associate CCGs.
Since 2016, four fundamental changes to the commissioning landscape have impacted on ambulance commissioning arrangements, meaning that they required review. These are:

(i) The development of Sustainability Transformation Partnerships (STP) and Integrated Care System (ICS) footprints.

(ii) The requirement to move away from a stand-alone NHS 111 ‘service’ to deployment of the 111 and 999 telephone numbers as a gateway to a single integrated urgent and emergency care system (encompassing multiple providers).

(iii) The implications of the Ambulance Response Programme (ARP) upon existing ambulance operational models, blurring traditional boundaries between A&E and PTS services and requiring greater integration with place based care pathways.


6. Our New Approach

In context of the above, YAS and commissioners have committed to a more collaborative and strategic approach moving forward. The need to involve a wider range of urgent and emergency care providers and the new approach will see all parties working together to:

- **Vision** - Agree a shared vision for the ambulance service’s role in IUEC, exploring opportunities for greater provider integration beyond traditional organisational or contractual boundaries. This may evolve into a more formal alliance of providers working together. A work programme builds upon a joint set of commissioning intentions, key phases of work with appropriate linkages to STP/ICS plans and milestones to transform the service as part of an IUEC system.

- **Action** – Provide strategic level oversight and assurance to the development (through contract management board) of (i) investment to deliver the ambulance response standards (ARP) and (ii) transformation of the ambulance service to achieve the aims of IUEC as part of the whole system.

- **Evaluation** - Agree a shared set of metrics which we will collectively use to evaluate the system-wide impact of investment and resultant transformation as well as overall demand and performance of the ambulance service.
Role of the Joint Strategic Partnership Board (JSPB)

In light of an agreement reached at a joint workshop with Y&H commissioners and YAS in June 2018, it was agreed that we continue to develop a more partnership approach at JSCB - now to be renamed JSPB - and contractual matters are to be taken through the IUEC Contract Management Board (CMB).

The role of the JSPB will be to provide strategic oversight and assurance in relation to investment decisions and delivery plans implemented through the CMBs. This approach will specifically encompass:

- Oversight of the delivery of the commissioners strategic intentions
- Co-production and assurance of delivery of the providers responses to the agreed commissioning intentions as a whole system
- Oversight of the national IUC and 999 specification and associated performance standards

The revised JSPB arrangements will aim to address and balance multiple and potentially conflicting requirements as follows:

- The need for commissioning and for Y&H IUEC provider organisations to collaborate to deliver genuine transformation of health and social care systems
- The need to appropriately reflect and balance a diversity of requirements, models and views including regional resilience, STP / ICS / NHS E and place based delivery plans
- The need to maintain separate contract governance arrangements for IUEC and PTS and other services contributing to our integrated urgent and emergency care system in order to provide assurance to commissioners

The JSPB will support the development of trust and transparency across all parties through:

- Appropriate senior leadership and stewardship
- Wider system engagement
- Clear and co-ordinated work plans with the IUEC CMB, ensuring a strong evidence base to inform decision-making
- Senior and consistent representation at relevant groups
- Consistent engagement with STP/ICS Urgent & Emergency Care Programme Boards/Networks

Revised governance arrangements

The onus is on the sub regional representative at both the JSPB and CMB meetings to bring a mandate for the area they represent and to have fully discussed the financial implications of any recommendations prior to the meetings of the JSCB. Sub regional groups, where these exist, need to
gather intelligence from their ICS/STP partnership boards and networks thereby informing the JSPB. The JSPB membership sets the strategy and it is enacted through the IUEC CMB and the IUEC Development Group. This ensures there is a bottom up approach connecting sub regional leadership across Y&H.

A scheme of delegation (to coordinating commissioner(s)) incorporated within a revised Y&H IUEC collaborative commissioning MOU will reflect that decisions with financial implications will be made at ICS/STP and CCG level.

A revised governance structure for joint strategic commissioning of the ambulance service and IUEC is shown at Appendix 3. The arrangements are reflected in the revised terms of reference for each group. The structure and membership of each group aims to reconcile the need for regional and sub regional discussions, and the need to develop a transformational dialogue alongside the performance management arrangements already in place.

Sitting below the JSPB the key groups include:

<table>
<thead>
<tr>
<th>Group</th>
<th>Frequency</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y&amp;H IUEC Development Group (SG)</td>
<td>Monthly as required</td>
<td>Service and clinical development</td>
</tr>
<tr>
<td>Y&amp;H IUEC Contract Management Board (CMB)</td>
<td>Bi-monthly</td>
<td>Contractual matters</td>
</tr>
<tr>
<td>Y&amp;H IUEC Clinical Assurance Group (CAG)</td>
<td>Bi-monthly</td>
<td>Quality and patient safety along the total pathway of care</td>
</tr>
<tr>
<td>YAS Joint Partnership Panel (JPP)</td>
<td>Fortnightly as required during the period of contract negotiations</td>
<td>Task and finish group overseeing contract negotiations for the YAS 999 and IUC contracts</td>
</tr>
</tbody>
</table>

The responsibility for meeting our obligations for place based patient and public engagement lies with local system leaders. Service reconfiguration and development will be clinically led using the skills and experience of our local teams.

New commissioning intentions 2019/21

Appendix 1 sets out the Y&H partnership framework (commissioning intentions) for IUEC for the three years 2019-21. We intend that the JSPB owns the framework for the IUEC system across Y&H. Strategic decisions will therefore be enacted at this level.
7. **How we aim to execute the strategy**

A work programme (Appendix 4) owned by the ICS/STPs and NHS E, covering the key IUEC transformation priorities for 2019/20 has been developed and implemented overseen through the IUEC CMB with key milestones and risks overseen by JSPB.

Following the publication of the NHS England national ambulance commissioning framework a review was undertaken by Audit Yorkshire of the Y&H IUEC contracting and commissioning support functions. A plan to take forward the recommendations, published in May 2019, is being developed and will be brought to a future JSPB meeting.

This paper was approved in draft by the Y&H JSPB in June 2019.

8. **Recommendations**

Members of the Governing body are asked to:

- Note the progress made to date on developing the needs of IUEC across Y&H
- Approve the 2019/21 Ambulance partnership framework
- Approve the Y&H IUEC collaborative commissioning MOU
- Support the plans to drive forward the strategic intentions and timeline

**Appendices**

Appendix 1: Y&H IUEC strategic partnership framework 2019-21
Appendix 2: Y&H IUEC collaborative commissioning MOU
Appendix 3: Y&H IUEC governance structure
Appendix 4: JSPB work programme 2019/20
**Title of meeting:** Governing Body

**Agenda Item:** 12

**Date of Meeting:** 12 November 2019

**Public/Private Section:**
- Public ✓
- Private
- N/A

**Paper Title:**
- Quarter 1 2019/20 Quality Reports
- Patient Safety and Outcomes and summary of CQC Inspection Update Reports

**Purpose (this paper is for):**
- Decision
- Discussion ✓
- Assurance ✓
- Information

**Report Author and Job Title:**
- Lucy O'Lone, Quality Co-ordinator

**Responsible Clinical Lead:**
- Stephen Hardy, Lay Member

**Responsible Governing Board Executive Lead:**
- Suzannah Cookson, Chief Nurse

**Recommendations:**
It is recommended that the Governing Body note:-
- i. the current trends against indicators in the patient safety and outcomes dashboard;
- ii. the themes relating to patient safety and outcomes; and
- iii. the full report has been discussed in detail at the Integrated Governance Committee.
- iv. note the outcome of recent CQC inspections, and the actions being taken to support providers rated as Requires Improvement.

**Executive Summary**
The Governing Body is presented with the Patient Safety and Outcomes report and CQC inspection update report for Quarter 1 2019/20.

The key headlines from the Patient Safety and Outcomes report include:

**Place based**
NHS Wakefield CCG

**The NHS Patient Safety Strategy**
During July 2019, NHSE/I published the NHS Patient Safety Strategy which builds upon two foundations: patient safety culture and patient safety system. The aim of the strategy is to remove individual blame and increase continuous improvement in patient safety.
Medicines Safety Reporting – Quarter 1 2019/20
111 Medicine Safety Incidents were reported during Quarter 1 2019/20. The main themes from were:

1. Duplicate prescribing on repeat template (lack of housekeeping).
2. Poor quality and untimely discharge communication from Acute Trust.
3. Inappropriate prescribing in domiciliary environment due to lack of clinical information to support prescribing decision.

Safeguarding Update – Quarter 1 2019/20
The first safeguarding team update is included in the report detailing key achievements and areas for development from the last quarter.

Perfect Ward® - Quarter 1 2019/20
The top three questions that care homes performed best and worst in from all Quarter 1 2019/20 Perfect Ward® visits are documented for the three audits that relate to patient safety: Environment, Leadership and Documentation. Photographs of recent findings from the care homes are included to demonstrate good practice and areas of improvement.

Spire Methley Never Event
Wakefield CCG was notified of an incident for a Wakefield patient in September 2019. The incident occurred 07/12/18 and was reported to Leeds CCG on the 14/03/19. During December the patient’s wound had healed and the patient was mobilising well.

Patient Safety Walkabouts (PSW)
During June 2019 a walkabout took place at Wakefield Intermediate Care Unit (WICU).

Acute Commissioning
Mid Yorkshire Hospitals Trust (MYHT)

Healthcare Associated Infections
- During Quarter 1 2019/20 two MRSA cases were assigned to MYHT against a target of zero for the same patient. The total YTD figure is two.
- Eight cases of Clostridium Difficile were assigned to MYHT during Quarter 1 2019/20 (target of 6 / 73).

Never Event
During July 2019, MYHT reported a medication incident that met the criteria for a Never Event (Unintentional connection of a patient requiring oxygen to an air flowmeter). There was no patient harm.

Sentinel Stroke National Audit Programme (SSNAP) – Quarter 4 2018/19
During Quarter 4 2018/19 MYHT’s overall SSNAP performance improved and resulted in a Level B. Previously, in Quarter 3 2018/19 MYHT scored a Level C.

The key headlines from the CQC inspection update report include:

GP Practices
Seven GP Practices recently completed their Annual Regulatory Review (ARR) during Quarter 1 2019/20:
Care Homes
Manor Park is a care home. Previously, during February 2018 the service was rated overall Requires Improvement. After a recent unannounced inspection during April 2019 this service remained overall Requires Improvement achieving Good for the Caring domain.

Yorkshire Ambulance Service (YAS)
In 2016, YAS was rated Good overall. In the latest CQC inspection during 2019 the service remained Good overall with an improvement in the rating for Patient Transport Services (PTS).

<table>
<thead>
<tr>
<th>Link to overarching principles from the strategic plan:</th>
<th>Reduction in hospital admissions where appropriate leading to reinvesting in prevention</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>New Accountable Care Systems to deliver new models of care</td>
</tr>
<tr>
<td></td>
<td>Collective prevention resource across the health and social care sector and wider social determinant partners</td>
</tr>
<tr>
<td></td>
<td>Expanded Health and Wellbeing board membership to represent wider determinants</td>
</tr>
<tr>
<td></td>
<td>A strong ambitious co-owned strategy for ensuring safe and healthy futures for children</td>
</tr>
<tr>
<td></td>
<td>A shift towards allocation of resources based upon primary and secondary prevention and social determinants of ill health</td>
</tr>
<tr>
<td></td>
<td>Transforming to become a sustainable financial economy</td>
</tr>
<tr>
<td></td>
<td>Organising ourselves to deliver for our patients</td>
</tr>
</tbody>
</table>

Outcome of Integrated Impact Assessment completed (IIA)
Not applicable

Outline public engagement – clinical, stakeholder and public/patient:
Not applicable

Management of Conflicts of Interest:
Information about specific GP Practices may present a conflict of interest to GP Governing Body members.

Assurance departments/organisations who will be affected have been consulted:
A quarterly report produced by the Quality Team with input from the Safeguarding and Medicines Optimisation teams.
<table>
<thead>
<tr>
<th>Previously presented at committee / governing body:</th>
<th>Integrated Governance Committee – 19 September 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reference document(s) / enclosures:</td>
<td>Not applicable</td>
</tr>
<tr>
<td><strong>Risk Assessment:</strong></td>
<td>Any risks identified to patient safety will be reflected on the risk register. Corporate Risk 1163 - There is a risk of declining quality of care and poor resident experience due to care homes being rated by the CQC as Inadequate and placed in special measures resulting in a potential decrease in the quality and range of services on offer to residents through the closure of the service.</td>
</tr>
<tr>
<td><strong>Finance/ resource implications:</strong></td>
<td>Not applicable</td>
</tr>
</tbody>
</table>
Patient Safety and Outcomes Report
Acute and Place-based reporting

Quarterly submission to the Governing Body

Quarter 1 2019/20
November 2019
## Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>3</td>
</tr>
<tr>
<td><strong>Place-based reporting</strong></td>
<td>4-22</td>
</tr>
<tr>
<td>NHS Wakefield Clinical Commissioning Group (WCCG)</td>
<td>4-18</td>
</tr>
<tr>
<td>The NHS Patient Safety Strategy</td>
<td>4-7</td>
</tr>
<tr>
<td>Medicines Related Incident Reporting – Quarter 1 2019/20</td>
<td>8-9</td>
</tr>
<tr>
<td>Antimicrobial Resistance – Prescribing</td>
<td>10-11</td>
</tr>
<tr>
<td>Safeguarding update</td>
<td>12-13</td>
</tr>
<tr>
<td>Learning Disabilities Mortality Review (LeDeR) – Quarter 4 2018/19</td>
<td>14-15</td>
</tr>
<tr>
<td>Perfect Ward® - Care home Visits</td>
<td>16-18</td>
</tr>
<tr>
<td><strong>Mid Yorkshire Hospitals Trust (MYHT) – Community</strong></td>
<td>19-20</td>
</tr>
<tr>
<td>Mid Yorkshire Hospitals Trust (Community Services) Dashboard</td>
<td>19</td>
</tr>
<tr>
<td>Patient Safety Walkabouts – Quarter 1 2019/20</td>
<td>20</td>
</tr>
<tr>
<td><strong>South West Yorkshire Partnership Foundation Trust (SWYPFT)</strong></td>
<td>21</td>
</tr>
<tr>
<td>SWYPFT Dashboard</td>
<td>21</td>
</tr>
<tr>
<td>Yorkshire Ambulance Service (YAS)</td>
<td>22</td>
</tr>
<tr>
<td>YAS Dashboard</td>
<td>22</td>
</tr>
<tr>
<td><strong>Acute reporting</strong></td>
<td>23-27</td>
</tr>
<tr>
<td>Mid Yorkshire Hospitals Trust (MYHT) – Acute</td>
<td>23-27</td>
</tr>
<tr>
<td>MYHT Dashboard</td>
<td>23</td>
</tr>
<tr>
<td>Venous Thromboembolism (VTE) Exception Report – Division of Medicine</td>
<td>24</td>
</tr>
<tr>
<td>Acute Quality Dashboard</td>
<td>25</td>
</tr>
<tr>
<td>Sentinel Stroke National Audit Programme (SSNAP)</td>
<td>26-27</td>
</tr>
</tbody>
</table>
Introduction

The quarterly Patient Safety and Outcomes report provides a detailed summary of the quality of care that Wakefield patients receive based on the services that NHS Wakefield Clinical Commissioning Group (WCCG) commission. The report identifies good practice and where areas for improvement need to be considered to support and improve patient safety and outcomes.

This summary Patient Safety and Outcomes report provides an overview of the quality of care for Quarter 1 2019/20. The full report was discussed in detail at the Integrated Governance Committee (IGC) in September 2019.

Items covered in the full Patient Safety and Outcomes report included the following:

- Serious Incidents: MYHT (Acute and Community), SWYPFT and YAS – Quarter 1 2019/20
- Serious Incidents: Summary Against the Framework: MYHT, SWYPFT and YAS – Quarter 1 2019/20
- Independent Providers CQUIN Achievements – Quarter 4 2018/19
- MYHT CQUIN Reporting Structure 2019/20
- Healthcare Associated Infections exception reports for MRSA
- National Audit of Cardiac Rhythm Management Devices and Ablation – 2016-18 Report
- Learning Disabilities Mortality Review (LeDeR) Case Study
- Care Homes under enhanced surveillance
- MYHT (Community) exception reports
- MYHT exception reports
- Summary of Never Events
Safer culture, safer systems, safer patients

Background

This NHS Patient Safety Strategy was released by NHSE/I in July 2019. The strategy enables the NHS to build upon two foundations: patient safety culture and patient safety system. The strategy aims to remove individual blame and increase continuous improvement in patient safety. This will save 1000 extra lives and £100 million in care costs each year from 2023/24. It will adopt a ‘whole systems approach’ to safety, driven by aligned data, established communications channels, continuous improvements and strong clinical governance.

Key messages

• A new Patient Safety Incident Response Framework (PSIRF) will replace the Serious Incident Framework and support insight generation at the point of care.

• Will make references to ‘systems based patient safety investigation’ not ‘root cause analysis’.

• Investigations will be led by people with dedicated time and resource to complete the work, along with safety investigation training and expertise.

• Introduce a transformative medical examiner system, with medical examiners who will scrutinise deaths occurring in their trust. In 2020/21 this will expand to community and independent providers.

• The medical examiner system is due to be rolled out in Primary Care from March 2021.

• The National Patient Safety Alerts Committee (NaPSAC) will widen its duties to become a safety committee akin to safety boards in other safety critical industries like transport. NaPSAC will oversee the implementation of the Healthcare Safety Investigation Branch (HSIB) recommendations.
Safer culture, safer systems, safer patients

- Create patient safety partners (PSP) to allow patients, carers, families and lay people to be involved in improving patient safety.

- Health Education England (HEE), NHSI/E will create a national patient safety training syllabus to apply across a variety of competence levels and address different needs of learning.

- Shift focus of thinking from safety I (focus on when things go wrong) to safety II (when things go routinely right).

- Four national priorities have been identified for 2019/20: Sepsis, medicines safety, maternal and neonatal safety, adoption of tested interventions.

- Recognise the importance of staff well-being for patient safety.

Actions (these are a few of many included in the strategy)

- Acute trusts to establish medical examiners offices by end of Quarter 4 2019/20.
- Local systems to declare 100% compliance for all patient safety alerts from Quarter 2 2019/20.
- Local, regional and national health organisations to identify to the national patient safety team at least one patient safety specialist per organisation by end of Quarter 4 2019/20.
- Deliver the National Patient Safety Improvement Programme (NPSIP) and the Mental Health Safety Improvement Programme (MHSIP) priorities by Quarter 4 2019/20.
- Use existing systems culture metrics like the NHS Staff Survey to understand their safety culture and focus on staff perceptions for the fairness and effectiveness of incident management.
- Organisations should develop a patient safety incident review and investigation strategy to allow them to use a range of proportionate and effective learning responses to incidents.
The NHS Patient Safety Strategy (3 of 4)

Safer culture, safer systems, safer patients

Actions (these are a few of many included in the strategy)

• NPSIP priorities:
  • Deterioration – NEWS2 adoption by all acute and ambulance trusts by Quarter 4 2019/20.
  • Emergency laparotomy – 87% patients benefiting from the care bundle by Quarter 4 2019/20.
  • PReCePT – 33% increase in eligible mothers to whom MgSO4 is given by Quarter 4 2019/20.
  • COPD discharge bundle – 50% increase in sites that use the care bundle over baseline by Quarter 4 2019/20.
  • ED checklist – 50% increase in acute sites that benefit from the ED checklist or equivalent over baseline by Quarter 4 2019/20.

• Accelerate LeDer and align with the medical examiner system.

• Deliver the UK National Action Plan for Anti Microbial Resistance (AMR) – Local systems should develop plans to:
  • Halve healthcare associated Gram-negative blood stream infections by 2024 (25% by 2021).
  • Reduce community antibiotic use by 25% (from 2013/14 baseline) by 2024.
The NHS Patient Safety Strategy (4 of 4)

Model for the Patient Safety Strategy

Continuously improving patient safety

Insight
- Measurement, incident response, medical examiners, alerts, litigation

Involvement
- Patient safety partners, curriculum and training, specialists, Safety II.

Improvement
- Deterioration, spread, maternity, medication, mental health, older people, learning disability, antimicrobial resistance, research.

A patient safety culture
A patient safety system
Medicines Safety Reporting (1 of 2)

Quarter 1 2019/20

Background

It is apparent that nationally, primary care organisations have poor incident reporting rates. The role of the NHS Wakefield CCG Medicines Safety Officer is to promote incident reporting locally and champion a positive medicines safety culture. The mechanism for practices to report a medicines related incident is via the Datix incident reporting tool. Incidents are uploaded by the CCG onto the National Reporting and Learning System (NRLS) which contributes to the development of safety resources such as, MHRA (Medicines Health and Regulatory Agency) Drug Safety Updates and Patient Safety Alerts.

Incident analysis

![Number of medicine related incidents reported](image)

<table>
<thead>
<tr>
<th>Level of Harm</th>
<th>No Harm</th>
<th>Low Harm</th>
<th>Moderate Harm</th>
<th>Severe Harm or Death</th>
</tr>
</thead>
<tbody>
<tr>
<td>April - June 19</td>
<td>100</td>
<td>6</td>
<td>5</td>
<td>0</td>
</tr>
</tbody>
</table>

Sources of Incidents

<table>
<thead>
<tr>
<th>Source</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP Practice</td>
<td>84</td>
</tr>
<tr>
<td>Acute Provider</td>
<td>14</td>
</tr>
<tr>
<td>Community Pharmacy</td>
<td>4</td>
</tr>
<tr>
<td>Care Home</td>
<td>2</td>
</tr>
<tr>
<td>Other</td>
<td>7</td>
</tr>
</tbody>
</table>

The main themes for Quarter 1 2019/20 were:

1. Duplicate prescribing on repeat template (lack of housekeeping).
2. Poor quality and untimely discharge communication from Acute Trust.
3. Inappropriate prescribing in domiciliary environment due to lack of clinical information to support prescribing decision.
Medicines Safety Reporting (2 of 2)

Quarter 1 2019/20

Practices are encouraged to report at least 2 Medicine Related Incidents (MRIs) per 1000 registered patients.

<table>
<thead>
<tr>
<th>Top 5 GP Practices: Highest Reporting Activity</th>
<th>Lowest 5 GP Practices Reporting Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Eastmoor Surgery</td>
<td>12 practices did not submit any MRIs in this quarter</td>
</tr>
<tr>
<td>2. Ash Grove Surgery</td>
<td></td>
</tr>
<tr>
<td>3. King’s Medical Centre</td>
<td></td>
</tr>
<tr>
<td>4. Health Care First</td>
<td></td>
</tr>
<tr>
<td>5. The Grange</td>
<td></td>
</tr>
</tbody>
</table>

So what?

- The practices that are not reporting incidents as much as others may require further support from the Medicines Safety Officer to clarify the process of reporting, what type of incidents should be reported and benefits of reporting.
- Incident reporting provides crucial intelligence that contributes to improving patient safety at a national and local level.
- GP practices and clinicians can utilise incident submissions as supporting evidence to demonstrate that the practice is proactive in adopting a positive approach to patient safety e.g. CQC inspections, professional revalidation.

Actions

- The Quarter 1 2019/20 MRIs summary will be shared at the next Quality Intelligence Group.
- GP practices are made aware of the recurrent themes where they can influence positive action and change.
- CCG Medicines Safety Officer to liaise with the practices that are under reporting incidents to offer additional support.
Background

In January 2019 the Department of Health and Social Care published ‘Tackling Antimicrobial Resistance’, a new 5 year strategy with an aim to champion the responsible use of antibiotics, by ensuring NHS staff have the skills, knowledge and training to prescribe and administer antibiotics appropriately. One of the strategy targets is to reduce UK antimicrobial use in humans by 15% by 2024. Wakefield has one of the highest antimicrobial prescribing rates in the country; whilst it is reducing, it is not reducing as quickly as the national rate.

Key messages

• There is a large variation of antibiotic prescribing rates between the top and lowest performing practices in Wakefield.
• Some practices have reduced prescribing significantly whilst others have stayed still/worsened.
• Urinary tract infection management remains a key concern as this is implicated in gram negative bloodstream infections.
• Out of hours prescribing by Local Care Direct accounts for 20% of all antibiotic prescribing in Wakefield.
**Actions**

- Gain assurance from out of hours provider that good antimicrobial stewardship is being practised.
- Highlight unwarranted variation between practices through Primary Care Home and Prescribing Lead GP events and encourage sharing of good practice; as well as peer support and challenge.
- Work with MYHT to develop and implement a UTI management pathway.
- Work with the NHSE National Project Lead for Antibiotics to provide support in reducing volume of prescribing.
- Provide pharmacy leadership to WYaH ICS on their AMR strategy.
- Continue to participate in West Yorkshire Research Centre LAMP (Lowering Antimicrobial Prescribing) study.
- Link in with the place-based E.coli Reduction Plan.
Safeguarding update (1 of 2)

Quarter 1 2019/20

Background

This is the first safeguarding team update to be included in the Patient Safety and Outcomes Report. Recognising the abuse and neglect of children and adults at risk, and responding to this appropriately, is essential for all organisations. The CCG safeguarding team undertake a wide range of functions including information gathering and sharing, representing the CCG at partnership meetings and undertaking assurance from providers in regards to their safeguarding functions.

Key messages

• There were no Safeguarding Adults Reviews (SARs), Child Safeguarding Practice Reviews (CSPR) or Domestic Homicide Reviews (DHR) published during Quarter 1 2019/20.

• Quarterly training compliance rates for CCG staff at the end of June were:

<table>
<thead>
<tr>
<th>Target</th>
<th>Safeguarding adults</th>
<th>Safeguarding children</th>
<th>Prevent (basic awareness and WRAP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1</td>
<td>85%</td>
<td>84%</td>
<td>85%</td>
</tr>
<tr>
<td>Level 2</td>
<td>85%</td>
<td>88%</td>
<td>83%</td>
</tr>
<tr>
<td>Level 3</td>
<td>85%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Level 4/5</td>
<td>85%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

• The safeguarding team continues to represent the CCG at Safeguarding Adult Board (SAB) and Safeguarding Children Partnership (SCP) meetings continuing to strengthen partnership arrangements. During Quarter 1 2019/20 the Deputy Designated Professional for Safeguarding Adults took over chairing of the SAB L&D sub group.
Safeguarding update (2 of 2)

Quarter 1 2019/20

Key achievements – Q1 19/20

• During June 2019, Safeguarding week was held across West Yorkshire and a display was put on at White Rose House which focused on Adverse Childhood Experiences (ACEs).
• CCG Prevent policy was ratified at IGC in May 2019.
• The safeguarding team received a 100% return on the GP safeguarding standards self-assessment.
• 1 update delivered to SMT re the Liberty Protection Safeguards (LPS) (expected to replace MCA - DoLS in October 2020).
• First safeguarding team newsletter for GPs was produced and circulated in June 2019.
• Successfully recruited to Nurse post in MASH team.
• Head of Safeguarding was part of the peer review in Wolverhampton Local Authority.
• Wakefield CCG chaired the first meeting of West Yorkshire and Harrogate ICS Designated Professionals Meeting.
• One of the MASH nurses completed the NHS Academy Mary Seacole course for Safeguarding.

Areas for development – Q2 19/20

• Produce Safeguarding Team Annual Report.
• Produce a more detailed report for IGC in December re GP safeguarding standards self-assessment.
• Work with Primary Care to identify GPs (on Governing Body) who undertook WRAP at a Network Event and ensure this is captured by Organisational Development and their compliance recorded.
• Co-produce a summary of the likely impact on the CCG of the new LPS for the October IGC meeting.

Key
L&D – Learning and Development
MCA – Mental Capacity Act
DoLS – Deprivation of Liberty Safeguards
WRAP- Workshop to Raise Awareness of Prevent
MASH- Multi-Agency Safeguarding Hub
Learning Disabilities Mortality Review (LeDeR) (1 of 3)
Quarter 1 2019/20

Background

The national LeDeR programme involves reviewing the deaths of all people with a learning disability to identify potentially avoidable contributory factors. LeDeR focuses on the learning that can be gained from reviewing the circumstances in which a person with learning disabilities dies, and their care and treatment through their life.

The LeDeR programme is now included in the NHS Oversight Framework 2019/20 with requirements for CCGs to be a member of the LeDeR Steering Group; have a named person with lead responsibility for LeDeR; have a plan in place to ensure reviews are undertaken within 6 months of the notification of death; have systems in place to analyse and address the themes and recommendations from completed reviews; and produce an annual report for appropriate committees for all statutory partners, demonstrating action taken and outcomes from reviews.

The CCG is compliant with each of these requirements but is not currently able to ensure reviews are undertaken within 6 months of the notification of death. This is on the risk register (1337).

There is a risk that the CCG will not be able to meet the national requirements in the NHS Operational Planning and Contracting Guidance 2019/20 to ensure LeDeR (learning disabilities mortality review) reviews are undertaken within 6 months of the notification of death due to the capacity of trained reviewers across Wakefield compared to the number of cases being notified.

This may result in a delay in identifying learning to improve care for people with learning disabilities and a potential reputational risk to the CCG assurance process.
Learning Disabilities Mortality Review (LeDeR) (2 of 3)
Quarter 1 2019/20

The table details the number of Wakefield district cases notified to the CCG since April 2017 and the stage in the review process.

<table>
<thead>
<tr>
<th>Position as at 12.08.2019</th>
<th>Notifications</th>
<th>Reviewer allocated</th>
<th>Reviews undertaken</th>
<th>Awaiting additional information</th>
<th>Awaiting CCG review</th>
<th>Awaiting allocation of a reviewer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr 17 - Dec 18</td>
<td>29</td>
<td>2 *</td>
<td>16</td>
<td>1</td>
<td>1 **</td>
<td>9</td>
</tr>
<tr>
<td>Jan 19 - Jul 19</td>
<td>19</td>
<td>7 *</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>10</td>
</tr>
</tbody>
</table>

*One case is a child who will be reviewed under the Child Death Overview Process (CDOP).

**Case subject to a multi-agency review.

Progress

• LeDeR reviewer training is delivered on-line to give flexibility for new reviewers. There continues to be challenge with allocating cases to allow a timely review (within 6 months of notification) in line with the national 2019/20 operational planning guidance. Existing reviewers are struggling to undertake their reviews due to capacity in their day to day role. Six additional CCG reviewers have been identified – 3 have completed their training.

• Utilising NHS England funding for 2018/19 a regional reviewer was appointed for six months to undertake reviews across West Yorkshire; provide professional support to reviewers; buddy with new reviewers; and link with the local learning into action forums. The funding for this post ends on 30 September 2019.

• Since publication of the annual report NHS England has commissioned North East Commissioning Support (NECS) to complete all backlog cases (those reported prior to 1 January 2019). This project will start in September and NECS will be allocated the 9 outstanding Wakefield cases.

• A LeDeR Learning into Action Group has been established across the Calderdale, Kirklees and Wakefield footprint to ensure that the findings from reviews across the patch inform commissioning and improve services and experience for people with a learning disability. A further meeting was held in August 2019.

• The CCG has strengthened contractual requirements with GP practices to ensure 100% of patients with a learning disability are invited for a health check (with at least 75% receiving a health check, at year end). At 30 June 2019, to date, 15.4% of patients have had their health check. 11 practices are above the Q1 target of 18.75%.

• The MYHT Learning from Deaths Policy will be strengthened to ensure copies of Structured Judgement Reviews (SJR) documents (as relevant) are shared with the LeDeR reviewer; and to include all deaths for people with a learning disability in the SJR process.
Perfect Ward® - Care Home Visits (1 of 3)

Quarter 1 2019/20

Background
Perfect Ward® is jointly funded by the CCG and Local Authority and is a smartphone / iPad application that enables walkabout teams to monitor the quality of care in care homes. Within the app there are four audits which are completed on each inspection: Environment, Resident Experience, Leadership and Documentation. (Resident Experience details are reported in the quarterly Experience of Care Report). The app provides instant feedback and RAG ratings by generating a detailed report for each module after each audit is completed.

<table>
<thead>
<tr>
<th>Environment</th>
<th>Documentation</th>
<th>Leadership</th>
</tr>
</thead>
<tbody>
<tr>
<td>The top three questions that care homes performed best in were:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is only medication stored in the drug fridge?</td>
<td>Are all entries legible and signed?</td>
<td>Are staff given protected time to administer medication?</td>
</tr>
<tr>
<td>Are room temperatures recorded daily with actions recorded is outside the normal range?</td>
<td>If unable to consent is there a capacity assessment?</td>
<td>Are training records complete for staff trained to administer medication?</td>
</tr>
<tr>
<td>Are drugs stored in a locked cupboard/trolley?</td>
<td>Have all care plans been reviewed at least monthly?</td>
<td>Are staff up to date with the statutory fire training?</td>
</tr>
</tbody>
</table>

The three questions that care homes performed worst against in were:

<table>
<thead>
<tr>
<th>Environment</th>
<th>Documentation</th>
<th>Leadership</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are all staff bare below the elbow?</td>
<td>If a resident lacks capacity, is there DoLs in place with any conditions transferred to an appropriate care plan?</td>
<td>Are there regular audits for crash mats with evidence of an action plan?</td>
</tr>
<tr>
<td>Is the environment clean including bedrooms, communal areas and bathrooms?</td>
<td>Is there a care plan for giving medicines covertly?</td>
<td>Are there regular audits for cot sides with evidence of an action plan?</td>
</tr>
<tr>
<td>Is the laundry room well organised?</td>
<td>Are fluid charts accurate, up to date and contain details as to the 24 hr requirements and totals including target amounts?</td>
<td>Are there regular audits for pressure cushions with evidence of an action plan?</td>
</tr>
</tbody>
</table>

To support homes against negative findings:
• Homes are signposted to the Infection Prevention and Control website for information and advice.
• Homes are signposted to the local authority lead for DoLs for support with capacity assessments and understanding of DoLs conditions.
• Examples of exemplar charts templates for fluid, and examples of audits templates have been shared with providers.
Examples of good practice

- Well organised cupboard.
- Nutrition chart completed with amounts given and eaten.
- Confectionary trolley for residents to access.

- The outcomes from visits are also used as a monitoring tool for contracts held by both the CCG and Local Authority.
- In July 2019 an initial workshop for the development of a care home strategy was held. The outputs from the event will inform the Wakefield place strategy.
Examples of areas for improvement

- Broken drawer with missing front residents bedroom.
- Fluid chart not completed correctly. No target amount or amount of fluid given.
- Dirty and stained crash mat.
Place-based reporting – Quarter 1 2019/20

Mid Yorkshire Hospitals Trust (Community Services) dashboard

This scorecard provides an overview of the community quality measures and details the performance for Quarter 1 2019/20. The data is based on the information that is provided at MYHT’s Community Contract Group. The measures are categorised against the Care Quality Commission domains: Safe, Effective, Responsive and Well-led.

<table>
<thead>
<tr>
<th>Key Performance Indicator</th>
<th>Target</th>
<th>Latest monthly trend</th>
<th>2018/19 YTD</th>
<th>Apr-19</th>
<th>May-19</th>
<th>Jun-19</th>
<th>Q1 2019/20</th>
<th>2019/20 YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Safe</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Serious incidents: new in month (excluding pressure ulcers)</td>
<td>0</td>
<td>NC</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Serious incidents: pressure ulcers (Category 3 and 4) reported to StEIS</td>
<td>0</td>
<td>B</td>
<td>7</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Pressure ulcers: trust acquired pressure ulcers (category 2-4)</td>
<td>41</td>
<td>D</td>
<td>708</td>
<td>59</td>
<td>66</td>
<td>-</td>
<td>-</td>
<td>127</td>
</tr>
<tr>
<td>Pressure ulcers: trust acquired pressure ulcers (category 3)</td>
<td>1</td>
<td>B</td>
<td>25</td>
<td>3</td>
<td>2</td>
<td>-</td>
<td>-</td>
<td>5</td>
</tr>
<tr>
<td>Pressure ulcers: trust acquired pressure ulcers (category 4)</td>
<td>0</td>
<td>B</td>
<td>17</td>
<td>2</td>
<td>0</td>
<td>-</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>Falls: total patients falls</td>
<td>4</td>
<td>B</td>
<td>81</td>
<td>3</td>
<td>5</td>
<td>2</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Falls: patient falls resulting in harm</td>
<td>1</td>
<td>B</td>
<td>14</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Falls: rate of patient falls resulting in harm per 1000 bed days</td>
<td>2.32</td>
<td>B</td>
<td>2.05</td>
<td>1.32</td>
<td>2.65</td>
<td>0.0</td>
<td>1.34</td>
<td>1.34</td>
</tr>
<tr>
<td>Trust attributable MRSA infection cases</td>
<td>0</td>
<td>NC</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Trust attributable C. difficile infection cases</td>
<td>0</td>
<td>NC</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Trust attributable E.coli incidence</td>
<td>0</td>
<td>NC</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Effective</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of patients with a Purpose - T score on initial assessment (pressure ulcer assessment)</td>
<td>&gt;95%</td>
<td>D</td>
<td>95.9%</td>
<td>85.9%</td>
<td>86.3%</td>
<td>86.1%</td>
<td>86.1%</td>
<td>86.1%</td>
</tr>
<tr>
<td>% of patients with a FRAT (falls risk assessment)</td>
<td>&gt;95%</td>
<td>D</td>
<td>-</td>
<td>95.9%</td>
<td>95.9%</td>
<td>94.9%</td>
<td>95.6%</td>
<td>95.6%</td>
</tr>
<tr>
<td>% of patients with a MUST score (nutrition/hydration assessment)</td>
<td>&gt;95%</td>
<td>D</td>
<td>-</td>
<td>95.9%</td>
<td>96.0%</td>
<td>95.1%</td>
<td>95.7%</td>
<td>95.7%</td>
</tr>
<tr>
<td><strong>Responsive</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgent (Same Day) - audited</td>
<td>&gt;95%</td>
<td>NC</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Delayed transfers of care (DTOC): community beds (WICU)</td>
<td>&lt;7.5%</td>
<td>B</td>
<td>7.09%</td>
<td>10.58%</td>
<td>13.89%</td>
<td>4.83%</td>
<td>9.83%</td>
<td>9.83%</td>
</tr>
<tr>
<td><strong>Well-led</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff sickness rate (Divisional)</td>
<td>5.0%</td>
<td>D</td>
<td>5.59%</td>
<td>4.82%</td>
<td>5.11%</td>
<td>-</td>
<td>-</td>
<td>4.96%</td>
</tr>
</tbody>
</table>
Patient Safety Walkabouts

Quarter 1 2019/20

Background

Patient Safety Walkabouts (PSWs) take place at the Mid Yorkshire Hospitals Trust and involve a small team of clinical and non-clinical staff (from the CCG and volunteers from Healthwatch) walking onto a ward to note their first impressions. The PSW teams speak to patients and staff, review patient documentation and observe the environment and staff interaction to identify areas of good practice and areas for improvement. Below is a summary of all the walkabouts that took place during Quarter 1 2019/20 that captures the patient safety and clinical elements of the visits. The quarterly Experience of Care report details experience of care and feedback.

During April and May 2019 the walkabouts were cancelled due to pressures and infection outbreaks within the Trust.

Wakefield Intermediate Care Unit (WICU) - 25th June 2019

The environment was visibly clean and well maintained. Staff were seen to be observing Bare Below the Elbows and disinfecting their hands on a regular basis. A number of fire doors were seen propped open. It was observed that controlled drugs were stored in accordance with Trust policy. Records were up to date with all assessments recorded at the appropriate frequency (falls, MUST, Purpose T) with the appropriate follow up assessments. Handover notes were clear and concise with excellent use of pictures to depict incontinence, dementia, risk of falls and bold type for critical information such as allergies and DNACPR.

Actions

• All immediate issues were raised on the day of the Patient Safety Walkabout.
• A debrief takes place immediately after the walkabout with senior nursing staff and a MYHT Director.
• The full report and MYHT’s response are shared with the visit team.
• MYHT report walkabout findings in their quarterly Quality and Safety Report.
Place-based reporting – Quarter 1 2019/20

South West Yorkshire Partnership Foundation Trust (SWYPFT)

<table>
<thead>
<tr>
<th>Measure</th>
<th>Target</th>
<th>Trend</th>
<th>Latest data</th>
<th>Apr-19</th>
<th>May-19</th>
<th>Jun-19</th>
<th>Q1 19/20</th>
<th>19/20 YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>South West Yorkshire Partnership Foundation Trust (SWYPFT)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of Never Events</td>
<td>0</td>
<td>NC</td>
<td>Jun-19</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Number of SWYPFT serious incidents reported (Wakefield)</td>
<td>-</td>
<td>-</td>
<td>NC</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Safety Thermometer: Proportion of patients that have had an omission of medication in the last 24 hours (Trust)</td>
<td>16.8%</td>
<td>B</td>
<td>Jun-19</td>
<td>24.5%</td>
<td>27.0%</td>
<td>15.8%</td>
<td>22.4%</td>
<td>22.4%</td>
</tr>
<tr>
<td>Number of falls (inpatients) (Trust)</td>
<td>tbc</td>
<td>D</td>
<td>Jun-19</td>
<td>52</td>
<td>37</td>
<td>41</td>
<td>130</td>
<td>130</td>
</tr>
<tr>
<td>Number of restraint incidents (Trust)</td>
<td>n/a</td>
<td>B</td>
<td>Jun-19</td>
<td>287</td>
<td>303</td>
<td>193</td>
<td>783</td>
<td>783</td>
</tr>
<tr>
<td>Staff sickness absence (Wakefield) (monthly)</td>
<td>≤4.6%</td>
<td>B</td>
<td>Jun-19</td>
<td>5.6%</td>
<td>4.7%</td>
<td>3.9%</td>
<td>4.7%</td>
<td>4.7%</td>
</tr>
<tr>
<td>Staff sickness absence (Trust) (monthly)</td>
<td>≤4.4%</td>
<td>D</td>
<td>Jun-19</td>
<td>4.7%</td>
<td>4.7%</td>
<td>5.2%</td>
<td>4.9%</td>
<td>4.9%</td>
</tr>
</tbody>
</table>

NHS Safety Thermometer: Medicines Omissions

SWYPFT formally report the medication omission (inpatient only) measure of the mental health safety thermometer through their Integrated Performance report. The impact of the actions described in previous reports is that the medicines omissions as measured by the monthly safety thermometer are decreasing. Ward and pharmacy teams have been working closely on the causes and solutions to include in their practice – some wards have included medicines omissions in safety crosses and others are undertaking medication reviews each day. A ‘Medicines refused? Refer to pharmacy’ campaign was launched in February 2019. A data collection brief has been circulated to assist with recording as it has been identified that if a patient is absent from the ward then an omission is being recorded.
### Place-based reporting – Quarter 1 2019/20

**Yorkshire Ambulance Service (YAS)**

#### Ambulance Clinical Quality Indicators CQI Measures (ACQI) – Quarter 4 2018/19

<table>
<thead>
<tr>
<th>Measure</th>
<th>Target</th>
<th>Trend</th>
<th>Latest data</th>
<th>Jan-19</th>
<th>Feb-19</th>
<th>Mar-19</th>
<th>Q4 18/19</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Yorkshire Ambulance Service (YAS)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Call to Angiography (STEMI) (90th%)</td>
<td>&lt;150 mins</td>
<td>172</td>
<td>B</td>
<td>Mar-19</td>
<td>176</td>
<td>175</td>
<td>166</td>
</tr>
<tr>
<td>Stroke Care (%)</td>
<td>-</td>
<td>96.1</td>
<td>NA</td>
<td>Mar-19</td>
<td>-</td>
<td>96.1</td>
<td>-</td>
</tr>
<tr>
<td>Call to Thrombolysis (Stroke) (90th %)</td>
<td>&lt;180 mins</td>
<td>204</td>
<td>B</td>
<td>Mar-19</td>
<td>200</td>
<td>223</td>
<td>190</td>
</tr>
<tr>
<td>Survival to Discharge (Utstein) (%)</td>
<td>&gt;30%</td>
<td>26</td>
<td>D</td>
<td>Mar-19</td>
<td>22.2</td>
<td>34.6</td>
<td>22.2</td>
</tr>
</tbody>
</table>

#### YAS Measures – Quarter 1 2019/20

<table>
<thead>
<tr>
<th>Measure</th>
<th>Target</th>
<th>Trend</th>
<th>Latest data</th>
<th>Apr-19</th>
<th>May-19</th>
<th>Jun-19</th>
<th>Q1 19/20</th>
<th>19/20 YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Yorkshire Ambulance Service (YAS)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Serious Incidents (EOC / 999)</td>
<td>-</td>
<td>-</td>
<td>B</td>
<td>Jun-19</td>
<td>4</td>
<td>7</td>
<td>2</td>
<td>13</td>
</tr>
<tr>
<td>Serious Incidents (Treatment Delay)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>Q1 19/20</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>8</td>
</tr>
<tr>
<td>Incidents (Delayed Response)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>Q1 19/20</td>
<td>274</td>
<td>239</td>
<td>196</td>
<td>709</td>
</tr>
<tr>
<td>Incidents (Patient Related - Trust Wide)</td>
<td>-</td>
<td>-</td>
<td>B</td>
<td>Jun-19</td>
<td>12</td>
<td>19</td>
<td>10</td>
<td>41</td>
</tr>
<tr>
<td>Incidents (Moderate and above - A&amp;E / EOC)</td>
<td>-</td>
<td>-</td>
<td>B</td>
<td>Jun-19</td>
<td>6.2</td>
<td>6.1</td>
<td>6.0</td>
<td>6.1</td>
</tr>
<tr>
<td>Staff absence: Trust absence rate</td>
<td>5.0%</td>
<td>B</td>
<td>Jun-19</td>
<td>6.2</td>
<td>6.1</td>
<td>6.0</td>
<td>6.1</td>
<td>6.1</td>
</tr>
</tbody>
</table>

**RAG**
- B - Better
- D - Deteriorated
- NC - No Change
The Patient Safety and Outcomes Provider Dashboard provide a detailed overview and illustrate the trends of quality measures for Quarter 1 2019/20. The indicators in this scorecard are grouped based on the five domains of quality identified by the Quality Strategy; Safety of our patients, Patient (and staff) experience, Improving staff experience, Timely access to services and Patient outcomes.

## Measure Table

<table>
<thead>
<tr>
<th>Measure</th>
<th>Target</th>
<th>Trend</th>
<th>Latest data</th>
<th>Jan-19</th>
<th>Feb-19</th>
<th>Mar-19</th>
<th>Q4 18/19</th>
<th>18/19 YTD</th>
<th>Apr-19</th>
<th>May-19</th>
<th>Jun-19</th>
<th>Q1 19/20</th>
<th>Jul-19</th>
<th>19/20 YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mid Yorkshire Hospitals Trust (Acute) Quality Strategy Performance Measures</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Safety of our patients</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trust attributable MRSA infection cases</td>
<td>0</td>
<td>NC</td>
<td>Jun-19</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Trust attributable Clostridium Difficile infection cases</td>
<td>6/73</td>
<td>NC</td>
<td>Jun-19</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>7</td>
<td>46</td>
<td>1</td>
<td>2</td>
<td>5</td>
<td>8</td>
<td>3</td>
<td>11</td>
</tr>
<tr>
<td>% of patients risked accessed for Venous Thromboembolism</td>
<td>&gt;95%</td>
<td>D</td>
<td>Apr-19</td>
<td>83.7%</td>
<td>68.8%</td>
<td>81.8%</td>
<td>78.1%</td>
<td>89.4%</td>
<td>85.3%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Number of never events: identified in month</td>
<td>0</td>
<td>NC</td>
<td>May-19</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>Number of new serious incidents for the month</td>
<td>-</td>
<td>-</td>
<td>Jun-19</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>15</td>
<td>75</td>
<td>13</td>
<td>5</td>
<td>5</td>
<td>23</td>
<td>-</td>
<td>23</td>
</tr>
<tr>
<td>Reported patient safety incidents that are harmful: acute services</td>
<td>22%</td>
<td>B</td>
<td>Jul-19</td>
<td>22.1%</td>
<td>23.1%</td>
<td>24.6%</td>
<td>23.3%</td>
<td>23.6%</td>
<td>21.8%</td>
<td>18.4%</td>
<td>24.5%</td>
<td>21.6%</td>
<td>24.1%</td>
<td>22.1%</td>
</tr>
<tr>
<td><strong>Improving staff experience</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff sickness absence</td>
<td>4.4%</td>
<td>D</td>
<td>Jul-19</td>
<td>5.33%</td>
<td>5.16%</td>
<td>4.28%</td>
<td>4.92%</td>
<td>4.72%</td>
<td>4.61%</td>
<td>4.75%</td>
<td>4.68%</td>
<td>4.68%</td>
<td>4.96%</td>
<td>4.79%</td>
</tr>
<tr>
<td><strong>Patient outcomes</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stroke care: SSNAP overall level</td>
<td>B</td>
<td>D</td>
<td>Q4 18/19</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>B</td>
<td>n/a</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Hospital Standardised Mortality Ratio (HSMR)</td>
<td>≤100</td>
<td>B</td>
<td>May-19</td>
<td>104.05</td>
<td>107.24</td>
<td>97.16</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>323.18</td>
<td>92.92</td>
<td>-</td>
<td>-</td>
<td>108.56</td>
</tr>
<tr>
<td>Hospital Standardised Mortality Ratio - emergency weekend admissions</td>
<td>≤100</td>
<td>As expected</td>
<td>D</td>
<td>Jan-19</td>
<td>107.27</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>110.04</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

Some measures are reported monthly or quarterly.

B - Better  
D - Deteriorated  
NC - No Change
Venous Thromboembolism (VTE) Exception Report – Division of Medicine

September 2019

Background

The Trust VTE report shows that the Division of Medicine continues to underachieve the expected 95% threshold compared to other divisions. The assessment of venous thromboembolism (VTE) risk is mandatory for all admissions to the trust. This is achieved through the completion of a proforma within the admission process which should be completed by the clerking professional (ANP or Junior Doctor) and followed up by prescribing any appropriate medication. The primary cause is that these proformas are inadequately completed.

Current performance with Trajectory for recovery of the target:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Actual position</td>
<td>71.1%</td>
<td>73.4%</td>
<td>78.2%</td>
<td>80.7%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Trajectory</td>
<td>78%</td>
<td>78%</td>
<td>78%</td>
<td>82%</td>
<td>90%</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
</tr>
</tbody>
</table>

Actions undertaken by the Division of Medicine

- The Division has undertaken a VTE Audit and on 12-14 June 2019 a Mini Kaizen event was held.
- Clinical leaders will reinforce to the clerkng doctor as well as review on the post take ward round full completion and sign off of the VTE assessments. This will also be included in the induction process.
- An education video has been produced and educational posters are in clinical areas.
- A Standard Operating Process has been implemented to ensure the electronic recording of VTE on discharge.
- Daily monitoring processes have been introduced in the acute clinical areas led by ward managers.
- As of August 2019 VTE data will be included in the Quality data shared at Divisional Specialty Performance meetings.
- Clinical oversight of VTE performance will be embedded in performance meetings.
- Further consultant leadership with the introduction of daily safety huddles supported by Matrons to review and ensure VTE assessments have been completed, acted upon and recorded as required.
- This issue has been discussed at MYHT Quality Committee and MY System Executive Group.
Acute Quality Dashboard

Quarter 1 2019/20

<table>
<thead>
<tr>
<th>Acute Trust Quality Measure</th>
<th>Target</th>
<th>Period</th>
<th>Barnsley Hospital</th>
<th>Bradford Teaching Hospitals</th>
<th>Calderdale and Huddersfield Foundation Trust</th>
<th>Doncaster and Bassetlaw Hospitals</th>
<th>Leeds Teaching Hospitals</th>
<th>Mid Yorkshire Hospitals Trust</th>
<th>Sheffield Teaching Hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safe</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clostridium Difficile assigned cases against trust target</td>
<td>Varies by Trust</td>
<td>Apr 19 – Jul 19</td>
<td>-</td>
<td>7</td>
<td>-</td>
<td>16</td>
<td>-</td>
<td>18</td>
<td>-</td>
</tr>
<tr>
<td>Incident reporting – staff who stated the incident reporting procedure was fair and effective</td>
<td>-</td>
<td>Aug-19</td>
<td>Within the middle range</td>
<td>Within the middle range</td>
<td>Within the middle range</td>
<td>Within the middle range</td>
<td>Within the middle range</td>
<td>Within the middle range</td>
<td>Data not available</td>
</tr>
<tr>
<td>Effective</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Summary Hospital Mortality Indicator (SHMI)</td>
<td>≤1</td>
<td>Apr 18 - Mar 19</td>
<td>As expected</td>
<td>NC</td>
<td>As expected</td>
<td>NC</td>
<td>As expected</td>
<td>NC</td>
<td>As expected</td>
</tr>
<tr>
<td>Sentinel Stroke National Audit Programme (SSNAP) Level</td>
<td>A-C</td>
<td>Q4 18/19</td>
<td>Level D</td>
<td>NC</td>
<td>Level B</td>
<td>NC</td>
<td>Level A</td>
<td>NC</td>
<td>Level B</td>
</tr>
<tr>
<td>Governance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CQC Rating</td>
<td>Good</td>
<td>Aug 19</td>
<td>Good</td>
<td>NC</td>
<td>Requires Improvement</td>
<td>NC</td>
<td>Good</td>
<td>NC</td>
<td>Requires Improvement</td>
</tr>
</tbody>
</table>

Key messages

Sentinel Stroke National Audit Programme
During Quarter 4 2018/19 MYHT's overall SSNAP performance improved and resulted in a Level B. Previously, in Quarter 3 2018/19 MYHT scored a Level C. Performance for Doncaster and Bassetlaw Teaching Hospital deteriorated from a Level A to Level B during Quarter 4 2019/20. The other providers remained the same.

Summary Hospital Mortality Indicator (SHMI)
NHS Digital published the latest SHMI data during August 2019 for the reporting period April 2018 – March 2019. All providers remained ‘as expected’ and scored a Band 2 SHMI rating.
Sentinel Stroke National Audit Programme (SSNAP) (1 of 2)

SSNAP Performance Summary – Quarter 4 2018/19

Background

This is a summary update on the results of the quarterly Sentinel Stroke National Audit Programme (SSNAP) reports for January – March 2019. Trusts are ranked between levels A to E (Level A best performing and Level E worst) across a range of domains covering the entire inpatient stroke pathway. The ranking is based on a SSNAP score out of 100.

Results for MYHT

<table>
<thead>
<tr>
<th>Team-Centred Key Indicators Levels</th>
<th>January – March 2019 (Period 23) SSNAP Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Scanning</td>
<td>Level B</td>
</tr>
<tr>
<td>2. Stroke Unit</td>
<td>Level C</td>
</tr>
<tr>
<td>3. Thrombolysis</td>
<td>Level B</td>
</tr>
<tr>
<td>4. Specialist Assessments</td>
<td>Level A</td>
</tr>
<tr>
<td>5. Occupational Therapy</td>
<td>Level B</td>
</tr>
<tr>
<td>6. Physiotherapy</td>
<td>Level A</td>
</tr>
<tr>
<td>7. Speech and Language Therapy</td>
<td>Level E</td>
</tr>
<tr>
<td>8. MDT Working</td>
<td>Level D</td>
</tr>
<tr>
<td>9. Standards by Discharge</td>
<td>Level A</td>
</tr>
<tr>
<td>10. Discharge Processes</td>
<td>Level A</td>
</tr>
</tbody>
</table>

Key messages

- Overall, MYHT’s SSNAP performance has improved during January – March 2019 (Quarter 4 2018/19). MYHT’s latest performance resulted in a Level B SSNAP Level. During Quarter 3 2018/19 MYHT scored a Level C, with a score of 68.4.
- Performance has remained static in Domains: 2, 5, 6, 8, 9 and 10.
- Performance deteriorated for Domain 7 (Speech and Language Therapy). Previously, scored a Level D and latest performance scored a Level E.
- There were improvements for Domains: 1, 3 and 4.
- MYHT achieved a Level A for four domains: Scanning (Domain 1), Occupational Therapy (Domain 5), Standards by Discharge (Domain 9) and Discharge Processes (Domain 10).
### SSNAP Performance Summary – Quarter 4 2018/19

<table>
<thead>
<tr>
<th>Period 11</th>
<th>Period 12</th>
<th>Period 13</th>
<th>Period 14</th>
<th>Period 15</th>
<th>Period 16</th>
<th>Period 17</th>
<th>Period 18</th>
<th>Period 19</th>
<th>Period 20</th>
<th>Period 21</th>
<th>Period 22</th>
<th>Period 23</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSNAP Level</td>
<td>D</td>
<td>D</td>
<td>D</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>B</td>
<td>B</td>
<td>B</td>
<td>C</td>
<td>B</td>
<td>C</td>
</tr>
<tr>
<td>SSNAP Score</td>
<td>54</td>
<td>54</td>
<td>55</td>
<td>69</td>
<td>66</td>
<td>68</td>
<td>70</td>
<td>77</td>
<td>73</td>
<td>68</td>
<td>72.2</td>
<td>68.4</td>
</tr>
</tbody>
</table>

#### Team-Centred Key Indicators Levels

1) **Scanning**

| | D | C | B | A | B | B | B | A | B | B | B | A |

2) **Stoke Unit**

| | C | C | C | B | C | C | C | B | C | C | C | C |

3) **Thrombolysis**

| | D | D | D | C | B | C | C | B | B | B | B | C |

4) **Specialist Assessments**

| | D | D | C | C | C | C | C | C | C | B | C | C |

5) **Occupational Therapy**

| | B | C | C | B | C | B | B | A | B | C | A | A |

6) **Physiotherapy**

| | C | C | D | B | B | B | C | B | C | B | B | B |

7) **Speech and Language Therapy**

| | E | E | E | E | E | E | E | D | C | D | C | E |

8) **MDT Working**

| | D | D | E | D | E | E | D | D | D | D | D | D |

9) **Standards by Discharge**

| | B | B | B | A | A | A | B | B | A | A | A | A |

10) **Discharge Processes**

| | B | B | B | A | A | A | A | B | A | A | A | A |
CQC Inspection Update
For Governing Body
November 2019
**Latest Care Quality Commission (CQC) Ratings**

The following table provides an overview of the latest CQC inspection ratings that have been published for providers within Wakefield area. The CQC monitors, inspects and regulates health and social care services. A summary of the CQC report for each service is available via the web links below. A full exception report will be included for services that received a Requires Improvement or Inadequate rating.

<table>
<thead>
<tr>
<th>Organisation Name</th>
<th>Provider Name</th>
<th>Specialism / Services</th>
<th>Date of Inspection visit</th>
<th>Overall CQC Rating</th>
<th>CQC rating by domain</th>
<th>Link to full CQC Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trusts</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yorkshire Ambulance Service NHS</td>
<td>Emergency services</td>
<td>28th May - 1st July 2019</td>
<td>Good</td>
<td></td>
<td></td>
<td>YAS</td>
</tr>
<tr>
<td>Manor Park Care Home</td>
<td></td>
<td></td>
<td></td>
<td>Requires Improvement</td>
<td></td>
<td>Manor Park</td>
</tr>
</tbody>
</table>

**CQC Ratings Key**
- Outstanding
- Good
- Requires Improvement
- Inadequate
- Not inspected
**Annual Regulatory Reviews (ARRs)**

Background

Annual Regulatory Reviews (ARR) of GP practices commenced in April 2019 for all practices rated Good or Outstanding.

The ARR will not change a practice’s rating; this can only happen following an inspection. However, the ARR may trigger an inspection if there are indications of substantial changes (positive or negative) in the quality of care since the last inspection or review.

Latest Annual Regulatory Reviews (ARRs)

Seven GP Practices completed their Annual Regulatory Review (ARR) during July and August 2019:

- Dr Meulendijk and Partners
- Dr Singh and Partners
- Queen Street Surgery
- Rycroft Medical Centre
- Stanley Health Centre
- Trinity Medical Centre
- White Rose Surgery

None of these reviews triggered an inspection.
## Exception Report – Manor Park Care Home

<table>
<thead>
<tr>
<th>Manor Park Care Home</th>
<th>Key information about Manor Park</th>
</tr>
</thead>
<tbody>
<tr>
<td>CQC Domains</td>
<td>Previous CQC Rating</td>
</tr>
<tr>
<td>Safe</td>
<td>Requires Improvement</td>
</tr>
<tr>
<td>Effective</td>
<td>Requires Improvement</td>
</tr>
<tr>
<td>Caring</td>
<td>Requires Improvement</td>
</tr>
<tr>
<td>Responsive</td>
<td>Requires Improvement</td>
</tr>
<tr>
<td>Well-led</td>
<td>Requires Improvement</td>
</tr>
<tr>
<td>Overall Rating</td>
<td>Requires Improvement</td>
</tr>
</tbody>
</table>

**CQC History**

Manor Park is a care home with three separate units divided into nursing care, residential care and care for people living with dementia. Previously, during February 2018 the service was rated overall Requires Improvement.

After a recent unannounced inspection during April 2019 this service remained overall **Requires Improvement** achieving Good for the Caring domain.

CQC concluded the following breaches:

- Regulation 12 - Safe care and treatment
- Regulation 17 - Good governance
Actions

The Quality Support Manager is continuing to provide support to enable the home to make improvements. Improvements will be evidenced and monitored through Perfect Ward® visits.

- A PerfectWard® quality assurance visit was undertaken on 03 June 2019.
- The findings from the PerfectWard® quality assurance visits were shared with the nominated individual for Countrywide Care Homes Limited.
- At the last visit the team observed and found improvements in the resident experience, environment and leadership audits. However, the documentation audit needed to improve, for example, risk assessments were not always updated to reflect any changes following a resident fall.
- A PerfectWard® visit is scheduled for 27th November 2019.
The CQC inspected YAS from 28th May to 1st July 2019 with the final report published on 14th October 2019. The CQC undertook unannounced inspections of the Patient Transport Service (PTS) and Emergency Operations Centre (EOC) and the Trust was subject to their first well-led review. PTS had been rated as ‘requires improvement’ at the previous inspection in 2016. The Integrated Urgent Care (IUC) (NHS 111) service was not inspected as this is subject to a separate CQC inspection process.

Ratings for the EOC service line remained as ‘good’ across the domains and overall. Ratings for PTS improved to ‘good’ across the domains and overall (the rating was previously ‘requires improvement’ overall and for safe, responsive and well-led).

The CQC highlighted 10 ‘should do’ actions to comply with minor breaches to improve service quality, but no ‘must do’ actions or regulatory action were identified.

Key highlights
- The service had enough staff to meet patient demand and keep them safe.
- Staff provided good care and treatment and worked well together for the benefit of patients.
- The service planned care to meet the needs of local people.
- Staff had training in key skills, understood how to protect patients, including from abuse. However, some staff in PTS did not have the confidence to report and escalate safeguarding concerns.
- Leaders ran services well using reliable information systems and supported staff to develop their skills.
• People’s needs were central to the delivery of the service. Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
• Escalation processes for deteriorating or seriously ill patients were in place in PTS
• The service engaged with patients, staff, and equality groups, the public and local organisations
• The leadership, governance and culture were used to drive and improve the delivery of high quality, sustainable patient care. The Board and leaders had the right skills and abilities. There was clear leadership in place from a chief executive who was visible, approachable, and well regarded throughout the organisation.
• There was a lack of diversity at board level and the workforce was not representative of the population.
• Leaders modelled and encouraged compassionate and supportive relationships, so that staff felt respected, valued and supported.
• A systematic approach was taken to improve care for patients with mental health needs. However, training in mental health crisis was limited in the EOC and appraisal rates did not meet the trust target.
• Learning from complaints and concerns was not always shared effectively in the EOC.
• There were processes in place to support staff and to promote well-being.
• There was a successful pilot paramedic rotation scheme for specialist and advanced paramedics
• Proactive engagement with patients, staff, the public and local organisations with an annual programme of community engagement events, notable practice in a strong Critical Friends Network (CFN).
• An innovative approach to collaborate with other ambulance services in a Northern ambulance alliance.
• There was a network of end of life care champions across the region.

Actions
• The CQC inspection report will be shared and discussed via the YAS Joint Quality Board on 19th November 2019. Implementation of the ‘should do’ actions will be monitored via the Joint Quality Board.
• The report will also be shared via the sub-regional Quality Meetings.
<table>
<thead>
<tr>
<th>Title of meeting:</th>
<th>Governing Body</th>
<th>Agenda Item:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Meeting:</td>
<td>12 November 2019</td>
<td>13</td>
</tr>
<tr>
<td>Paper Title:</td>
<td>Performance Report (Governing Body Summary)</td>
<td></td>
</tr>
<tr>
<td>Purpose (this paper is for):</td>
<td>Decision</td>
<td>✓</td>
</tr>
<tr>
<td>Report Author and Job Title:</td>
<td>Natalie Tolson, Head of Business Intelligence Nicola Richardson, Performance, Data and Information Analyst</td>
<td></td>
</tr>
<tr>
<td>Responsible Clinical Lead:</td>
<td>Dr Adam Sheppard</td>
<td></td>
</tr>
<tr>
<td>Responsible Governing Board Executive Lead:</td>
<td>Jonathan Webb, Chief Finance Officer Suzannah Cookson, Chief Nurse</td>
<td></td>
</tr>
</tbody>
</table>

**Recommendations:**
It is recommended that the Governing Body:-
1. Note the current CCG performance against NHS Constitutional standards;
2. Note those indicators where performance is below target and the exception reports provided.

**Executive Summary**
Due to the timing of the Integrated Governance Committee, the October Performance Report has not been presented and discussed.

The Performance Report includes the following:
- CCG performance against the NHS Constitutional standards – August 2019
- Oversight Framework – Published October 2019
- Yorkshire Ambulance Response Times Dashboard – August 2019

The Executive Summary in the Performance Report outlines the key highlights of the Performance report.

**Link to overarching principles from the strategic plan:**
- Reduction in hospital admissions where appropriate leading to reinvesting in prevention
- New Accountable Care Systems to deliver new models of care
- Collective prevention resource across the health and social care sector and wider social determinant partners
- Expanded Health and Wellbeing board membership to represent wider determinants
- A strong ambitious co-owned strategy for ensuring safe and healthy futures for children
<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>A shift towards allocation of resources based upon primary and secondary</td>
<td>Transforming to become a sustainable financial</td>
</tr>
<tr>
<td>prevention and social determinants of ill health</td>
<td>economy</td>
</tr>
<tr>
<td>Organising ourselves to deliver for our patients</td>
<td>![Checkmark]</td>
</tr>
</tbody>
</table>

| Outcome of Integrated Impact Assessment completed (IIA)                  | Not applicable                              |
| Outline public engagement – clinical, stakeholder and public/patient:   | Not applicable                              |
| Management of Conflicts of Interest:                                    | None identified                             |
| Assurance departments/organisations who will be affected have been      | Performance, Quality, Transformation,       |
| consulted:                                                              | Integrated Commissioning, Primary Care      |
|                                                                         | Co-commissioning                            |
| Previously presented at committee / governing body:                     | Integrated Governance Committee – 19         |
|                                                                         | September 2019                              |
| Reference document(s) / enclosures:                                     | Not applicable                              |
| Risk Assessment:                                                       | Mitigating actions have been included within |
|                                                                         | the report and risks are captured as        |
|                                                                         | appropriate in the Governing Body Assurance  |
|                                                                         | Framework and Corporate Risk Register.       |
| Finance/ resource implications:                                         | Mitigating actions required to improve      |
|                                                                         | performance or quality are assessed on an   |
|                                                                         | individual basis for any finance or resource |
|                                                                         | implications.                               |
Performance Report
August 2019
For Governing Body
November 2019
Executive Summary

The monthly Performance Report provides a high level overview of the CCG’s performance against both constitutional performance metrics and national performance measures that are used to assess the CCG’s overall rating as part of the Improvement and Assessment Framework (IAF).

The report also features the monthly Yorkshire Ambulance Service Response Times Dashboard.

Highlights:

Oversight Framework

- The Oversight Framework (OF) for 2019/20 has replaced the provider’s Single Oversight Framework and the CCG’s Improvement and Assessment Framework (IAF). The framework comprises of 59 CCG measures. The measures which are new to the 2019/20 framework are as follows:
  - Patient experience of booking a GP appointment
  - Proportion of people on GP severe mental illness register receiving physical health checks in primary care
  - Learning disabilities mortality review
  - Overall size of the waiting list
  - Patients waiting over 52 weeks for treatment
  - Children and Young People and Eating Disorders investment as a percentage of total mental health spend
  - Reducing the rate of low priority prescribing

- The first release of the Oversight Framework, ‘October 2019’ includes 33 refreshed measures. Of the refreshed measures, 5 reported in the best quartile range, 12 reported in the interquartile range, 8 reported in the worst quartile range and 8 were not ranked to a quartile range.

- The CCG improved to the best quartile range from the interquartile range against ‘Improving access to psychological therapies – access’. However the measure for ‘Improving access to psychological therapies – recovery’ remains in the worst quartile.

- The ‘Primary care workforce’ measure has deteriorated to the interquartile range, however reports in the best position amongst the CCG’s peer group.

- There are two newly reported measures for planned care, one measure for ‘Overall size of the waiting list’ and ‘Patients waiting over 52 weeks for
treatment’, both of these are reporting in the worst quartile.

- The measure for ‘Patients waiting 6 weeks or more for a diagnostic test’ has improved from the worst quartile to the interquartile range.
- There are 8 measures that are classified as ‘unable to identify’, this is due to there being no national level data reported.

**Constitutional Performance**

- For the month of August, 7 of the 9 cancer waiting time standards achieved the assigned target.
  - Both of the 2 week wait measures have continued to improve, with ‘breast’ achieving 100% and ‘urgent GP’ achieving 99%.
  - All of the 31 day measures have achieved standard, with ‘anti-cancer drug regime’ remaining at 100% and ‘first definitive treatment’ improving by 3% to 97.7%.
  - The 62 day measure for ‘referral from a NHS Screening Service to first definitive treatment’ continues to decrease, but achieves the standard with 91.7%.

  - Of the 62 day cancer measures, the following are below target:
    - The measure for ‘urgent GP referral to first definitive treatment for cancer’ has decreased by 6% to 76.8% for August.
    - The measure for ‘first definitive treatment following consultant decision to upgrade’ has significantly declined by 23% to 59.1%.

- For August, the referral to treatment 18 week standard has continued to deteriorate, reporting a position of 86.6%. The incomplete waiting list has decreased by 25 pathways in August to 26,658. The waiting list position reports 10.4% above the March 18 position.

- Calderdale and Huddersfield NHS Foundation Trust (CHFT) are participating in a national pilot that will be testing different measures of RTT performance. CHFT will not be publically reporting their RTT incomplete position from August 2019.

- August reported 6 referral to treatment 52 week breaches for Trauma and Orthopaedics. Of these, 3 were newly reported with the remainder recurrent.

- Diagnostic 6 week waiting time performance continues to improve, reporting at 97.9% for August. However, provisional data for September reports a further improvement with performance of 99.6%, which is above the national standard.

- For Healthcare Associated Infections:
  - There were 3 cases of MRSA reported in August 2019 against a target of 0. The year to date total is 4.
  - There were 8 cases of Clostridium Difficile during August 2019 against a monthly target of 8. The year to date total is 29.
  - There were 26 cases of E.Coli reported in August 2019. The new target has yet to be confirmed. The year to date total is 137.

**Yorkshire Ambulance Service**

- The Yorkshire average for August continues to report a higher position than the national average against all of the response time measures.
- Category 1 performance for Yorkshire has decreased in mean duration, achieving the 7 minute target for August with a time of 6 minutes and 50 seconds. Of the remaining measures with a target assigned, 2 of the 3, show a decrease in duration, achieving the target. The measure for Category 1T has continued to not achieve the target mean time during August.
- The Mid Yorkshire overall handover performance has continued to decline with both measures failing to meet the 100% target. The 15 minute measure is reporting at 85.4% for August, with the 30 minute measure reporting at 97.4%.
The outline below shows the CCG’s performance for the October 2019 Oversight Framework and indicates if the reported position was an improvement or deterioration from the position reported at the end of Q4 2018-19.

Out of the 59 indicators, 33 were refreshed with the latest published data. Against the 33 indicators, Wakefield CCG performed as follows:

**Against 5 of the measures, the CCG reported in the best quartile range.** Of these measures, 4 remained in the best range with 1 measure improving to the best quartile range:
- 123b Improving access to psychological therapies - access

**Against 12 of the measures, the CCG reported in the interquartile range.** Of these measures, 11 remained in the interquartile range with 1 measure improving to the interquartile range:
- 133a Patients waiting six weeks or more for a diagnostic test

**Against 8 of the measures, the CCG reported in the worst quartile range:**
- 107a Antimicrobial resistance: appropriate prescribing of antibiotics in primary care
- 121a Provision of high-quality care: hospitals (deteriorated to)
- 122d Cancer patient experience (deteriorated to)
- 123a Improving access to psychological therapies – recovery
- 123j Ensuring the quality of mental health data submitted to NHS Digital is robust (DQMI) (deteriorated to)
- 125d Maternal smoking at delivery

2 of these measures are newly reported and are in the worst quartile range:
- 129b Overall size of the waiting list
- 129c Patients waiting over 52 weeks for treatment

For those measures that have deteriorated to worst quartile range, a detailed performance review will be undertaken and the results will be reported in next month’s Performance Report.

8 of the measures are not ranked into a quartile range.
The dashboards below are based on the National Oversight Framework, which was published on 24th October. Please note that not all measures are refreshed on a quarterly basis and are marked with an ‘R’ in the data refresh column where updated.

**Key**
- **Worst quartile in England**
- **Best quartile in England**
- **Interquartile range**
- **Direction of travel opposite to desired**
- **Direction of travel as desired**
- **Indicator value stagnant between now and last period**
- **Direction unable to be calculated**

### New Service Models

#### Integrated Primary and Community Health Services

<table>
<thead>
<tr>
<th>Measure</th>
<th>Desired Direction</th>
<th>Deviation from</th>
<th>Period</th>
<th>CCG</th>
<th>Trend</th>
<th>National</th>
<th>Peers</th>
<th>England</th>
<th>Data Refreshed</th>
</tr>
</thead>
<tbody>
<tr>
<td>127b Emergency admissions for urgent care sensitive conditions</td>
<td>National</td>
<td>Low ▼</td>
<td>19-20 Q2</td>
<td>2279</td>
<td>▼</td>
<td>2125</td>
<td>4/11</td>
<td>111/131</td>
<td>R</td>
</tr>
<tr>
<td>128b Patient experience of GP services</td>
<td>National</td>
<td>High ▲</td>
<td>2019</td>
<td>82.66%</td>
<td>○</td>
<td>82.90%</td>
<td>7/11</td>
<td>111/131</td>
<td>R</td>
</tr>
<tr>
<td>130a Achievement of clinical standards in the delivery of 7-day services</td>
<td>National</td>
<td>Low ▼</td>
<td>2017-18</td>
<td>2</td>
<td>○</td>
<td>-</td>
<td>2/11</td>
<td>16/191</td>
<td>R</td>
</tr>
<tr>
<td>131a Percentage of NHS continuing healthcare full assessments taking place in an acute hospital setting</td>
<td>National</td>
<td>Low ▼</td>
<td>19-20 Q1</td>
<td>0.00%</td>
<td>▲</td>
<td>6.54%</td>
<td>1/11</td>
<td>1/191</td>
<td>R</td>
</tr>
</tbody>
</table>

#### Acute Emergency Care and Transfers of Care

<table>
<thead>
<tr>
<th>Measure</th>
<th>Desired Direction</th>
<th>Deviation from</th>
<th>Period</th>
<th>CCG</th>
<th>Trend</th>
<th>National</th>
<th>Peers</th>
<th>England</th>
<th>Data Refreshed</th>
</tr>
</thead>
<tbody>
<tr>
<td>127e Delayed transfers of care per 100,000 population</td>
<td>National</td>
<td>Low ▼</td>
<td>2019</td>
<td>10.9</td>
<td>▼</td>
<td>10.9</td>
<td>8/11</td>
<td>108/191</td>
<td>R</td>
</tr>
</tbody>
</table>

#### Personalisation and Patient Choice

<table>
<thead>
<tr>
<th>Measure</th>
<th>Desired Direction</th>
<th>Deviation from</th>
<th>Period</th>
<th>CCG</th>
<th>Trend</th>
<th>National</th>
<th>Peers</th>
<th>England</th>
<th>Data Refreshed</th>
</tr>
</thead>
<tbody>
<tr>
<td>105b Personal health budgets</td>
<td>National</td>
<td>High ▲</td>
<td>19-20 Q1</td>
<td>32</td>
<td>▲</td>
<td>160</td>
<td>8/11</td>
<td>111/131</td>
<td>R</td>
</tr>
<tr>
<td>144a Use of the NHS e-referral service to enable choice at first routine elective referral</td>
<td>National</td>
<td>Green</td>
<td>2019 Q1</td>
<td>99.87%</td>
<td>▼</td>
<td>99.8%</td>
<td>10/11</td>
<td>104/191</td>
<td>R</td>
</tr>
</tbody>
</table>
### Preventing Ill Health and Reducing Inequalities

#### Smoking

<table>
<thead>
<tr>
<th>Indicator</th>
<th>National/ Constitutional/ Local</th>
<th>Desired Direction</th>
<th>Deviation from</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal smoking at delivery</td>
<td>National</td>
<td>Low ▼</td>
<td>6%</td>
</tr>
</tbody>
</table>

#### Obesity

<table>
<thead>
<tr>
<th>Indicator</th>
<th>National/ Constitutional/ Local</th>
<th>Desired Direction</th>
<th>Deviation from</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of children aged 10-11 classified as overweight or obese</td>
<td>National</td>
<td>Low ▼</td>
<td>England Mean</td>
</tr>
</tbody>
</table>

#### Falls

<table>
<thead>
<tr>
<th>Indicator</th>
<th>National/ Constitutional/ Local</th>
<th>Desired Direction</th>
<th>Deviation from</th>
</tr>
</thead>
<tbody>
<tr>
<td>Injuries from falls in people aged 65 and over</td>
<td>National</td>
<td>Low ▼</td>
<td>England Mean</td>
</tr>
</tbody>
</table>

#### Antimicrobial Resistance

<table>
<thead>
<tr>
<th>Indicator</th>
<th>National/ Constitutional/ Local</th>
<th>Desired Direction</th>
<th>Deviation from</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antimicrobial resistance: appropriate prescribing of antibiotics in primary care</td>
<td>National</td>
<td>Low ▼</td>
<td>0.965</td>
</tr>
<tr>
<td>Antimicrobial resistance: appropriate prescribing of broad spectrum antibiotics in primary care</td>
<td>National</td>
<td>Low ▼</td>
<td>10%</td>
</tr>
</tbody>
</table>

#### Health Inequalities

<table>
<thead>
<tr>
<th>Indicator</th>
<th>National/ Constitutional/ Local</th>
<th>Desired Direction</th>
<th>Deviation from</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inequality in unplanned hospitalisation for chronic ambulatory care sensitive and urgent care sensitive conditions</td>
<td>National</td>
<td>Low ▼</td>
<td>-</td>
</tr>
</tbody>
</table>

### Q1 (Apr-Jun 2019/20)

<table>
<thead>
<tr>
<th>Period</th>
<th>CGG</th>
<th>Trend</th>
<th>National Peers</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019 2Q</td>
<td>18.56% ▲</td>
<td>10.40% 9/11</td>
<td>180/191</td>
<td>R</td>
</tr>
<tr>
<td>2019 3Q</td>
<td>35.67% ▲</td>
<td>34.20% 7/11</td>
<td>116/191</td>
<td>R</td>
</tr>
<tr>
<td>2019 4Q</td>
<td>1763 3/11</td>
<td>58/191</td>
<td>R</td>
<td></td>
</tr>
<tr>
<td>2020 1Q</td>
<td>2184 ▲</td>
<td>2109 3/11</td>
<td>94/191</td>
<td>R</td>
</tr>
</tbody>
</table>

### Status between Q4 (18-19) IAF & Q1 (19-20) Of Performance Direction

- **Deteriorated**
- **Improved**
- **Remain - Interquartile**
- **Remain - Worst**
- **Remain - Best**
## Oversight Framework - October 2019

### Quality of Care and Outcomes

<table>
<thead>
<tr>
<th>General</th>
<th>National/Constitutional/Local</th>
<th>Desired Direction</th>
<th>Deviation from</th>
<th>Data Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>121a Provision of high-quality care in hospitals</td>
<td>National</td>
<td>High ▲</td>
<td>-</td>
<td>Q1 19/20 58 ▲ - 11/11 11/11/199</td>
</tr>
<tr>
<td>121b Provision of high-quality care in primary medical services</td>
<td>National</td>
<td>High ▲</td>
<td>-</td>
<td>Q1 19/20 67 ▲ - 11/11 11/11/199</td>
</tr>
<tr>
<td>132a Evidence that unsafe awareness raising among healthcare professionals has been prioritized by CCGs</td>
<td>National</td>
<td>-</td>
<td>-</td>
<td>2018 Green ▲ - 5/11</td>
</tr>
<tr>
<td>125a Evidence-based interventions</td>
<td>National</td>
<td>High ▲</td>
<td>-</td>
<td>Q1 19/20 Amber ▲ - 7/11</td>
</tr>
</tbody>
</table>

### Maternity Services

| 152a Neonatal mortality and stillbirths | National | Low ▼ | - | 2016 5.5 ▲ - 8/11 11/11/199 |
| 152b Women’s experience of maternity services | National | High ▲ | England Mean | 2016 81.5 ▲ 82.7 | 9/11 11/11/199 |
| 152c Choice in maternity services | National | High ▲ | England Mean | 2018 83.1 ▲ 84.4 | 2/11 11/11/199 |

### Cancer Services

| 122a Cancer diagnosed at early stage | National | High ▲ | 53.5% | 2017 52.7% ▲ 52.2% | 6/11 11/11/199 |
| 122b People with urgent GP referral having first definitive treatment for cancer within 62 days of referral | National | High ▲ | 85% | 2016 85.3 ▲ 77.3% | 10/11 11/11/199 |
| 122c One-year survival from all cancers | National | High ▲ | 75% | 2017 73.5% ▲ 72.8% | 6/11 11/11/199 |
| 122d Cancer patient experience | National | High ▲ | England Mean | 2018 8.7 ▲ - 10/11 11/11/199 |

### Mental Health

| 133a Improving access to psychological therapies - recovery | National | High ▲ | 50% | 2016 50.3% ▲ 52.3% | 10/11 11/11/199 |
| 133b Improving access to psychological therapies - access | National | High ▲ | - | 2017 5.2% ▲ 4.0% | 2/11 11/11/199 |
| 133c People with first episode of psychosis starting treatment with a NICE recommended package of care within two weeks of referral | National | High ▲ | 64% | 2017 63.4% ▲ 63.8% | 3/11 11/11/199 |
| 131f Mental health out-of-area placements | National | Low ▼ | - | 2019 0 ▲ 156 | 1/11 11/11/199 |

### Learning Disability and Autism

| 124b Provision of people with a learning disability on the GP register receiving an annual health check | National | High ▲ | England Mean | 2017/18 51.63% ▲ 51.40% | 2/11 11/11/199 |
| 124c Completeness of the GP learning disability register | National | High ▲ | - | 2017/18 5.64% ▲ 5.49% | 3/11 11/11/199 |

### Diabetes

| 102a Diabetic patients that have achieved all the NICE recommended treatment targets: three (HbA1c, cholesterol and blood pressure) for adults and one (HbA1c) for children | National | High ▲ | England Mean | 2017/18 41.51% ▲ 38.70% | 4/11 11/11/199 |
| 102b People with diabetes diagnosed less than a year who attend a structured education course | National | High ▲ | England Mean | 2014 cohort 14.80% ▲ 8.54% | 4/11 11/11/199 |

### People with Long Term Conditions and Complex Needs

| 106c Percentage of deaths with three or more emergency admissions in last three months of life | National | Low ▼ | - | 2017 7.8% ▲ 7.4% | 2/11 11/11/199 |
| 106a The proportion of care with a long-term condition who feel supported to manage their condition | National | High ▲ | 100% | 2017 98.2% ▲ 91.7% | 1/11 11/11/199 |
| 126a Estimated diagnosis rate for people with dementia | Local | High ▲ | 65% | 2016 65.6% ▲ 65.5% | 8/11 11/11/199 |

### Planned Care

| 129a Patients waiting 8+ weeks or less from referral to hospital treatment | National | High ▲ | 92% | 2017 78.1% ▲ 78.1% | 4/11 11/11/199 |
| 129b Overall size of the waiting list | National | Low ▼ | - | 2017 100% ▲ 100% | 5/11 11/11/199 |

### Status between Q1 (18-19) MAP & Q1 (19-20) CP Performance Breakdown

<table>
<thead>
<tr>
<th>Period</th>
<th>CGG Trend</th>
<th>National</th>
<th>Peers</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1 19/20</td>
<td>58 ▲</td>
<td>11/11</td>
<td>11/11/199</td>
<td></td>
</tr>
<tr>
<td>Q1 19/20</td>
<td>67 ▲</td>
<td>11/11</td>
<td>11/11/199</td>
<td></td>
</tr>
<tr>
<td>2018</td>
<td>Green ▲</td>
<td>5/11</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q1 19/20</td>
<td>Amber ▲</td>
<td>7/11</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Status between Q1 (18-19) MAP &amp; Q1 (19-20) CP Performance Breakdown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deteriorated</td>
</tr>
<tr>
<td>No Change</td>
</tr>
<tr>
<td>Unable to identify</td>
</tr>
<tr>
<td>Improved</td>
</tr>
</tbody>
</table>

Note: The table above represents the quality of care and outcomes across various aspects, including but not limited to maternity services, mental health, learning disabilities, and diabetes, among others. Each section details specific performance indicators and status levels for the given period.
Oversight Framework - October 2019

Leadership and Workforce

<table>
<thead>
<tr>
<th>126d Primary care workforce</th>
<th>National/Constitutional/Local</th>
<th>Desired Direction</th>
<th>Deviation from</th>
<th>Period</th>
<th>CGG</th>
<th>Trend</th>
<th>National Peers</th>
<th>England</th>
<th>Data Refreshed</th>
<th>Status between Q4 (18-19) IAF &amp; Q1 (19-20) OF Performance Direction</th>
<th>Status between Q4 (18-19) IAF &amp; Q1 (19-20) OF Quartile Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>National</td>
<td>High ▲</td>
<td>England Mean</td>
<td></td>
<td>2019/03</td>
<td>1.14%</td>
<td>▲</td>
<td>1.06</td>
<td>1/11</td>
<td>18/190</td>
<td>No Change</td>
<td>Deteriorated - Interquartile</td>
</tr>
</tbody>
</table>

| 162a Probity and corporate governance | National | Fully Compliant | - | 2018 | 3.70% | ▲ | 3.82 | 9/11 | 145/153 | No Change | Unable to Identify |
| 161a Staff engagement index | National | High ▲ | - | 2018 | 0.21% | ▲ | 0.14 | 11/11 | 135/135 | No Change | Unable to Identify |
| 163b Progress against the Workforce Race Equity Standard | National | High ▲ | - | 2018-19 | 76.3% | ▲ | 44/11 | 40/189 | 145/153 | No Change | Unable to Identify |
| 164a Effectiveness of working relationships in the local system | National | Green | - | Q1 19/20 | Green | ▲ | 6/11 | - | R | No Change | Unable to Identify |
| 165a Quality of leadership | National | Green | - | Q1 19/20 | Green | ▲ | 5/11 | - | R | No Change | Unable to Identify |
| 166a Compliance with statutory guidance on patient and public participation in commissioning health and care | National | Green | - | Q1 19/20 | Green | ▲ | 1/11 | - | R | No Change | Unable to Identify |

Finance and Use of Resources

<table>
<thead>
<tr>
<th>109a Reducing the rate of low priority prescribing</th>
<th>National/Constitutional/Local</th>
<th>Desired Direction</th>
<th>Deviation from</th>
<th>Period</th>
<th>CGG</th>
<th>Trend</th>
<th>National Peers</th>
<th>England</th>
<th>Data Refreshed</th>
<th>Status between Q4 (18-19) IAF &amp; Q1 (19-20) OF Performance Direction</th>
<th>Status between Q4 (18-19) IAF &amp; Q1 (19-20) OF Quartile Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>National</td>
<td>-</td>
<td>-</td>
<td></td>
<td>Q1 19/20</td>
<td>Green</td>
<td>▲</td>
<td>11/11</td>
<td>-</td>
<td>R</td>
<td>Unable to Identify</td>
<td>Unable to Identify</td>
</tr>
<tr>
<td>National</td>
<td>-</td>
<td>-</td>
<td></td>
<td>Q1 19/20</td>
<td>Green</td>
<td>▲</td>
<td>1/11</td>
<td>-</td>
<td>R</td>
<td>No Change</td>
<td>Unable to Identify</td>
</tr>
<tr>
<td>National</td>
<td>Green</td>
<td>-</td>
<td></td>
<td>Q1 19/20</td>
<td>Amber</td>
<td>▲</td>
<td>10/11</td>
<td>-</td>
<td>R</td>
<td>No Change</td>
<td>Unable to Identify</td>
</tr>
<tr>
<td>National</td>
<td>Green</td>
<td>-</td>
<td></td>
<td>Q1 19/20</td>
<td>Green</td>
<td>▲</td>
<td>1/11</td>
<td>-</td>
<td>R</td>
<td>No Change</td>
<td>Unable to Identify</td>
</tr>
</tbody>
</table>
N.B. The CCG are no longer being measured against the 4 hour waiting time standard due to Mid Yorkshire participating in the pilot of the new emergency care standards. The CCG will report against these new standards once they are publically available.
NHS Constitutional Performance Exception Reporting Action Log – August

Reason for Escalation: Performance reports below national standard

18 week performance for the CCG at the end of August reported at 86.6%. With 5 specialties achieving the 92% national standard.

The national expectation is for the waiting list to remain at the position reported at the end of March 2018 (23,874) by the end of March 2020. At the end of August, the waiting list reports at 10.4% above the expected level.
New actions being taken – including highlights from the Oversight Committee

Transforming Outpatients Programme
Mid Yorkshire Hospitals Trust (MYHT) have established a Transforming Outpatients Programme. This programme of work focusses around the delivery of key work-stream areas designed to increase outpatient productivity, release capacity and aid in the Trust’s transition to a more digitally orientated future. Within this programme of work, also sits a number of ‘enabler’ projects designed to facilitate delivery of such key work-streams. This programme of work encompasses a dossier of over 20 individual projects designed to deliver significant benefit to both the Trust and its patients within the next 2 years.

It was agreed that a Clinical Lead would be assigned to the Outpatients Programme to support the projects that impact on clinical/front line areas and engage with clinicians. The Outpatient Board has now been established and the presence of a Clinical Lead on this Board would be highly beneficial. A job description and person specification has been developed for the role of Clinical Lead for Outpatients. Expressions of interest to be requested for the Clinical Lead or recruitment process are to be undertaken.

An absence of an Outpatient Dashboard has been identified; the Outpatient Dashboard would allow us to track overall progress of projects and their delivery of outputs. A project group and working group is now in place to effectively drive progress against the development of an Outpatient Dashboard. Overall governance structure in place to enable escalation where appropriate (see below).

Overall programme KPIs to be formulated once all project working groups are fully functional with individual projects scoped and project KPIs developed.

Key Achievements Include:

Validation
• A Prioritisation Plan has been created to determine the order in which specialties require a follow up backlog to be validated. This is based on the clinical risk evaluation and services which have the largest opportunity for beneficial impact.
• A process is in place to review the validation resource that is available across MYHT (RRT DQ, ABC and in specialty), review the skill set and the validation that they can undertake.

Patient Initiated Follow Up (PIFU)
• Review taking place of all specialities that have been identified as potential for PIFU. Meetings arranged to support the teams to document the requirements from PIFU.
• Investigation into the metrics that can be used to measure the outcomes of PIFU including where the patients are now on the waiting list.
• Process flow for the set up and management of PIFU is to be created by December.
Mid Yorkshire Hospitals Trust continue to work towards reducing the incomplete waiting list towards the March 2018 position by the end of March 2020.
### Reason for escalation

**Performance reports below national standard**

6 breaches were reported in August against patients waiting for treatment in trauma and orthopaedics.

The total of YTD breaches for Wakefield CCG is 30.

### New actions being taken – including highlights from the Oversight Committee

**CCG 52 Week Breaches**

![Breaches Graph](image)

**Leeds Teaching Hospitals Trust**

The number of over 52 week waiters at Leeds Teaching Hospitals Trust (LTHT) increased by 3 in August to 6 overall, all in Spinal Surgery. LTHT have met with NHSE to review a sustainable capacity and clinical delivery model for the whole system and service, agreeing a number of actions. The growth in potential 52 week waiters means there is a greater chance of more patients requiring treatment in the coming months; assuming the current rate of conversion holds up for the next cohorts of patients.

LTHT continues to seek alternative capacity for outpatients and have encouraged local MSK services to ensure that only patients who have had appropriate work are referred into the service. Any GP routine spinal referrals are planned to be rejected and re-referred via the agreed locally commissioned routes.
### Mid Yorkshire

Whilst there have been no 52 week breaches at Mid Yorkshire Hospitals Trust, the number of over 35 week waiters has been increasing and consequently increases the risk of a 52 week breach occurring. This increase has been reported within ENT and Gynaecology.

The Planned Care Improvement Group is closely monitoring the position.

<table>
<thead>
<tr>
<th>Identified impact and expected timeframe for recovery</th>
</tr>
</thead>
<tbody>
<tr>
<td>At LTHT there is continued risk of further breaches as those waiters over 38 weeks continue to increase with a total of 53 reported to August. Further work is currently underway to quantify the impact of those on the waiting list.</td>
</tr>
</tbody>
</table>
**Reason for escalation**

**Performance reports below national standard**

Max 62 day wait from urgent GP referral to first definitive treatment for cancer:
- Performance reports at 76.8% for August.
- August reported 22 breaches.

Max 62 day wait for first definitive treatment following consultant decision to upgrade:
- Performance reports at 59.1% for August.
- August reported 9 breaches.

**New actions being taken – including highlights from the Oversight Committee**

**Mid Yorkshire Hospitals Trust actions for recovery - 62 day:**
The following information has been taken from the Mid Yorkshire Hospitals Trust Board paper of 10 October 2019 titled ‘Review of the issues surrounding cancer 62 day performance at Mid Yorkshire Hospitals’.

The key specialties of Urology, Gynaecology and Lower GI are driving this position and have been highlighted as requiring additional support outside of Mid Yorkshire Hospital Trust (MYHT) normal governance arrangements to address this. The Trust’s assessment of the factors influencing breaches of the 62 day standard to date are as follows:

**Diagnostic Delays**
- Diagnostic radiology (capacity) and reporting (capacity)
- Pathology turnaround times
- Endoscopy capacity / demand imbalance resulting in longer than 7 day pathways

**Capacity**
- Volumes of referrals increasing year on year with an inability to step change capacity in response to deliver a 7 day maximum first appointment / diagnostic intervention
- Theatre capacity and increase in joint case requirements linked to patient complexity
- Lone surgeon in Gynaecology

**Partner and Pathway**
- Radiotherapy delays (Leeds Teaching Hospitals Trust (LTHT))
- Targeted prostate biopsy (LTHT)
- Clinical Oncology outreach model and associated host organisation impacts

**Future potential influences on the position**
The emerging local intelligence in Urology which is likely to deteriorate their performance further is linked to the loss of a pelvic cancer surgeon, there is likely to be a gap of 6 months to the next appointment.
Urology Recovery
Short term mitigation
• Risk-assess the prioritisation of same-day MRI (as per the optimal pathways guidance). This would be at the detriment to other cancer pathways or other targets (Referral to Treatment (RTT) or Diagnostics (DM01)).
• Arrange internal cover arrangements to reduce the impact of the loss of a pelvic cancer surgeon.
• Maximise the potential of the Urology robot.
• Advertise the substantive cancer surgeon post as soon as possible.

Long term mitigation
• Purchase of a second MRI scanner at Dewsbury or Pinderfields with associated workforce and administrative infrastructure to deliver a 7 day diagnostic pathway for all patients.
• Review the cancer provision with a view to a third dedicated Urology surgeon.

Lower GI Recovery
Short term mitigation
• Prioritise cancer endoscopy and ensure diagnostic is completed within 7 days to the detriment of other pathways and other standards such as JAG.
• Outsource fast track 2ww referrals to community providers with appropriate clinical governance structures in place.
• Reduce the waiting times within Mid Yorkshire to support the introduction of a straight to test pathway.
• Ensure that sufficient non face to face capacity is in alignment to prevent waits post endoscopy pending straight to test introduction.

Long term mitigation
• To increase endoscopy workforce and skill mix to match the demand across all disciplines.

Gynaecology Recovery
Short term mitigation
• Strengthen support from the cancer team to mitigate breaches and reduce the time between patient pathway interventions.
• Introduce pathways to ensure 7 day access to hysteroscopy and colposcopy one stop shop clinics for all 2ww fast track patients.

Long term mitigation
• Strategy to increase local Consultant Gynaecology capacity.

Planned Care Improvement Group will be undertaking a deep dive into the specialities driving the underperformance position. The outcomes of this will be reported to ICG when available.
<table>
<thead>
<tr>
<th>Identified impact and expected timeframe for recovery</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Mid Yorkshire Hospitals Trust does not anticipate that the national standard will be achieved in Q2 and Q3.</td>
</tr>
<tr>
<td>• The short term actions which could be taken to improve the cancer position in Urology and Lower GI cannot be taken forwards without an associated detrimental impact on other cancer pathways, patient outcomes or access standards.</td>
</tr>
<tr>
<td>• 62 day cancer performance is not expected to recover to 85% without the long term mitigations being in place.</td>
</tr>
</tbody>
</table>
### Reason for escalation

#### C.Diff

**Performance reports below national standard**

10 cases of C.Diff were assigned to Wakefield CCG during September 2019 against a target of 8/97. The YTD figure is 39 cases.

- All post 72 hour cases are in the process of being reviewed under the new definition of case assignment.
- The IPC team has provided input into post 72 hour cases which have been identified in LTHT.
- Three cases were defined as hospital onset, healthcare associated; one case was community onset, healthcare associated; five case community onset, community associated and one case community onset indeterminate association.
- All cases have been reviewed. Seven cases had a previous history of CDI, seven cases had received recent antibiotics and one case had no information available.

#### E.Coli

**Performance reports below national standard**

28 cases of E.coli were assigned to Wakefield CCG during September 2019. The YTD figure is 165 cases.

- Further data collated to date shared with NHS Improvement.
- Hydration training carried out in one care home. Further sessions planned.
- Good practice event for care home managers – subjects covered AMR, TB, vaccinations and E Coli.
- Link workers updates included AMR, outbreak management, hydration and flu.
- Attended registered care home managers meetings to update on hydration.
- Sepsis information continues to be shared with care homes and on social media.
- Joint meeting with Medicines Management /Optimisation and NHS Improvement to discuss UTI CQUIN.
- Three cases were hospital onset, 11 cases were community onset healthcare associated, 6 cases were healthcare associated and 8 cases were community onset, non-healthcare associated. These 8 cases had received no healthcare intervention in the previous 28 days.
| MRSA | 3 pre 48 hour MRSA bacteraemias reported in August. Following the post-infection review (PIR) process, one case was deemed preventable and two cases non preventable.  
The preventable case was an oncology patient with a Hickman Line in situ. The patient had a history of MRSA and was aware of the result. Lessons learnt were management of the line in the community and no escalation of issues when flushing the line.  
One non preventable case was a person who injects drugs with a history of leg ulcers. There was no previous history of MRSA. Lessons learnt were missed opportunities for swabbing of the wounds in both primary and secondary care.  
Actions have been shared at both the MYHT Infection Control Committee and the Division of Adult Community Services. Actions have been completed  
One case was a health tourist not registered with a GP so automatically defaults to the CCG where the blood culture was processed. The patient had attended the Pontefract Urgent Treatment Centre on a number of occasions and was also diagnosed with malaria. Lessons learnt were admissions screening on patient admitted to the paediatric wards |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Performance reports below national standard</td>
<td></td>
</tr>
</tbody>
</table>
3 cases of MRSA were assigned to Wakefield CCG during August 2019. The YTD figure is 4 cases against a target of zero.  
Public Health England (PHE) will release the national objectives shortly. |
| Identified impact and expected timeframe for recovery |  
- Medium Impact  
- Actions ongoing |
The following table provides an overview of the Yorkshire Ambulance Service (YAS) performance and includes response times ranked against the national rate, crew clearance and handover performance for MYHT.

### Yorkshire Ambulance Service

The following table provides an overview of the Yorkshire Ambulance Service (YAS) performance and includes response times ranked against the national rate, crew clearance and handover performance for MYHT.

<table>
<thead>
<tr>
<th>Category</th>
<th>Mean (hour:min:sec)</th>
<th>90th Centile (hour:min:sec)</th>
<th>Reporting Period</th>
<th>Mean (hour:min:sec)</th>
<th>90th Centile (hour:min:sec)</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category 1</td>
<td>0:07:00</td>
<td>0:15:00</td>
<td>Aug-19</td>
<td>0:07:05</td>
<td>0:06:30</td>
<td>↓</td>
</tr>
<tr>
<td>Category 1T</td>
<td>0:07:00</td>
<td>0:15:00</td>
<td>Aug-19</td>
<td>0:10:44</td>
<td>0:08:39</td>
<td>↑</td>
</tr>
<tr>
<td>Category 2</td>
<td>0:18:00</td>
<td>0:40:00</td>
<td>Aug-19</td>
<td>0:21:13</td>
<td>0:17:04</td>
<td>↓</td>
</tr>
<tr>
<td>Category 3</td>
<td>0:40:00</td>
<td>2:00:00</td>
<td>Aug-19</td>
<td>1:02:42</td>
<td>0:38:03</td>
<td>↓</td>
</tr>
<tr>
<td>Category 4</td>
<td>-</td>
<td>3:00:00</td>
<td>Aug-19</td>
<td>1:14:34</td>
<td>0:40:54</td>
<td>↓</td>
</tr>
<tr>
<td>2 hour response</td>
<td>-</td>
<td>-</td>
<td>Aug-19</td>
<td>1:30:35</td>
<td>0:55:03</td>
<td>↓</td>
</tr>
</tbody>
</table>

### Response Times

**Category 1**: Time critical, life threatening event needing immediate intervention and/or resuscitation - National Standard of 7 minute mean response.

**Category 1T**: The clock stops at the arrival of the vehicle of the type that transports the patient.

**Category 2**: Potentially serious conditions that may require rapid assessment, urgent intervention and/or transport - National Standard of 18 minute mean response.

**Category 3**: Urgent problem that needs treatment to relieve suffering and transport, or assessment and management at scene – National Standard of 120 minutes.

**Category 4**: Problems that are not urgent but need assessment and possibly transport within an appropriate timeframe – National Standard of 180 minutes.
Executive Summary:

- The year to date position is £0.5m better than plan. This relates to the phasing of efficiencies unidentified at the start of the planning year and is expected to reduce over the next six months.
- The year-end forecast is expected to be in line with the planned full-year surplus of £2m.
- Following a robust and detailed review, all expected risks and mitigations that are now relatively certain have been included in the financial forecast position.
- The remaining key financial risks in 2019/20 for the CCG relates to the risk of not fully delivering the identified efficiency schemes.
- The CCG is forecasting delivery of £9.9m of efficiency against the target of £12.2m. The adverse impact of the delivery shortfall is being managed through the contingency fund and other underspends.
- Based on the current forecast, the CCG underlying surplus is £0.7m which will form the starting point of the 2020/21 financial plans.
<table>
<thead>
<tr>
<th>principles from the strategic plan:</th>
<th>Reduction in hospital admissions where appropriate leading to reinvesting in prevention</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>New Accountable Care Systems to deliver new models of care</td>
</tr>
<tr>
<td></td>
<td>Collective prevention resource across the health and social care sector and wider social determinant partners</td>
</tr>
<tr>
<td></td>
<td>Expanded Health and Wellbeing board membership to represent wider determinants</td>
</tr>
<tr>
<td></td>
<td>A strong ambitious co-owned strategy for ensuring safe and healthy futures for children</td>
</tr>
<tr>
<td></td>
<td>A shift towards allocation of resources based upon primary and secondary prevention and social determinants of ill health</td>
</tr>
<tr>
<td></td>
<td>Transforming to become a sustainable financial economy</td>
</tr>
<tr>
<td></td>
<td>Organising ourselves to deliver for our patients</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outcome of Integrated Impact Assessment completed (IIA)</th>
<th>Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outline public engagement – clinical, stakeholder and public/patient:</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Management of Conflicts of Interest:</td>
<td>None identified</td>
</tr>
<tr>
<td>Assurance departments/organisations who will be affected have been consulted:</td>
<td>There is a formal monthly reporting requirement to NHS England / Improvement</td>
</tr>
<tr>
<td>Previously presented at committee / governing body:</td>
<td>Finance Committee</td>
</tr>
<tr>
<td>Reference document(s) / enclosures:</td>
<td>None</td>
</tr>
<tr>
<td>Risk Assessment:</td>
<td>Relevant risks are identified on the CCG risk register</td>
</tr>
<tr>
<td>Finance/ resource implications:</td>
<td>This report sets out the financial position of the CCG.</td>
</tr>
</tbody>
</table>
Executive Summary – Key Messages

• The year to date position is £0.5m better than plan. This relates to the phasing of efficiencies unidentified at the start of the planning year and is expected to reduce over the next six months.

• The year-end forecast is expected to be in line with the planned full-year surplus of £2m.

• Following a robust and detailed review, all expected risks and mitigations that are now relatively certain have been included in the financial forecast position.

• The remaining key financial risks in 2019/20 for the CCG relates to the risk of not fully delivering the identified efficiency schemes.

• The CCG is forecasting delivery of £9.9m of efficiency against the target of £12.2m. The adverse impact of the delivery shortfall is being managed through the contingency fund and other underspends.

• Based on the current forecast, the CCG underlying surplus is £0.7m which will form the starting point of the 2020/21 financial plans.
### 2019/20 Financial Summary and Key Performance Indicators

#### Summary of Key Financial Measures

<table>
<thead>
<tr>
<th>Indicator</th>
<th>YTD Plan £m</th>
<th>YTD Actual £m</th>
<th>YTD Variance £m</th>
<th>FOT Plan £m</th>
<th>FOT Actual £m</th>
<th>FOT Variance £m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Programme spend within plan</td>
<td>G</td>
<td>G</td>
<td></td>
<td>A</td>
<td>G</td>
<td></td>
</tr>
<tr>
<td>Running costs spend within plan</td>
<td>G</td>
<td>G</td>
<td></td>
<td>G</td>
<td>G</td>
<td></td>
</tr>
<tr>
<td>QIPP delivery</td>
<td>A</td>
<td>A</td>
<td></td>
<td>A</td>
<td>A</td>
<td></td>
</tr>
<tr>
<td>Mental Health Investment Standard (MHIS) 6.4%</td>
<td>G</td>
<td>G</td>
<td></td>
<td>G</td>
<td>G</td>
<td></td>
</tr>
<tr>
<td>Cash balance at month end is within 1.25% of monthly drawdown</td>
<td>A</td>
<td>A</td>
<td></td>
<td>G</td>
<td>G</td>
<td></td>
</tr>
<tr>
<td>% of Maximum Cash Drawdown Utilised (MCD)</td>
<td>G</td>
<td>G</td>
<td></td>
<td>G</td>
<td>G</td>
<td></td>
</tr>
<tr>
<td>Better Payment Practice Code (Number processed)</td>
<td>G</td>
<td>G</td>
<td></td>
<td>G</td>
<td>G</td>
<td></td>
</tr>
<tr>
<td>Better Payment Practice Code (£)</td>
<td>G</td>
<td>G</td>
<td></td>
<td>G</td>
<td>G</td>
<td></td>
</tr>
</tbody>
</table>
## 2019/20 Reported Financial Position

<table>
<thead>
<tr>
<th>Expenditure</th>
<th>Annual Budget £'000</th>
<th>Budget to Date £'000</th>
<th>Actual to Date £'000</th>
<th>Variance to date £'000</th>
<th>FOT £'000</th>
<th>FOT Variance £'000</th>
<th>'Trading' Variance £'000</th>
<th>QIPP Variance £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allocation</td>
<td>623,894</td>
<td>311,945</td>
<td>311,945</td>
<td>0</td>
<td>623,894</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Acute</td>
<td>348,481</td>
<td>174,240</td>
<td>174,053</td>
<td>188</td>
<td>348,294</td>
<td>187</td>
<td>402</td>
<td>(216)</td>
</tr>
<tr>
<td>Mental Health</td>
<td>56,035</td>
<td>28,017</td>
<td>27,952</td>
<td>65</td>
<td>55,934</td>
<td>100</td>
<td>70</td>
<td>30</td>
</tr>
<tr>
<td>Community</td>
<td>44,201</td>
<td>22,100</td>
<td>22,089</td>
<td>11</td>
<td>44,164</td>
<td>36</td>
<td>46</td>
<td>(10)</td>
</tr>
<tr>
<td>Continuing Care</td>
<td>29,397</td>
<td>14,699</td>
<td>14,955</td>
<td>(257)</td>
<td>29,885</td>
<td>(488)</td>
<td>(512)</td>
<td>24</td>
</tr>
<tr>
<td>Prescribing</td>
<td>58,785</td>
<td>29,393</td>
<td>30,951</td>
<td>(1,558)</td>
<td>61,652</td>
<td>(2,867)</td>
<td>(2,517)</td>
<td>(350)</td>
</tr>
<tr>
<td>Co-Commissioning</td>
<td>58,049</td>
<td>29,025</td>
<td>29,025</td>
<td>0</td>
<td>58,049</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other Primary Care</td>
<td>8,168</td>
<td>4,083</td>
<td>3,960</td>
<td>124</td>
<td>7,777</td>
<td>391</td>
<td>91</td>
<td>300</td>
</tr>
<tr>
<td>Other Programme Services</td>
<td>10,408</td>
<td>4,653</td>
<td>3,955</td>
<td>699</td>
<td>8,988</td>
<td>1,420</td>
<td>1,449</td>
<td>(28)</td>
</tr>
<tr>
<td>Unidentified QIPP</td>
<td>(2,282)</td>
<td>(591)</td>
<td>0</td>
<td>(591)</td>
<td>0</td>
<td>(2,282)</td>
<td>(2,282)</td>
<td>0</td>
</tr>
<tr>
<td>0.5% Contingency</td>
<td>3,042</td>
<td>1,521</td>
<td>0</td>
<td>1,521</td>
<td>0</td>
<td>3,042</td>
<td>3,042</td>
<td>0</td>
</tr>
<tr>
<td>Total Programme Services</td>
<td>614,284</td>
<td>307,140</td>
<td>306,939</td>
<td>201</td>
<td>614,744</td>
<td>(460)</td>
<td>(211)</td>
<td>(250)</td>
</tr>
<tr>
<td>Running Costs</td>
<td>7,610</td>
<td>3,805</td>
<td>3,522</td>
<td>283</td>
<td>7,150</td>
<td>460</td>
<td>210</td>
<td>250</td>
</tr>
<tr>
<td>Total Running Costs services</td>
<td>7,610</td>
<td>3,805</td>
<td>3,522</td>
<td>283</td>
<td>7,150</td>
<td>460</td>
<td>210</td>
<td>250</td>
</tr>
<tr>
<td>Total CCG Net Expenditure</td>
<td>621,894</td>
<td>310,945</td>
<td>310,461</td>
<td>484</td>
<td>621,894</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Surplus/(deficit)</td>
<td>2,000</td>
<td>1,000</td>
<td>1,484</td>
<td>484</td>
<td>2,000</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

### Key
- **Underspend**
- **(Overspend)**

---

NHS Wakefield Clinical Commissioning Group

Locally Valued
The tables below show the movement in expenditure between month 5 and month 6.

Although there were variations between each sector the underlying surplus has remained the same due to certain pressures being of a non-recurrent nature. This mainly relates to Prescribing costs.

<table>
<thead>
<tr>
<th></th>
<th>£m</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FOT Pd 5</strong></td>
<td></td>
</tr>
<tr>
<td>Improvements in Acute trading</td>
<td>0.8</td>
</tr>
<tr>
<td>CHC pressures</td>
<td>(0.6)</td>
</tr>
<tr>
<td>Improvements in MH</td>
<td>0.2</td>
</tr>
<tr>
<td>Improvement in Neuro Rehab</td>
<td>0.2</td>
</tr>
<tr>
<td>Prescribing pressure</td>
<td>(2.3)</td>
</tr>
<tr>
<td>Release Unidentified QIPP</td>
<td>(2.3)</td>
</tr>
<tr>
<td>Release Contract reserve</td>
<td>1.0</td>
</tr>
<tr>
<td>Release Contingency</td>
<td>3.0</td>
</tr>
<tr>
<td><strong>FOT Pd 6</strong></td>
<td>2.0</td>
</tr>
</tbody>
</table>
## 2019/20 Allocations

<table>
<thead>
<tr>
<th>Allocation</th>
<th>Total</th>
<th>Recurrent</th>
<th>Non-Recurrent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000's</td>
<td>£000's</td>
<td>£000's</td>
</tr>
<tr>
<td><strong>Total Allocation to Pd 5 (excludes bfwd deficit)</strong></td>
<td>622,579</td>
<td>608,449</td>
<td>14,130</td>
</tr>
<tr>
<td>Diabetes Transformation</td>
<td>28</td>
<td>0</td>
<td>28</td>
</tr>
<tr>
<td>LTP Implementation – Ageing Well Programme – transforming community care- ICS Funding</td>
<td>145</td>
<td>0</td>
<td>145</td>
</tr>
<tr>
<td>MH Clinical Standards Review</td>
<td>91</td>
<td>0</td>
<td>91</td>
</tr>
<tr>
<td>Community Mental Health Transformation Funding - ICS Funding</td>
<td>766</td>
<td>0</td>
<td>766</td>
</tr>
<tr>
<td>LD transformation funding to TCP</td>
<td>30</td>
<td>0</td>
<td>30</td>
</tr>
<tr>
<td>BCF support</td>
<td>255</td>
<td>0</td>
<td>255</td>
</tr>
<tr>
<td><strong>Total Allocation to Pd 6 (excludes bfwd deficit)</strong></td>
<td>623,894</td>
<td>608,449</td>
<td>15,445</td>
</tr>
</tbody>
</table>
2019/20 Financial Position - Narrative (1)

Reporting a balanced full year forecast position, with overspends noted in red being offset by underspends noted in green in the narrative below.

In month 6 all risks and mitigations have been released into the position and therefore the position shows a significant movement within some sectors when compared to month 5 expenditure. This is mainly due to the increased forecast on Prescribing, release of unidentified QIPP target and release of contingency reserve.

The table on page 9 shows the movement between each line. This excludes any WY&H ICS funding and allocations received in Pd 6.

**Total Acute services are £0.2m underspent**

Mid Yorkshire Hospitals NHS Trust is £0.2m underspent due to adjusting for favourable trading on High Cost Drugs which are not a fixed cost in the Aligned Incentive Agreement.

Other Acute NHS providers are £0.1m favourable to Plan, mainly due to Leeds Teaching Hospital (general under trading).

£0.3m overspends on independent sector (mainly One Health). Total AQP / Other Acute services are £0.2m favourable, mainly due to Neuro Rehab.

**Mental Health is £0.1m underspent** as a £0.1m efficiency scheme was not in the plan.

**Community** is broadly in line with plan and **Co-Commissioning** is in line with plan.

**Continuing Healthcare is £0.5m overspent.** The CHC Broadcare system is used to record all patients included under the CHC umbrella. This includes CHC, Mental Health and Neuro rehab patients. The budget lines are set based on the previous years outturn. In year the profile of patients being assessed can change and therefore large fluctuations can be experienced.

Overall there is a an overspend on the whole of CHC with the largest overspending in CHC PHB’s. This is due to the Personalisation Agenda whereby a PHB offer is the default position. Although there is an overspend the costs of PHB packages are showing less than the cost of a traditional package of care.

(The overspends are in part offset by an underspend on Neuro Rehab within Acute services)
Prescribing is **£2.8m overspent**. Nationally, there are issues on category M drugs, no cheaper stock available (NCSO) and drug prices which are causing financial pressures for NHS England as a whole. In August NHS Business Services Authority (NHSBSA) published the first forecast of the year which has resulted in a larger overspend than initially anticipated.

Medicines Optimisation and Finance teams are in discussions with other organisation peers with a view to determining the factors influencing the BSA forecast.

Caution should be applied as this is the first forecast of the year and the forecasting profile methodology often changes during the year.

The CCG is looking in detail to understand the factors driving the year to date position.

Other Primary Care is **£0.4m underspent**. This is due to the £0.3m efficiency for the Community contract adjustment and £0.1m underspend from vacancies in the Meds Optimisation team.

Other Programme services are **£1.4m underspent**. This mainly relates to the settlements with providers for final 2018/19 closing activity being less than the estimates made at the end of the year. At the beginning of the year a contract reserve was created which was used to align financial envelopes to agreed contracts. As all contracts are now agreed, the £1m reserve has been released.

Unidentified QIPP efficiency **£2.3m** – The total unidentified QIPP efficiency gap within the planning submission was £2.3m. At P6 this remained at £2.3m and a decision has been made to release it into the position.

Contingency fund - The **£3.0m** value has been released in full.

Running Costs are **£0.5m underspent**. There has been an exercise to identify further savings against the 2019/20 running cost allocation/budget. A further exercise has been undertaken to identify solutions to close the recurrent gap in 2020/21.
Medicines and CHC

- The Meds Optimisation Transactional (scheme 70) increased its current forecast by £100k to £950k. This is due to a drug that Wakefield has within its over-active bladder pathway, developed by the Meds Opt Team. Other CCGs may already be using a slightly more cost-effective drug but at the time we chose to use this particular drug and will now reap the benefits (more than the benefits we would have seen using the alternative drug over the last 3 years) due to patent expiry.

- CHC and PHB schemes are on track to deliver against current forecast.

Planned and Urgent Care

- The August 2019 Contract KPI Dashboard shows that five of the six Unplanned Care programme KPIs are performing below target. August activity relative to 2018 was 9.3% higher. The bulk of the growth continues to come from PGI UTC although an activity increase was also noted at DDH for August. Volumes of attendances at PGH were more or less static however a small increase in acuity (Cat 1 and Cat 2) was noted.

- In Planned Care Demand Management three of the four KPIs are under target and seven of the thirteen planned care performance indicators are under performing.

- A decision was made to close the Clinical Review – IS (scheme 80).

- The two 2019/20 AQP schemes (General & Vascular scheme 60.2 and Urology scheme 60.1) have now fully delivered and surpassed their original planned forecasts by a further £80k.

Primary Care and Mental Health

- No current concerns – remaining schemes are expected to deliver.
The 2019-20 Efficiency Plan is £12.2m which included an unidentified gap at the planning stage of £2.3m.

Identified schemes were £10.0m at P5 and have decreased slightly by £0.1m to £9.9m. The gap has therefore increased from £2.2m to £2.3m and is therefore matching the Plan gap. The £2.3m risk has been released into the position in P6.

Green schemes have improved by £1.2m due to schemes moving from yellow/amber. These are scheme 57 Optimising Pharmacological Treatment of Diabetes £0.2m, scheme 68 Personal Health Budgets £0.5m and scheme 84 Review of CHC shared costs £0.4m.

It should also be noted that scheme 60.1 Urology and scheme 60.2 General & Vascular have now fully delivered with a further increase of £80k above Plan.

Schemes 78,79 and 80 relating to Acute activity reduction in the Independent Sector are now flagging red and are not expected to deliver any of the £0.3m planned savings in 2019-20.

The risk assessed value has improved from £8.8m reported at P5 to £9.6m. This is mainly due to the schemes now flagging as green as noted above. The £0.3m delivery risk noted in the second table is reported in the Risks and Mitigations slide.
## 2019/20 Risks and Mitigations

<table>
<thead>
<tr>
<th>Risk</th>
<th>£m</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>QIPP efficiency - Risk</td>
<td>0.3</td>
<td>Risk of partial or nil delivery of schemes</td>
</tr>
<tr>
<td>Total Risk</td>
<td>0.3</td>
<td></td>
</tr>
<tr>
<td>Mitigations</td>
<td>£m</td>
<td></td>
</tr>
<tr>
<td>Additional mitigations</td>
<td>0.3</td>
<td>Progess of pipeline efficiency schemes and identification of additional flexibility</td>
</tr>
<tr>
<td>Total Mitigations</td>
<td>0.3</td>
<td></td>
</tr>
<tr>
<td>Net Risk</td>
<td>0.0</td>
<td></td>
</tr>
</tbody>
</table>

All risks and mitigations have been released into the position with the exception of QIPP efficiency delivery risk above.
## Committee minutes – items for escalation

<table>
<thead>
<tr>
<th>Committee</th>
<th>Chair</th>
<th>Items for escalation (including summary of the issues, risks identified, any mitigations and any actions proposed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audit Committee</td>
<td>Richard Watkinson</td>
<td>Nothing to highlight</td>
</tr>
<tr>
<td>Clinical Cabinet</td>
<td>Dr Adam Sheppard</td>
<td>Nothing to highlight</td>
</tr>
<tr>
<td>Connecting Care Executive</td>
<td>Andrew Balchin</td>
<td>Nothing to highlight</td>
</tr>
<tr>
<td>Finance Committee</td>
<td>Richard Hindley</td>
<td>Nothing to highlight</td>
</tr>
<tr>
<td>Integrated Governance Committee</td>
<td>Richard Hindley</td>
<td>Nothing to highlight</td>
</tr>
<tr>
<td>Probit Committee</td>
<td>Richard Hindley</td>
<td>Nothing to highlight</td>
</tr>
<tr>
<td>Public Involvement and Patient Experience Committee</td>
<td>Stephen Hardy</td>
<td>PIPEC members felt that they could not give assurance to the Governing Body that the Primary Care Home engagement with the patient representatives had been timely or appropriate.</td>
</tr>
</tbody>
</table>
AUDIT COMMITTEE

Thursday 25 July 2019
14:00 – 16:00
BOARDROOM, WHITE ROSE HOUSE

MINUTES

Present
Richard Watkinson (Chair)
Dr Deborah Hallott

Lay Member
Nominated clinical member

In Attendance
Karen Parkin
Amrit Reyat
Jonathan Hodgson
Olivia Townsend
Rob Jones
Rebecca Kelly
Eamonn May
Emma Scholey (Minute Taker)

Associate Director of Finance & Contracting
Governance and Governing Body Secretary
Internal Audit Manager, Audit Yorkshire
Anti-Crime Specialist, Audit Yorkshire
Director, KPMG
Ledger Accountant
Corporate Financial Accountant
Governance and Committee Officer

19/78 Apologies for Absence

Apologies for absence were received from:
Dr Clive Harries
Dr Adam Sheppard
Jonathan Webb
Ruth Unwin
Shaun Fleming
Richard Hindley
Rachel Pearson

Nominated clinical member
Nominated clinical member
Chief Finance Officer
Director of Corporate Affairs
LSMS, Audit Yorkshire
Lay Member
KPMG

19/79 Declarations of Interest

The Chair invited attendees to declare any conflicts of interest.

19/82 Governance Exceptions Report

Dr Deborah Hallott declared an interest in this item as the report includes details of an approved tender waiver where the provider is Conexus Health Care and Dr Hallott’s practice is a shareholder of Conexus Health Care. She also noted that her practice holds shares in Novus.

The Chair noted this declaration. As this is not a “decision making” item, the Chair determined that Dr Hallott could provide input into the debate.
19/840 Register of Procurement Decisions
Dr Deborah Hallott declared an interest in this item as her practices hold shares with Novus who are a provider of services referred to in the report. She also noted that her practice, New Southgate Surgery provides the Wakefield Care Homes Enhanced Service and the General Medical Service contract and Wakefield Practice Premium Contract. Dr Deborah Hallott also declared an interest in this item for all services where the provider is Conexus Health Care as her practice is a shareholder of Conexus Health Care.

The Chair noted this declaration. As this is not a “decision making” item, the Chair determined that Dr Hallott could provide input into the debate.

19/80 Minutes of the Last Meeting held on
The minutes of the meeting held on 23 May 2019 were agreed as an accurate record.

19/81 Action Log Update
19/28 - Consider how to develop members understanding of quality appropriate to the Audit Committee Terms of Reference

Amrit Reyat updated the Committee on the current actions. The terms of reference for Audit Committee will be reviewed as part of the wider constitution review. Audit Committee will be updated on the progress following the Governing Body session on 12 November 2019.

The way to address this action would be to share the minutes from Integrated Governance Committee to ensure Audit Committee has an overview of the controls in place. Jonathan Hodgson confirmed he would share anonymised Audit Committee terms of reference from other CCGs.

19/28 - Consider best time to undertake the Effectiveness Survey for 2019/20

Amrit Reyat also updated the Committee on the timing for undertaking the Audit Committee effectiveness survey for 2019/20, which will be January 2020. This will ensure timely reporting to Governing Body and into the Annual Report.

Governance and systems of internal control

19/82 Governance Exceptions Report

Amrit Reyat presented this paper and highlighted that during the period from 6 April 2019 to 12 July 2019 there have been no declarations made under the CCGs Standards of Business Conduct relating to hospitality/ gift declarations, outside employment/ private practice sponsorship or external remunerated activity. There have been six requests for rebate scheme approvals and 14 tender waivers that have been approved and signed. Amrit Reyat noted that the CCG’s seal has not been used to execute any documents and there have been no suspensions of Standing Orders and no instances of Losses and Special Payment.
Karen Parkin queried the lack of Sponsorship declarations made during the reported period compared to 2018/19 where a total of 12 Sponsorship declarations were made. Audit Committee agreed that there would be a reminder issued to staff regarding their responsibilities following the review of the Standards of Business Conduct Policy. The policy will be updated and presented at Integrated Governance Committee in September 2019.

It was RESOLVED that:
   i) Audit Committee noted the paper and the governance control exceptions detailed.

19/83 **Annual Accounts 2018/19 Post Balance Sheet events letter**
Eamonn May presented this item. He noted that NHS England requested that all NHS bodies consider whether any post balance sheet events have occurred, consulting external auditors as necessary.

Eamonn May confirmed that the CCG was able to submit a positive return with no events to report.

It was RESOLVED that:
   i) Audit Committee noted the Post Balance Sheet Events Letter for 2018/19.

19/84 **Register of Procurement Decisions**
Simon Rowe attended Audit Committee to discuss this paper. The report provides an update on all of the procurement decisions undertaken by the CCG between the 1 January 2019 and the 1 July 2019, including the authorisation and governance for each procurement process and a record of the conflicts of interest declared during the procurement.

Simon Rowe confirmed that the process is now embedded and is easier to audit. It is also clearer what the governance requirements are internally and externally.

Karen Parkin commented on the clarity of the Executive Summary on the report front cover.

It was RESOLVED that:
   i) Audit Committee received the Register of Procurement Decisions
   ii) Audit Committee approved the publication on the CCG website the content of the Register.

19/85 **Internal Audit Progress Report**
Jonathan Hodgson presented this report which provided an update of the Internal Audit activity since the last Audit Committee meeting. It was acknowledged that during 2018/19 Wakefield CCG received an even split between Significant and High assurance.
Internal Audit has made a start on the 2019/20 work plan and the Quality Improvement audit has been finalised and reported as high assurance.

Since the 2019/20 Internal Audit plan was approved on 23 May 2019, there has been one change requested. Jonathan Webb proposed that Internal Audit carry out a Control Improvement audit. This will look at the Clinical Engagement and Advice and ensure that the CCG has robust processes over securing clinical engagement and advice. Days will be taken out of the contingency days to carry out this audit.

A discussion followed regarding the 2018/19 recommendations. Out of a total of 17 recommendations, 13 have been fully implemented, two recommendations are not currently due and two are outstanding. Audit Committee members agreed to remove the implemented recommendations from the tracker.

With regards to the two outstanding recommendations, it was noted that in comparison to other CCGs, Wakefield progress with the recommendations is positive.

Karen Parkin asked if there was anything the CCG could do to support progress of the Broadcare recommendation which has been outstanding since 3 May 2019. Jonathan Hodgson noted that this is ongoing and Internal Audit is not concerned from a control perspective.

It was RESOLVED that:
   i)  Audit Committee received the report and noted its contents.

19/86  Counter Fraud Progress Report
Olivia Townsend presented this report providing an update on the progress against the work plan.

When discussing Prevent and Deter, Olivia Townsend noted that an alert was distributed relating Mandate Fraud against Payroll. The Payroll Department was asked to ensure that a secure process is followed when employee bank details are requested to be changed. Eamonn May commented that HR and Payroll are aware and have processes in place.

During March 2019 the Local Counter Fraud Specialist (LCFS) met with the Senior Contracts Manager to discuss the process relating to the checking of provider counter fraud arrangements. Olivia Townsend informed the committee that she has reviewed Mid Yorkshire Hospital NHS Trusts arrangements and she has no concerns. This information has been fed back to the Trust.

It was acknowledged that that the organisation has been offered the opportunity to have a representative from North East Counter Terrorism Unit (CTU) attend to provide in depth training on checking identity documents. A list of potential candidates for the training has been provided and Karen Parkin and Jonathan Webb are working to capture as many people as
possible for this.

An update was provided on the four current investigations that are underway. Olivia Townsend will provide regular feedback to Jonathan Webb on the progress of these.

It was RESOLVED that:
   i) Audit Committee received the report and noted its contents.

19/87 Local Security Management
   a) Annual Security Management Report 2018/19
   b) Local Security Management Workplan 2019/20
Jonathan Hodgson updated the committee informing them that following Steve Nicholls’ retirement, Shaun Fleming is now the nominated Local Security Management Specialist Officer for Wakefield CCG.

It was acknowledged that the Local Security Management work plan 2018/19 provided a resource of 10 days to the CCG.

Jonathan Hodgson presented the draft 2019/20 Local Security Management Specialist Plan. It was noted that the NHS Standards for Security for Commissioning Organisations are currently under review by the NHS and currently there is no clear guidance on the date issue of new standards or the detailed content of that guidance.

The Local Security Management Specialist (LSMS) has looked at potential security management work streams and areas of priority risk which were most likely to form an element of any future commissioner security standards.

The 2019/20 work plan provides for an LSMS plan of four days to provide for this priority work. This provision will be reviewed in light of any further guidance on the development of new standards and associated requirements in year.

It was RESOLVED that:
   i) Audit Committee received the Annual Report and noted its contents.
   ii) Audit Committee approved the draft 2019/20 Local Security Management Specialist Plan.

External Audit

19/88 Annual Audit Letter 2018/19
Rob Jones noted that there was no additional content and this is the same messaging as the ISA 260 that was presented at Audit Committee on 23 May 2019.

19/89 Technical Update
Rob Jones highlighted the current technical issue relating to Department of Health and Social Care (DHSC) Group Accounting Manual 2019/20. It was
noted that there are no significant changes from the 2018/19 DHSC Group Accounting Manual (GAM) at this stage. Eamonn May is aware of the changes and is working through these.

KPMG also shared the Creating a Culture of Excellence in Healthcare report for information.

19/00 **Mental Health Investment Standard Audit Work**

Rob Jones provided a verbal update on the Mental Health Investment Standard audit work. NHS England and Audit providers have agreed the national specification and the pilot will be carried out.

It was acknowledged that CCGs will submit a return to NHS England which summarise the Mental Health spend across 15 categories, excluding Dementia and Learning Disabilities. External Audit will audit the return.

Rob Jones noted the three potential outcomes of the audit including a Clean Opinion, Adverse Opinion or Qualified Opinion. The completed audit will be fed back to the finance team and Audit Committee.

Rob Jones confirmed that Jonathan Webb is happy with the engagement letter and happy to proceed on this basis.

Dr Deborah Hallott asked if the outcome compared to other CCGs will be available for Audit Committee on 26 September 2019. Rob Jones didn't think that this will be available before the next committee but he will look at anonymised benchmarking for Wakefield CCG.

Rob Jones also noted that by the end of September 2019, all CCGs are required to include a statement on their website regarding the Mental Health Investment Standard. This statement will be agreed amongst the committee members at the next Audit Committee on 26 September 2019.

19/01 **Matters to be referred to Governing Body or other Committees**

It was agreed that the Mental Health Investment Standard will be discussed at the next Governing Body session on 10 September 2019.

19/02 **Any Other Business**

There was no other business raised.

19/03 **Date, Time and Venue of Next Meeting**

It was agreed that the next meeting would take place on Thursday, 26 September 2019, 14:00 – 16:00, Boardroom, White Rose House
FINANCE COMMITTEE

Thursday 15 August 2019
11:30- 13:30
Seminar Room

MINUTES

Present
Richard Hindley (Chair)
Lay Member
Adam Sheppard
Chair & Clinical Leader
Pravin Jayakumar
Governing Body member – GP
Ruth Unwin
Director of Corporate Affairs

In Attendance
Karen Parkin
Associate Director of Finance and Contracting and Performance
Emma Scholey (Minute Taker)
Governance and Committee Officer
Michele Ezro (Deputising for Pat Keane)

19/110 Apologies for Absence

Apologies for absence were received from:
Clive Harries
Governing Body member – GP
Jo Webster
Chief Officer
Jonathan Webb
Chief Finance Officer
Suzannah Cookson
Chief Nurse
Pat Keane
Chief Operating Officer
Richard Watkinson
Lay Member

19/111 Declarations of Interest

The Chair invited attendees to declare any conflicts of interest.

No declarations of interest were received.

19/112 Minutes of the Last Meeting held on 18 July 2019

The minutes of the meeting held on 18 July 2019 were agreed as an accurate record.

19/113 Action Log Update

The action log was noted.

19/114 Matters Arising

There were no matters arising.
Finance Report Month 4 2019/20
Karen Parkin presented this report advising that the year to date position and year-end forecast are both in line with the planned full year surplus of £2m. The CCG is forecasting a balanced risk position after disclosing £1.3m delivery risk in the yellow and amber efficiency schemes. Overall, the CCG is forecasting £10.1m of efficiency delivery against the target of £12.2m.

Karen Parkin noted that Wakefield CCG is now receiving trading data and other information and are able to forecast more accurately. This is now highlighted in the 2019/20 Reported Financial Position table.

It was acknowledged that there is a significant overspends of £0.5m in prescribing. This is due to under delivery in the efficiencies, particularly Clinical Pharmacy in General Practice due to recruitment issues. When discussing the 2019/20 efficiencies, Karen noted that scheme 82 – Integrated Care Equipment Services (ICES), has contributed to the £0.2m improvement to the gap as this has now moved into the green rating. It was also acknowledged that there have been a number of schemes that have moved from amber into yellow including corporate costs. This is due to the work that has taken place on running costs which has now identified savings £250k better than the original target. All yellow schemes have a high confidence level of full delivery.

It was confirmed that North Kirklees CCG has agreed to the principles of the CCG Risk Share (scheme 83) updated forecasted figure based on the agreed figure will be confirmed in the next reporting period.

Karen Parkin explained that all efforts are being made to reduce the financial risk within yellow and amber schemes. Therefore the risk assessed view has improved to £8.8m delivery (P3 £8.2m) against the £12.2m plan target.

NHS England has notified that there will be a price increase in category M drugs this year. The price is not yet known but this has been included in the 2019/20 Risks and Mitigation table.

It was RESOLVED that:
   i) Finance Committee noted the contents of the month four report.

Long Term Financial Planning Presentation
Karen Parkin presented an initial briefing on the NHS Long Term Plan to the Finance Committee.

The NHS Long Term Plan emphasises the need for collaboration and the alignment of member organisations and wider partners, adopting a common set of principles and leadership behaviours as they develop and deliver plans against a number of principles, including being clinically-led, locally owned and financially balanced. Karen Parkin noted that the Long Term Plan does not set any parameters and that Wakefield CCG will have a vital
role in bringing all partners within the system together.

Karen Parkin discussed the funding ‘must dos’ and the planning requirements for CCGs and Trusts. A discussion followed regarding the requirement for all member organisations to submit their own plan taking into consideration the different elements of the system.

It was noted that Wakefield CCG had received the planning tool week commencing 12 August 2019 and the team are working on populating this.

Finance Committee acknowledged the key milestone dates for submitting the plan which will be submitted through the ICP. Wakefield CCG Governing Body will be briefed on the first draft submission on 10 September 2019. Karen Parkin noted that any amendments to the first draft submission will be presented to Finance Committee on 19 September 2019 before the second submission to the ICS on 20 September 2019.

Karen Parkin discussed the financial planning headlines. She noted that we do not know much about the indicative and targeted funding yet, this will come from the ICS and into the system. The mental health and Learning Development growth is in line with programme allocation growth plus an ‘extra’ percentage which is currently assumed to be 0.7%. There will be a similar approach for Community and Continuing Health Care. The allocation growth on IGP primary care allocations will expected to be spent on that area according to the requirements of the planning guidance.

The planned expenditure is still being developed. Karen Parkin noted that Wakefield CCG is working closely with Mid Yorkshire and South West Yorkshire Partnership NHS Foundation Trust on alignment.

A discussion followed regarding the need for Wakefield CCG and the ICS to have a coordinated approach particularly in the areas of extra funding. In addition, it was agreed that the governance around these needs to be understood.

It was agreed that SMT will have an oversight of the planning and submission of the plan to the ICS and if needed delegated authority will be given to Finance Committee in September 2019 for sign off of the draft plan submission to the ICS. The final version of the plan is to be submitted to the ICS on 1 Nov 2019.

19/117 Anti-Fraud, Bribery and Corruption Policy
Karen Parkin presented the Anti-Fraud, Bribery and Corruption policy on behalf of the Local Counter Fraud Specialist.

The policy has been reviewed and there is one minor change to the appendix. The update is in line with the standard two year policy review schedule.

It was RESOLVED that:
i) Finance Committee approved the revised Anti-Fraud, Bribery and Corruption Policy.

19/118 Mid Yorkshire System Executive Group Minutes from the meeting held 4 July 2019
The minutes from the meetings held on 4 July 2019 were shared for information.

19/119 Matters to be referred to Governing Body or other Committees
It was agreed that the Long Term Financial Plan will be presented at a future Governing Body session.

19/120 Any Other Business
There was no other business raised.

19/121 Date, Time and Venue of Next Meeting
It was agreed that the next meeting would take place on Thursday, 19 September 2019, 11.30 am to 13.30 pm in the Seminar Room, White Rose House
FINANCE COMMITTEE

Thursday 19 September 2019
11:30- 13:30
Seminar Room

MINUTES

Present
Richard Hindley (Chair)
Dr Adam Sheppard Chair & Clinical Leader
Dr Clive Harries Governing Body member – GP
Dr Pravin Jayakumar Governing Body member – GP
Jonathan Webb Chief Finance Officer
Suzannah Cookson Chief Nurse
Pat Keane Chief Operating Officer
Ruth Unwin Director of Corporate Affairs

In Attendance
Richard Watkinson Lay Member
Emma Scholey Governance and Committee Officer
(Neasure Taker)
Natalie Tolson Head of Business Intelligence
Simon Rowe Interim Head of Contracting

19/122 Apologies for Absence
Apologies for absence were received from:
Jo Webster Chief Officer
Karen Parkin Associate Director of Finance and Contracting and Performance

19/123 Declarations of Interest
The Chair invited attendees to declare any conflicts of interest.

Dr Clive Harries, Dr Pravin Jayakumar and Dr Adam Sheppard, all declared
a primary care interest. The Chair accepted their declarations.

19/124 Minutes of the Last Meeting held on 15 August 2019
The minutes of the meeting held on 15 August 2019 were agreed as an
accurate record.

19/125 Action Log Update
The action log was noted.

19/126 Matters Arising
There were no matters arising.

19/127 Finance Report Month 5 2019/20
Jonathan Webb presented the month five finance report.

He advised that the year to date position and year-end forecast are both in line with the planned full-year surplus of £2m. The CCG continues to report a balanced risk position in the reporting after disclosing £1.3m delivery risk in the yellow and amber efficiency schemes. The CCG is forecasting £10.1m of efficiency delivery against the target of £12.2m. The CCG will continue to review the forecast and continue to assess the underlying position.

Jonathan Webb noted that the year to date figures in the Acute Commissioning Contract Monitoring Report are showing better than plan. This is due to issues with phasing and Wakefield CCG need to look at how jointly these numbers are correlated. Further work by the Finance, Contracting and BI teams is required to test assumptions on what forecast out turns look like.

Jonathan Webb reported that Wakefield CCG is reporting a balanced full year forecast position, with overspends such as prescribing, being offset by underspends such as running costs.

A discussion then followed regarding the efficiency schemes. Jonathan Webb explained that the schemes continue to get reviewed in financial value and he is confident in the delivery of the yellow schemes. He noted the importance of risk assessing the schemes in terms of delivery and all efforts are being made to reduce the financial risk within yellow and amber schemes. Therefore the risk assessed view has improved to £8.8m delivery (P3 £8.2m) against the £12.2m plan target. Suzannah Cookson asked if Wakefield CCG is confident that we are testing the quality impact of the efficiencies. Jonathan Webb explained that this is the intent but he will take the action away and confirm how robustly the group looks at this.

The 2019/20 Risks and Mitigations were then discussed. Jonathan Webb explained that we are still unsure of the impact of the Category M drug repricing and that the CCG is waiting on another month of prescribing forecast. Wakefield CCG is still pursuing further efficiency schemes for this year but most spend is locked down in contracts that cannot be reversed. Jonathan Webb highlighted to the committee that Wakefield CCG is clear about what the forecast and mitigations are and will continue to ensure that we put ourselves in the best place possible for 2020/21.

It was RESOLVED that:
   i) Finance Committee noted the contents of the report

19/128 Draft Financial Plan 2020/21 - 2023/24
Jonathan Webb presented to the committee the Draft Financial Plan 2020/21 to 2023/24. This presentation was discussed in detail at the
Governing Body Development session on 17 September 2019. Jonathan Webb noted that some changes had been made since the development session.

For context, Jonathan explained that there is a requirement for all NHS organisations to submit draft plans to WY&H ICS for aggregation by 20 September 2019. The plans focus on finance activity, workforce, performance standards, trajectory and narratives. Jonathan presented on the draft financial plan and noted that the wider submission will be discussed at Governing Body.

Jonathan Webb highlighted that the overall plan is in line with the financial recovery plan and the core allocation growth for 2020/21 is 4.1% to 3.5% in 2023/24. He also noted that the Primary Care allocation growth is 3.13% in 2020/21 to 4.15% in 2023/24 this is with the assumption that costs should be at least equal to average national growth.

Jonathan Webb had discussed the changes since the plan was presented at the Governing Body Development session. There is a change with the Mid Yorkshire Hospital NHS Trust planning assumptions with the plan now including £1.2m activity growth in community across the period of 2021/22 to 2023/24. Jonathan highlighted an affordability issue around including growth on community services in 2020/21.

A discussion followed regarding the activity growth in community and the local desire to invest resource into this key area of service. Pat Keane observed that CCG investment in community services has not grown in line with other programme growth in the last few years. He also felt that Wakefield CCG should be open and transparent with partners about what the system’s financial constraints are. Jonathan Webb discussed the possible option to increase the efficiency gap to £0.7m (from an existing gap of £0.4m) and include an indicative planning assumption of additional investment in community services in 2020/21.

There has also been a change with the Continuing Health Care assumptions in activity growth. This has now been increased to £1.4m per year which Jonathan Webb explains is a more realistic and consistent growth into Continuing Health Care.

Dr Clive Harries asked if the system felt mature enough in owning the total costs. Jonathan Webb felt Wakefield CCG is in a better position to where it was a few years ago. Pat Keane explained the focus needs to be on the bigger picture and how the wider system can help and grow together. Members felt that it would be valuable to hold a Governing Body to Governing Body meeting with Mid Yorkshire Hospital NHS Trust to allow for dialogue between lay members and Executive Directors. This will allow for context to be given and using partners to look for a solution. Suzannah Cookson felt that this would be a good opportunity to think about how we maintain our focus on population health management and improving health and wellbeing.
Jonathan Webb asked the committee to support increasing the efficiency gap to £0.7m to allow for a planning assumption around additional investment in community services in 2020/21. This would only be progressed in contractual terms later in the year if was affordable for the CCG. Finance Committee members were happy with this proposal.

It was RESOLVED that:
  i) Finance Committee noted the assumptions used to develop the draft financial plan
  ii) Finance Committee supported the submission of the draft plan
  iii) Finance Committee delegated authority to the Chief Finance Officer to make any further minor changes to the plan prior to submission to NHSE/I on 27 September 2019 (within the parameters set of in the current plan).

19/129 Acute Commissioning Contract Monitoring Report
Natalie Tolson attended the meeting to present this report providing an update on the CCG’s Acute Commissioning Contracting performance position for month four 2019/20 flex. Natalie noted that at the end of M4 (YTD) activity for the CCG reported 5.0% above activity plan and 4.4% above the level of activity reported during the same period in 2018/19.

Natalie Tolson highlighted the significant over-trade (£233k) reported against One Health. This is reported in Spinal and the CCG are looking if there are any pressures over MSK. The over-trade has been offset by under-trade reported against Spire Methley and Nuffield.

Natalie explained that the CCG continues to review T&O activity across the region against the impact of the MSK service and known pressures at Leeds Teaching. The Contracting Team are investigating the increase in spend at Barnsley and Spire Methley on more complex T&O procedures against MSK onward referral data to establish trends. Natalie Tolson will report more information regarding this at a future Finance Committee.

It was also noted that at the start of the year, A&E activity reported a sharp increase, however more recently activity has started to plan. Overall activity reports 2% above the level expected, which is driven by attendances at Pontefract UTC.

Pat Keane commented that the report showed a positive story against the plan and he felt that overall the activity was balanced.

It was RESOLVED that:
  i) Finance Committee noted the contents of the Acute Commissioning Contract Monitoring report, and
  ii) Finance Committee noted the reasons and actions in place for those providers that are currently reporting above contract plan.

19/130 Contract Governance and Assurance Report
Simon Rowe attended the meeting to provide an update to Committee on the issuing of contracts for 2019/20.

Simon noted that the position has moved since the report was written and there is currently only one healthcare contact outstanding. He felt the team have a clear plan and aim to sign off the contracts by the end of this month.

In terms of non-Healthcare, Simon explained that there are now nine Memorandums of Understanding (MoUs) outstanding. All of the outstanding MoUs are in areas where there has been a previous agreement in-place.

Simon explained that Continuing Health Care are 100% compliant and that Primary Care contracting are close to 100%. The contracts register will be published in October.

Simon Rowe also note that there have been 32 in year changes as procurement decisions have been made by the CCG, making 534 contracts/contract variations. Simon asked if the Finance Committee was happy to report against the 534 in future reports. The Finance Committee was happy to support this.

Jonathan Webb thanked Simon and the team for the rigour and grip on this and felt this was evidence to the committee that we have a strong narrative and know it is being managed well. The committee agreed that this now feels like business as usual and agreed that Simon will report to the committee on an exception basis.

It was **RESOLVED** that:

i) Finance Committee noted the content of this report

ii) Finance Committee approved that future updates report against the September 2019 position.

19/131  **Wakefield CCG Risk Register: Assessment of Financial Risks**

Jonathan Webb provided an update on the assessment of Wakefield CCG financial risks. He provided some context, explaining that the Capacity and Capability review suggested that the Finance Committee had sight of the key financial risks as described on the CCG risk register.

Risk 1355: There is a risk that the CCG will not meet its £2m surplus due to undelivered local plans and non-delivery of QIPP total of £12.2m resulting in an 'off plan' position, additional scrutiny, special measures and an 'except for ' audit opinion.

Jonathan Webb explained that the above risk was scored as a 16 in the last cycle, but has now reduced to eight due to the progress on the CCG efficiency schemes, further mitigations being identified to meet emerging risks and the unused contingency which will mitigate the unidentified efficiency gap.
Risk 1352: There is a risk that the CCG will not achieve its running cost target due to the inability and lack of opportunity to achieve the 20% reduction, resulting in the non-delivery of the financial plan and failure of its statutory duty.

The above risk about achieving the target running cost reduction remains at a score of 12 pending a further review which is currently underway. Dr Adam Sheppard commented that the financial risks felt manageable.

It was **RESOLVED** that:

i) The Committee noted the financial risks currently on the risk register

ii) Finance Committee noted the rationale for the decrease in risk scores on two of those risks

19/132 Mid Yorkshire System Executive Group Minutes from the meeting held 1 August 2019

The minutes from the meetings held on 1 August 2019 were shared for information.

Pat Keane explained that there was a detailed discussion on item 6.2.2 about the Mid Yorkshire Hospital NHS Trust Contract KPI dashboard. He also noted that PCIG carried out a deep dive into the increase into consultant to consultant referrals; Pat Keane wanted to provide assurance to Finance Committee that these issues are discussed in detail at the meeting.

Pat Keane also explained that there will be a paper going to next month’s MYSEG about the future of the meeting at a place level as there has been a level of overlap with the steering group identified.

19/133 Matters to be referred to Governing Body or other Committees

There were no matters that required referral to other committees or Governing Body.

19/134 Any Other Business

There was no other business raised.

19/135 Date, Time and Venue of Next Meeting

It was agreed that the next meeting would take place on Tuesday 15 October 2019, 09:00 am to 11:00 am in Meeting Room 5a, White Rose House.
Agenda item: 15c(i)

NHS Wakefield Clinical Commissioning Group

INTEGRATED GOVERNANCE COMMITTEE

Minutes of the Meeting held on 15 August 2019

Present:
Richard Hindley (Chair) Lay Member
Stephen Hardy Lay Member
Dr Pravin Jayakumar Nominated Clinical Member
Dr Adam Sheppard Nominated Clinical Member
Ruth Unwin Director of Corporate Affairs

In Attendance:
Kathryn Brown Quality Improvement Manager (Item 19/183)
Mel Brown Commissioning Director for Integrated Care (deputising for Jo Webster)
Nicola Richardson Performance, Data and Information Analyst (Item 19/185)
Pam Vaines Governance Officer (Item 19/186)
Stella Johnson Research Manager, West Yorkshire Research and Development (Item 19/187)
Emma Scholey Minute taker
Amrit Reyat Governance & Board Secretary
Karen Parkin Associate Director of Finance and Contracting / Deputy CFO (deputising for Jonathan Webb)
Joanne Fitzpatrick Head of Medicines Optimisation (deputising for Suzannah Cookson)

19/178 Apologies for Absence
Apologies for absence were received from Suzannah Cookson, Jo Webster and Jonathan Webb.

19/179 Declarations of interest
The Chair invited attendees to declare any conflicts of interest.

Item 19/183 The outcome and suggested next steps of the OSCAR stocktake post decommissioning
Adam Sheppard noted that as users of the OSCAR system, there may be a conflict for the GP members in relation to this item. The chair noted the potential conflict however he was happy for GP members to input into the debate and take part in the final decision making.

19/180 Minutes of the meeting held on 18 July 2019
The minutes of the meeting held on 18 July 2019 were agreed as an accurate record.

19/181 Action Sheet from the meeting held on 18 July 2019
All actions were noted.

19/182 **Matters Arising**
There were no matters arising.

19/183 **The outcome and suggested next steps of the OSCAR Stocktake post decommissioning.**
Kathryn Brown attended the committee to discuss the OSCAR stocktake and the suggested next steps. She provided some background information informing that the Referral Support System (RSS), hosted and managed by Wakefield CCG, on behalf of Wakefield and North Kirklees CCGs was established in 2017. One element of the RSS service was the provision of OSCAR ‘On-line Support and Clinical Advice Resource’. The RSS model was formally reviewed and a recommendation was approved by both Wakefield and North Kirklees to fully decommission this service which included OSCAR in February 2019.

Part of the process of decommissioning of the RSS model was the undertaking of a full stocktake of the content of OSCAR to determine what should happen to it. Kathryn provided the outcome of the stocktake explaining that 8 pathways were removed from the site as unsafe. 14 transferred to Values Based Checker tool and removed from the OSCAR site. 18 pathways were transferred into SystmOne site and 32 pathways were discarded due to duplication. This left eight pathways that are in draft until a commissioning decision is made.

A discussion then followed regarding the next steps. Kathryn highlighted that the preferred option is to disseminate appropriate pathways to hosts/websites/systems with a supporting hyperlink guide and agree to place the decision regarding an options appraisal and potential commissioning of a service on hold until the ‘proof of concept’ evaluation on Arden’s and VBC is complete.

IGC noted that there will need to be clear communication with Primary Care ensuring that there is effective clinical engagement and colleagues are signposted appropriately to the information.

Kathryn asked IGC to support the removal of OSCAR from the live system. She identified that when the information was pulled in June 2019 there had been 60 hits in the last four months. Kathryn clarified that there are flags on the system explaining that the service has been decommissioned but members felt that due to the low usage it was in the public’s interest to take it offline as soon as possible. It was agreed that Wakefield CCG should be in alignment with North Kirklees CCG therefore, Kathryn Brown will discuss the possible ways to close the system down sooner and then ratify the decision at the North Kirklees CCG Quality Committee.

It was **RESOLVED** that:
i) Integrated Governance Committee noted the content of the paper and considered the options set out in Section 2.3 of this paper.

ii) Agree removal of the OSCAR website and apps from the public domain with immediate effect.

iii) The committee noted the preferred options within the paper.

iv) The committee agreed the options in alignment with Quality Committee at North Kirklees CCG on 25 September 2019 to ensure there is a consensus on the decisions for both CCGs.

v) The committee identified further actions and information required.

19/184 Update on Care Quality Commission/Ofsted Special Educational Needs and Disabilities (SEND) Re-visit June 2019

Mel Brown provided an update on this item explaining that in July 2019 Ofsted published the outcome of their last CQC/Ofsted SEND Revisit to Wakefield which took place on the 3 and 4 June 2019.

Ofsted received 107 responses to an online survey before the visit. The team also met with 30 parents over two parent sessions and also considered over 100 case records during the visit.

The CQC and Ofsted report concluded in June 2019 that the ‘Local authority and CCG leaders have worked together in a committed way to tackle the area of significant weakness.’ Mel Brown explained that following the publication of the report the Parliamentary Under-Secretary of State for Children and Families wrote to Wakefield system advising that the formal monitoring period has now come to an end.

Mel Brown discussed the next steps and identified future events that have been arranged by the system to capture the views of children, young people and parents. She has invited Wendy Barker from NHS England and Elaine Baulcombe from DFE to the ASD Open Event on 4 October 2019 when Wakefield CCG will be hosting 60 people from across the country and explaining what we are doing with ASD.

It was acknowledged that the report asks the Wakefield system to focus on improving the waiting times for young people over age 14 years as there is concern that there are 55 children waiting on average 43 weeks. Mel Brown noted that the recovery plan identifies that they want to see the Wakefield System getting to a 26 weeks wait. In July 2019 South West Yorkshire Partnership NHS Foundation Trust have started work towards increased ASD assessments with Educational Psychologists aiming to do 12 assessments a month in the hope to get down to a maximum 26 weeks wait before December 2019. Mel Brown will keep Governing Body updated on this target.

Stephen Hardy noted the fantastic work in this area over the year and a half but explained that he was concerned about the children who don’t get a diagnosis of Autism. He asked what work was underway in the wider area to address this as the whole system needs to join up and institutions need to work closer with the interest of the children. Mel Brown explained that there is currently no integration with children’s
social care but that a steering group is being developed.

Richard Hindley noted the good progress but does not want the Wakefield System to lose sight of potential strategic risks and does not want the momentum to be lost.

Dr Adam Sheppard noted the excellent work that has gone on but asked how the board could get continued assurance regarding the issue of the waiting time for the over 14 pathway. Mel Brown has pulled together a CAMHS assurance and oversight group and will provide a quarterly update to IGG. The ASD strategy will come back to IGC in November 2019.

It was RESOLVED that:

i) Integrated Governance Committee noted the published report from CQC/Ofsted and the outcome of sufficient progress

ii) The committee noted the progress that has been made in reducing the waiting times for ASD assessments in Wakefield.

19/185 Performance Report
Nicola Richardson attended the meeting to present this report providing a summary of CCG performance against the Improvement and Assessment Framework, Constitutional Performance Measures and the Yorkshire Ambulance Service Response Times Dashboard.

Nicola highlighted the CCGs performance against the Improvement and Assessment Framework. This included the measure for ‘Mental Health: Children and Young People’ has achieved the assigned target of 32%. Also, the IAPT ‘Recovery Rate’ position for Q4 is 50%, meeting the target and showing an improvement of 4% since previous quarter.

The highlights from the CCG performance against the monthly Constitutional Performance Measures are:

- For June 2019 five of the nine cancer waiting time standards achieved the assigned target.
- The two week wait cancer measure for ‘breast’ reports below the 93% standard but has improved significantly by 44% to report at 75.8% for June.
- The measure for 31 days for ‘subsequent treatment where the treatment is surgery’ has declined since May, reporting at 86.4%.
- Referring to the 62 day cancer measures, the measure for ‘urgent GP referral to first definitive treatment for cancer’ has slightly decreased to 75.5% for June. Also, the measure for ‘first definitive treatment following consultant decision to upgrade’ has improved by 12%, reporting at 78.6%.
- For June, the referral to treatment 18 week standards has deteriorated slightly, reporting a position of 87.3%. The incomplete waiting list has decreased by 382 pathways in June to 27,131. The waiting list position reports 12% above the March 18 position.
- June reported six referral to treatment 52 week breaches for trauma
and orthopaedics. Of these, one was newly reported with the remainder recurrent.

- Diagnostic six week waiting time performance has slightly increased to 95.5% however it remains below the national standard of 99%.

Nicola advised that with regards to Yorkshire Ambulance Service the Yorkshire average for June continues to report a higher position than the national average against all of the response time measures. Nicola noted that Category one performance has remained the same, achieving the seven minute target for June.

Dr Adam Sheppard asked about the cancer performance targets and how Wakefield CCG can influence the other four Cancer Waiting Time Standards. Adam asked if we have done a deep dive to try and improve our position. Karen Parkin explained that MYSEC and PCIG will be doing a deep dive into Mid Yorkshire cancer performance. It was also noted that Mid Yorkshire Hospital NHS Trust have done a lot of work on breast and the performance has increased significantly. However, this service is currently being run by locums and this is not sustainable for the trust. Karen Parkin explained that Mid Yorkshire is looking for a solution and is making enquires with other acute providers.

Karen Parkin confirmed that NHS England have agreed that Wakefield CCG will not be reporting on the four hour target. It was agreed that future performance reports will include a standard line to explain this.

It was also agreed that future performance reports will include a paragraph that goes into more detail regarding how Wakefield CCG are dealing with the constitutional targets that are showing as red. This will allow for the board to understand the key measures and where Wakefield CCG can impact on the key variables.

It was RESOLVED that:

i) Integrated Governance Committee noted the current CCG performance against NHS Constitutional Standards and Improvement and Assessment Framework (IAF)

ii) The committee noted those indicators where performance is below target and the exception reports provided

iii) The committee discussed and agreed the recommended actions for the committee

19/186 Incident Reporting Policy

Pam Vaines attended the committee to provide an update on the Incident Reporting Policy. She explained that the additions and updates are relating to Information Governance with the strengthening of the definition and guidance relating to incidents and the inclusion of the role of the Senior Information Risk Owner (SIRO) and the Data Protection Officer (DPO).

The committee was happy to approve the revised policy.
It was RESOLVED that:

i) Integrated Governance Committee approved the revised version of the policy

19/187 NHS Wakefield CCG Intellectual Property (IP) Policy
Stella Johnson attended IGC to provide an update on the amendments to the Intellectual Property policy. The revised Intellectual Property Policy is updated to reflect that the CCG no longer retains Medipex services and will appoint IP legal advice where applicable.

Stella Johnson noted that the directorate of which the policy sits under will need to be confirmed and included. Ruth Unwin explained that this will be amended once the director portfolio changes have been agreed.

It was RESOLVED that:

i) Integrated Governance Committee approved the revised Intellectual Property Policy

19/188 Minutes of meetings
The minutes of the following meetings were shared for information

i) Mid Yorkshire System Executive Group – minutes of meeting held on 4 July 2019
ii) 999/111 Joint Quality Board – minutes of meeting held on 7 May 2019
iii) Integrated Urgent and Emergency Care (IUEC) (previously known as YAS 999 Contract Management Board) – minutes of meeting held on 21 May 2019
iv) Mid Yorkshire A&E Improvement Group – minutes of meeting held on 25 June 2019

These were all received.

19/189 Matters to be referred to other committees or Governing Body
It was agreed that the paper on the update on Care Quality Commission/Ofsted Special Educational Needs and Disabilities (SEND) Re-visit June 2019 will be presented at Governing Body in September 2019.

19/190 Any other business
There was no other business raised.

19/191 Date and time of next meeting:
Thursday, 19 September 2019, 9.00 to 11.00 am in the Seminar Room, White Rose House.
NHS Wakefield Clinical Commissioning Group  
CLINICAL CABINET  
APPROVED MINUTES  
Of the meeting held on Thursday 22 August 2019  

**Present:**  
Dr Adam Sheppard  Chair, Assistant Clinical Leader, WCCG  
Suzannah Cookson  Chief Nurse, WCCG  
Dr Aly Damji  GP, WCCG, Network Chair  
Dr Debbie Hallott  GP, WCCG, Network Chair  
Stephen Hardy  WCCG Board Member, Lay Member  

**In attendance:**  
Rachael Bolton  Head of Planned Care Service Delivery & Transformation, WCCG  
Sharon Cook  Service Delivery and Transformation Manager, WCCG  
Joanne Fitzpatrick  Head of Medicines Optimisation, WCCG  
Pat Gray  Business Support Officer, WCCG (Observing)  
Dr Amy Kuck  GP, PCH Network  
Dr Abdul Mustafa  GP, Cancer Clinical Lead  
Grace Owen  Senior Transformation Manager (Planned Care), WCCG  
Steve Turnbull  Public Health Consultant, Wakefield Council  
Dena Coe  WCCG (Minutes)  

<table>
<thead>
<tr>
<th>No.</th>
<th>Agenda Item</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>19/20-56</td>
<td><strong>Apologies for Absence were received from:</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dr Omar Alisha, Dr Chris Barracough, Dr Tim Dean, Michele Ezro, Dr Clive Harris, Dr Pravin Jayakumar, Pat Keane, Dr Jordache Myerscough, Dr Nadim Nayyar, Dr Colin Speers, Dr Dutta Soumitra Ruth Unwin, Jonathan Webb, Dr Patrick Wynn.</td>
<td></td>
</tr>
</tbody>
</table>
| 19/20-57 | **Declarations of interest:**  
A declaration of interest was noted for Item 19/20-61, Ophthalmology Service Redesign Model, as the Lupset Practice is a service provider. As this was not for approval Dr Sheppard remained in the meeting and took part in the discussion.  
A general declaration of interest from all clinicians for Item 19/20-62, Musculoskeletal Service Work Programme, was noted as this involved investment in GP training. As this item was not for financial approved all clinicians remained in the meeting and took part in discussion. |  |
| 19/20-58 | **Minutes of the meeting held on 25 July 2019:**  
The minutes of the meeting held on 25 July were agreed as a true record. |  |
Action log from the meeting held on 25 July 2019
An update was given on the Action Log circulated and Rachael Bolton gave a verbal update on the QI Finance Updates, a further update on Tele-Dermatology was requested for the September meeting.

Digitally Assembled Referral Toolkit (DART): Improving the quality and safety of suspected cancer referrals
Dr Abdul Mustafa attended to give a presentation on DART, background information was outlined including compatibility with current systems and how the proposed Toolkit would improve quality of referrals. It was highlighted that DART could be used by clinical and non-clinical staff.

Discussion took place on potential impact on GP time and possible likelihood of duplication, i.e. review of different pathways already underway, e.g. gynaecology.

Clinical Cabinet were assured that DART would complement existing systems rather than create additional processes.

Discussion took place on timing of pilot training as there are already a number of IT training programmes underway which impact on clinical time resources.

It was noted that feedback from other CCGs had been positive. It was agreed that a demonstration of the toolkit would be useful together with an overview and understanding of how the tool connects with other systems and existing procedures.

IT WAS RESOLVED THAT CLINICAL CABINET: noted and discussed the proposed next steps for approaching this project.

Draft Community Ophthalmology Service Re-Design model
Sharon Cook attended to present an update on the Ophthalmology Service Re-design. It was highlighted that ophthalmology is a high risk specialty in Wakefield due to the aging population. The timeline for the process was briefly outlined, including approval and governance arrangements and proposed model. It was noted that the minor amendments to the clinical pathways suggested previously at Clinical Cabinet had been made.

Discussion took place on signposting and communication to enable better quality referrals, i.e. patients referred to the right place at the right time and a shift in referrals from GPs to EOS providers. This included:
- Identify/Signpost relevant referring body
- Streamline pathway and refine urgent and non-referral pathway options
- Improvement required on written correspondence to ensure referrals are actually made
- Need to improve quality of communication between primary care and ophthalmology providers (potentially through local chairs steering group / bi-monthly meetings)

It was suggested that further clarification on the relationship between primary care and ophthalmology would be a useful addition and the model of working should further clarify pathways for urgent care.

Potential impact of the new guidelines, which included raised IOP thresholds was
briefly discussed including possible effect on waiting times and level of activity.

**IT WAS RESOLVED THAT CLINICAL CABINET:** supported the Community Ophthalmology re-design model on the understanding that some points of clarity would be made.

**19/20-62 Update on Musculoskeletal Service Work Programme**

Grace Owen attended to provide an update on the musculoskeletal service work programme. Background information was outlined including details on procurement, potential models considered, the Internal MSK Working Group, (GP representative required to at the group), RightCare guidance indicators and as well as the rapid implementation of MSK Triage (which is due for review September 2019).

Brief discussion took place on consideration of Subcut Methotrexate as Amber drug and x-ray for osteoarthritis.

Detailed discussion took place on referrals for neuro-surgery specifically around direct referral and issues around acceptance of Wakefield MSK Triage to Leeds and Sheffield and the potential for the increase in activity for private providers.

Detailed discussion also took place on the issue of MSK still being an option on ERS and the difference between referring to MSK (a booked slot) and referring to MSK triage (holding place), the lack of clarity and understanding as well as capacity and cost pressure of 100% referral via MSK triage.

It was suggested that information on what services and quantity of activity for neuro-surgery by private providers was obtained.

Brief discussion too place on wait times, including KPIs and overall wait times from referral to treatment. Also on osteoarthritis and x-rays and potential spike in referrals to physiotherapy.

A discussion took place on a pain management service, including looking at the option provided by North Kirklees (provided by Pain Management Solutions). The progression of the development of a Wakefield service provided by MYHT was outlined and a pain education programmes provided the third sector. This led onto discussion around opiates and the medicalisation of patients and managing patient expectations.

Further discussion took place on the course and it was clarified that the business case was for one person per practice, this did not necessarily have to be a GP.

**IT WAS RESOLVED THAT CLINICAL CABINET:** received and reviewed the update on musculoskeletal service work programme. The business case for a GP Pain Management Education course was approved in principal as a way forward.

**19/20-63 Gastroenterology Update (RAS)**

Grace Owen attended to give a brief update on Gastroenterology and request clinical feedback.

It was clarified that this was not triage rather that it has changed the way the form can be seen, i.e. can now be seen before the patient is booked. It is more of an
administrative process but will be further developed in the future to be more clinically effectively.

It was suggested that it was difficult to assess at this stage as the system had only been up and running for three weeks. However it was acknowledged that it should streamline the service and ensure patients are seen more effectively.

The clinical aspect of choosing the right clinic to be referred to was highlighted.

The increase in consultant capacity was noted.

**IT WAS RESOLVED THAT CLINICAL CABINET:** received and discussed the paper.

---

**19/20-64 Planned Care Transformation Update**

Rachael Bolton attended to give a summary of the Planned Care Transformation update.

Significant Risk Areas were summarised and discussed:

- **Criterial Led Pathways (Local and including and EBI and VBC)** – delivery was red (significant risk)
  - Discussion took place regarding the VBC and the issue of only 2 specialties agreed to be piloted at MYHT. Concern and frustration was stated regarding lack of usage/buy-in by the provider and how to ensure contracts were adhered to. It was noted that a further 20-30 EBI would be issued.

- **Outpatient Efficiency Programme**
  - Critical concerns regarding room and resource allocation. The working groups meetings were highlighted, it was noted that further detail had been requested from the Trust regarding the 19 projects. It had been agreed that the Trust would provide an update and detail at the next meeting. It was confirmed that details of outcomes would be included in the next report.
  - An update was given on the developments of a joint PMO

- **Theatres Report**
  - KPIs were highlighted. It was noted that a consistent highlight report would be requested at the next PCIG meeting. Attention was drawn to information on elected sessions on page 3 and the graphs on the number of actual elected sessions and late starts.

- **Respiratory Highlight Report**
  - The on-line self-management support was outlined, including the process and progress for Wakefield. It was highlighted that this is a joint piece of work between the MYHT and WCCG and NKCC which it was hoped would reduce some of the waiting times for patients for long-term conditions. The concerns were summarised and detail given on how these had been progressed. The evaluation and analysis process and how the patient could be referred was clarified.

- **E-consultation** was doing well and would be further rolled out and usage had
improved. Again some data was lacking and would continue to be requested in a consistent format.

- Contracts KPI Dashboard, it was noted that this is split between WCCG, NKCCG and MYHT to have clarity. Details of demand management were briefly summarised. Highlighted were:
  - Planned Care and Demand Management, overall targets were being achieved
  - 2 week wait cancer referrals, variance is down overall
  - Performance against national standards
  - Cancer data (breast symptomatic trajectory improvement noted)

- The RightCare Vision document was highlighted and it was noted that the transformation leads would be focusing on the services detailed.

- Regarding the Streamlining pathways paper it was noted that progress on new pathways were on hold (in order not to waste clinical time) until a replacement for Oscar was agreed.

Discussion took place on assurance that PCIG focus was on outcomes and also issues regarding the VBC, which included accountability issues and processes. This led to further to discussion regarding engagement and communication and standardisation of mechanisms of engagement around implementation of new processes with the potential to greatly alter existing ways of working.

**ACTION:** An update on the VBC was requested for the September 2019 meeting.

**IT WAS RESOLVED THAT CLINICAL CABINET:** noted and discussed the Planned Care Transformation Update.

19/20-65 **Standing item:**
There were no suggested pathways to be referred to PCIG.

19/20-66 **Minutes from Sub-Committees to Note**
Medicines Optimisation Group minutes from June 2019 and July 2019 were noted.

19/20-67 **The work with the ARMR for the ICS was noted.**

The Public Health Paper on smoking cessation was highlighted and the costs of prescribing issues outlined. The Smoking in Pregnancy Report was mentioned and also a request to include the possible liaison between the Alcohol Liaison Service and mental health services. it was agreed that updates would be brought to future Clinical Cabinet meetings

19/20-68 **Date and time of next meetings:**
Clinical Leadership Forum: Thursday 12 September 2019, 1.00– 2.30 pm, Boardroom, WRH

Clinical Cabinet: Thursday 26 September 2019, 09.00 – 12.30, Seminar Room, WRH.

**Deadline for papers 18 September 2019.**
**NHS Wakefield Clinical Commissioning Group**

**CLINICAL CABINET**

**APPROVED MINUTES**

Of the meeting held on Thursday 26 September 2019

**Present:**
- Dr Adam Sheppard: Chair, Clinical Chair, WCCG
- Dr Aly Damji: GP, WCCG, Network Chair
- Dr Debbie Hallott: GP, WCCG Board Member
- Dr Tim Dean: GP, WCCG, Network Chair
- Steven Hardy: WCCG Board Lay Member
- Dr Clive Harries: GP, WCCG Board Member
- Dr Pravin Jayakumar: GP, WCCG Board Member
- Dr Nadim Nayyar: GP, WCCG Network Chair
- Michele Ezro: Associate Director – Acute Commissioning, WCCG
- Ruth Unwin: Associate Director, Associate Director of Corporate Affairs

**In attendance:**
- Tracy Morton: Senior Service Development & Transformation Manager
- Dominic Blaydon: Associate Director Primary Care Co-Commissioning
- Phil Smedley: Head of Strategic Commissioning
- TJ Alexander: Senior Transformation Manager
- Joanne Fitzpatrick: Head of Medicines Optimization (on behalf of Suzannah Cookson*)
- Steve Turnbull: Public Health Consultant, Wakefield Council
- Dena Coe: WCCG (Minutes)

<table>
<thead>
<tr>
<th>No.</th>
<th>Agenda Item</th>
</tr>
</thead>
<tbody>
<tr>
<td>19/20-69</td>
<td><strong>Apologies for Absence were received from:</strong></td>
</tr>
<tr>
<td></td>
<td>Dr Omar Alisha, Dr Chris Barraclough, Suzannah Cookson*, Dr Sumitra Dutta,</td>
</tr>
<tr>
<td></td>
<td>Pat Keane, Dr Jordache Myerscough, Dr Colin Speers, Jonathan Webb, Jo</td>
</tr>
<tr>
<td></td>
<td>Webster, Dr Patrick Wynn.</td>
</tr>
<tr>
<td>19/20-69</td>
<td><strong>Declarations of interest:</strong></td>
</tr>
<tr>
<td></td>
<td><em>Agenda Item 19/20-77 - Tele-Dermatology Query Responses</em>*</td>
</tr>
<tr>
<td></td>
<td>It was noted that all GPs had a declaration of interest as this involved</td>
</tr>
<tr>
<td></td>
<td>equipment given to practices. As this did not involve discussions on finance</td>
</tr>
<tr>
<td></td>
<td>all GPs remained in the meeting and took part in the discussion.</td>
</tr>
<tr>
<td>19/20-70</td>
<td><strong>Minutes of the meeting held on 22 August 2019</strong></td>
</tr>
<tr>
<td></td>
<td>The minutes of the meeting held on 22 August 2019 were agreed as a true</td>
</tr>
<tr>
<td></td>
<td>record.</td>
</tr>
<tr>
<td>19/20-71</td>
<td><strong>Action log from the meeting held on 22 August 2019</strong></td>
</tr>
<tr>
<td></td>
<td>The Action Log was updated accordingly.</td>
</tr>
<tr>
<td></td>
<td>A verbal update was given on the outstanding Mental Health actions.</td>
</tr>
</tbody>
</table>
Matters Arising

Michele Ezro reported that she would be on secondment for six months working between the CCG and SWYPT working on a review of waiting times for access by children and young people into specialist mental health services. The Chair thanked Michele for her contribution to Clinical Cabinet and requested that she gave an update on the secondment work at a future Clinical Cabinet meeting.

There were no further matters arising.

Maternity Services Update

Tracy Morton attended to give an update on Maternity Services. It was emphasized that there is a system-wide strategy which covers three sites and incorporates national and local plans and the update was not just focused on the Pontefract FMLU.

Background and context were given and details included information on staffing, capacity, resources and challenges. It was highlighted that a key priority was continuity of carer and that a pilot was underway at Dewsbury. Increase in women with high acuity was noted and also highlighted was the progress made reducing smoking in pregnancy.

A summary was given regarding the process, engagement and progress for the case for change at Pontefract MMLU including feedback from the Clinical Senate. It was noted that the Clinical Senate had initially requested the CCG and Mid-Yorkshire look at wider potential alternative solutions to those already submitted. Following on from submission of further options which included an “on-demand” service at Pontefract FMLU, Clinical Senate recommended more information regarding sustainability of such a service.

Key areas of discussion included:
- Workforce and recruitment issues
- Responsibility to provide safe, effective and appropriate services
- Impacts on capacity, including housing, potential increasing birth rate and acuity of women and potential closure of services
- Assurance of level of acceptable risks for potential on-demand services
- Analysis of reasons for women choosing to birth at Pinderfields

It was agreed to share the draft Clinical Senate report when it was finalised.

IT WAS RESOLVED THAT CLINICAL CABINET:

Noted and considered the development in maternity strategy at national, regional and local level and the current position with regard to Pontefract FMLU.

Adult and Children’s Weight Management Update

Steve Turnbull gave a presentation on the Aspire Health Referral initiative. Background information was provided including the aim for a holistic approach by the Council which is district-wide, the “pledge” system, increase in numbers of referrals and savings made. It was noted that raw/actual numbers as well as percentages would be useful. The proposal to provide a service for children was highlighted.

It was highlighted that currently once a patient was referred to a service provider, e.g. Weight-Watchers no further feedback was received by the GP and there was a need to understand the pathway and support offered to patients. In response Dr Pravin Jayakumar gave details of the planned integrated pathway and how data
will be shared through SystmOne. It was highlighted that this was a health management service, not just weight management. Trinity Primary Care Network would be a pilot for the proposed children’s service and would also look to work with schools to identify children who may benefit from the service.

Discussion took place on Orlistat including number of patients currently prescribed the medication, costs and usage of the drug by consultants.

Discussion took place on prevention and the role of Primary Care and communications and sign-posting.

Also discussed was the Tier 4 service, benefits of physical activity and how services can link and integrate with mental health services. It was acknowledged that there were variable and complex cases and integration of services could require upskilling for staff.

**IT WAS RESOLVED THAT CLINICAL CABINET:** noted and discussed the weight management update and supported the proposal to develop the service for children’s model.

19/20-75

**ASD Strategy**

Dominic Blaydon attended to give an overview of the draft Autism Spectrum Disorder strategy, including how the strategy has evolved. The four key areas for priority had been developed from feedback from parents and carers and details were outlined. Information on the co-ordination and management of the strategy were also summarised.

Clarification was requested on an adult ASD pathway, it was acknowledged that the strategy was predominately for children and young people and that a further strategy would be required for adults.

It was requested that a strong communication strategy was developed to share the strategy, in particular with schools and those families which may have used the services previously, in order to highlight the improvements that had been made.

Areas of discussion included:

- Lack of clarity regarding acceptable and/or approved referral processes and the most appropriate agency for referral, e.g. school or GP
- Support required for GPs for adults, need for awareness of GP time constraints for referrals
- Positive feedback was given regarding school referrals and it was acknowledged that this could vary from school to school
- What will happen when challenging behaviour is not diagnosed as ASD and what support is offered to families. In response it was noted that the report is cited on this issue and work would be undertaken to provide support
- Issues regarding staffing and resources, i.e. waiting lists
- Under diagnosis in girls
- Practical issues for people with autism
- Engagement of schools, holistic assessments, non-medicalised assessments, robust process and assurance that all schools are fully aware and involved
- The ECHO project was highlighted (a third-sector organisation based in
Ferrybridge which supports patients, carers and families who need a referral).

**IT WAS RESOLVED THAT CLINICAL CABINET:** noted, discussed and supported the priorities set out in the draft ASD Strategy.

### 19/20-76 Value Based Checker Tool Update

Phil Smedley attended to give an update on usage of the VBC tool. An overview of the diagram Fig 4 was given which detailed the process of patient journey and data flows. The time lag for data was highlighted; approximately three months for data to show in activity figures.

Usage/take-up by GP practices and providers was briefly outlined. The issue of two practices unable to register to use VBC due to matters around usage of NHS.net mail had now been rectified. The benchmark position for WCCG was noted.

Key areas of discussion and points to note included:

- Commissioning policy applies to the registered population
- Custom and practice v policy adherence
- NHSE Contractual levers to enforce policy and demonstration of adherence to policy
- Issues around lack of uptake of usage by providers
- The NHSE requirement for commissioners to comply with adherence to policy provisos
- The Challenge File process (on the VBC) was further detailed and discussed
- The WY&H ICS strategy to fund different compliance options (rather than a consistent ICS approach taken by other regions)
- Frustration expressed on decision to use VBC despite lack of support for the tool by GPs and some providers
- Update on Devon CCG referral support system suggested for shared learning
- Whole system buy-in and rigorous contractual
- Issues on the provider list
- Future discussion at SLT – potential alternative options
- Potential process to influence independent GP colleagues

**IT WAS RESOLVED THAT CLINICAL CABINET:** noted and discussed the Value Based Checker Tool update.

### 19/20-77 Tele-Dermatology Query Responses

It was noted that GPs had a declaration of interest as this involved equipment given to practices. As this did not involve discussions on finance all GPs remained in the meeting and took part in the discussion.

TJ Alexander attended to present responses to queries raised at the August 2019 Clinical Cabinet meeting.

It was highlighted that the information provided for Leeds evaluation were incorrect, further details were given and a further update would be provided when the correct conversion rate was obtained.

Details of the hardware required were discussed, this would consist of an imaging
device and a dermatoscope, and provision would be calculated at 1 per 3,000; this would be at no cost to the practice. Details of the costings of maintenance of equipment, and on-going software and training of the equipment had not been finalised, this was due to the fact that the money for the equipment was not recurrent funding. It was clarified that the Cancer Alliance had agreed to pay for the dermatoscope and the CCG had agreed to pay for the software application (for 12 months) and MYHT were looking at how they would undertake the process.

Further discussion and clarification took place on conversion rates and potential outcomes. The challenges were also outlined, including GP buy-in and supply led demand, it was noted that evaluation of the process was not fully complete. The ANP figure of 99% inappropriate referrals was mentioned.

Discussion took place on:
- 2 week wait process clarification
- Governance process for non-cancer treatment
- It was felt that overall this business case would be well received by GPs
- Feedback from the dermatology summit noted that that MYHT could see the value of the business case

It was suggested that further consideration should be given to:
- The non-recurrent funding issue
- Potential mitigation versus capacity and resources
- Patient reassurance requirements
- Acceptable risk

It was agreed that a further update would be provided to Clinical Cabinet, which would include a draft communications strategy. A one-sided briefing paper to take to networks was requested in order to canvass GP opinions. It was also requested that that consultation with Leeds regarding lessons learned should be undertaken prior to drafting the briefing paper.

**IT WAS RESOLVED THAT CLINICAL CABINET: received, noted and received the paper.**

19/20-78 **Domestic Abuse Strategy 2019-2022**

Ruth Unwin highlighted the strategy for information. Details of where the strategy had been shared were provided including discussion at the WCCG Senior Leadership Team meeting. Funding available from the Ministry of Housing and Local Government has been made available to support 2 practices in the district to identify victims of domestic abuse by proactively asking all female patients over the age of 16. The link to deprivation and domestic abuse had been identified and further data would enable further analysis.

Other areas of discussion included:

- Safeguarding and risk register for both adults and children was highlighted and discussed, including consent and transparency issues.
- Percentages and incidence of domestic abuse to different genders.
- Unintended consequences of screening

**ACTION:** Clarification of the details regarding the risk register and safeguarding were requested.
<table>
<thead>
<tr>
<th>Item Number</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>IT WAS RESOLVED THAT CLINICAL CABINET:</td>
<td>noted and supported the contents of the Wakefield District Domestic and Sexual Abuse Strategy 2019-2022.</td>
</tr>
<tr>
<td>19/20-79</td>
<td>Standing item:</td>
</tr>
<tr>
<td></td>
<td>There were no suggested pathways to be referred to PCIG.</td>
</tr>
<tr>
<td>19/20-80</td>
<td>Minutes from Sub-Committees to Note</td>
</tr>
<tr>
<td></td>
<td>There had been no meeting of the Medicines Optimisation Group in August therefore no minutes to note.</td>
</tr>
<tr>
<td>19/20-81</td>
<td>Any other business:</td>
</tr>
<tr>
<td></td>
<td>It was noted that the Clinical Leadership Forum would in future have a change of name and focus.</td>
</tr>
<tr>
<td></td>
<td>It was agreed that a further discussion on dermatology would be included at a future meeting of what was the Clinical Leadership Forum.</td>
</tr>
<tr>
<td>19/20-82</td>
<td>Date and time of next meetings:</td>
</tr>
<tr>
<td></td>
<td>Clinical Leadership Forum: Thursday 10 October 2019, 1.00–2.30 pm, Boardroom, WRH</td>
</tr>
<tr>
<td></td>
<td>Clinical Cabinet: Thursday 24 October 2019, 09.00 – 12.30, Seminar Room, WRH.</td>
</tr>
<tr>
<td></td>
<td>Deadline for papers 16 October 2019.</td>
</tr>
</tbody>
</table>
Connecting Care Executive Meeting

Thursday 11 July 2019
11.00 to 12.30pm
Seminar Room, White Rose House

Present:

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jo Webster (JoW) Chair</td>
<td>Chief Officer, WCCG</td>
</tr>
<tr>
<td>Melanie Brown (MB)</td>
<td>Director of Commissioning and Integrated Care, WCCG</td>
</tr>
<tr>
<td>Dr Ann Carroll (DrC)</td>
<td>GP and Clinical Lead for Connecting Care, WCCG</td>
</tr>
<tr>
<td>Caroline Carter (CC)</td>
<td>Group Finance Manager, Children &amp; Young People, WMDC</td>
</tr>
<tr>
<td>Jonathan Webb (JW)</td>
<td>Chief Finance Officer, WCCG</td>
</tr>
<tr>
<td>Beate Wagner (BW)</td>
<td>Corporate Director, Children and Young People, WMDC</td>
</tr>
<tr>
<td>Anna Hartley (AH)</td>
<td>Director of Public Health, WMDC</td>
</tr>
<tr>
<td>Dr Adam Sheppard (DrS)</td>
<td>GP and Chair, WCCG</td>
</tr>
<tr>
<td>Gary Jevon (GJ)</td>
<td>Chief Executive Officer, Healthwatch</td>
</tr>
</tbody>
</table>

In attendance:

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stephen Crofts (SC)</td>
<td>Service Director Children’s Services Strategy and Innovation, WMDC</td>
</tr>
<tr>
<td>Monica Green (MG)</td>
<td>Head of Service, Children in Care and Corporate Parenting, WMDC</td>
</tr>
<tr>
<td>Judith Wilde (JWi)</td>
<td>Deputy Chief Nurse, WCCG</td>
</tr>
<tr>
<td>Martin Smith (MS)</td>
<td>Head of Connecting Care Commissioning, WCCG</td>
</tr>
<tr>
<td>Joanne Rooney (JR)</td>
<td>Senior Commissioning Manager, Children and Young People, WCCG</td>
</tr>
<tr>
<td>Lauren Adams (LA)</td>
<td>Observer, WCCG</td>
</tr>
<tr>
<td>Michelle Domoney (md)</td>
<td>Minute Taker</td>
</tr>
</tbody>
</table>

1. Welcome and apologies:
   Suzannah Cookson, Andrew Balchin (AB), Angela Nixon and Liz Goodson submitted their apologies.

2. Declarations of Interest:
   No declarations were made.

3. Minutes from 9 May 2019
   The minutes were approved as an accurate record.

4. Action Log
   Reviewing the action log, the following updates were given:
• 20190509-012: AB will share details of discussions between Kirklees, Calderdale and Wakefield Councils.
• 20190509-013: NE to attend future meeting with ideas for enhancing the CCE workplan from an adult’s perspective. MB and JWi added NE has already started some positive conversations regarding CHC Commissioners coming together with Adult Social Care Commissioners.

5. **FOR DECISION: Wakefield Children in Care Residential Placements:**

MB talked the CCE through the supporting paper, highlighting:

- In March 2019 CCE members were presented a paper regarding the benefits and opportunities of WCCG and WMDC working together on high cost spend i.e. placement for children with complex needs;
- There has been a growing number of children in complex care over the last 12 months;
- The number of out of area placements and cost to the Wakefield system has been reviewed; with costs ranging from £2.5k to £10k per week per child;
- Invest to save options to create some in house residential settings have been discussed as a means of reducing current costs. Some changes have already happened with Dacre Avenue changing to create 4 beds which are already being used;
- An additional 4 beds will be available by the end of September 2019 following 2 homes being converted to two, 2 bedded units; allowing Wakefield to bring four/five young people back into area. Although there will be savings made, MB was keen to emphasise the driver for such change is to improve outcomes for these young people adding, being able to place these young people within Wakefield will mean they are closer to family, friends and social relationships etc.

Providing additional information, MG advised:

- There will be a 12 beds in total across Wakefield;
- The changes aim to promote life-long links;
- Wakefield’s children’s homes are either good or outstanding and Wakefield children should therefore be cared for within them;
- There are some children with complex needs who cannot be treated within Wakefield, however most, if they have emotional difficulties, should be close to family and services within their local area;
- Group living needs to be assessed across all 12 beds to ensure the right match, fix, ages and staff skill mix are in place;
- Ages of children can vary, with some being as young as 11 years of age;
- Steps are being taking to invest in local services including the Emotional Wellbeing Team and Enhanced Outreach Teams so they can look after children in terms of emotional wellbeing, social and educational needs and health;
- The additional will be like regular houses; they will be staffed on a one to one basis, with the availability of additional support if required and steps will be taken to ensure therapeutic connections are available. MB added this was
very important in terms of measuring impact and success; adding updates will be provided to CCE to ensure the goals set are being met and future evidence is available for the purpose of any future inspections.

Referencing page 5 of the supporting paper and impact on young people, MB advised impact will be tracked in a variety of ways to assess how these young people are doing when they return to Wakefield in comparison to their out of area experiences/journeys. MB talked CCE members through the other methods of tracking impact as detailed in the supporting paper; confirming there is a commitment to capture the impact on young people and it is proposed a robust evaluation is presented to CCE in October 2020, though updates will be given to CCE every quarter; not just in terms of progress made in terms of benefits to children, but also updates on the cost projections and savings being delivered. It is therefore proposed MG will meet quarterly with finance colleagues (Naomi Ahfat-Smith) and Rob Hurren to discuss budgets and an update will come to CCE and provide assurances savings are being made.

Regarding funding, MG advised current CIC levels are approximately £600k. There is still some growth expected within that, therefore in terms of overall budgets, MG noted some caution adding some children will require joint investment going forwards.

Referencing the supporting paper, MB highlighted the governance conversations which have taken place and next steps to be taken. Reading the recommendations, MB asked the CCE to:

- Approve the investment requested by the CCG and WMDC for residential childcare development;
- Agree to receive updates at CCE on benefits realisation of the mobilisation of the schemes;
- Agree to capture impact on young people via evaluation.

The CCE discussed the supporting paper; noting the young people involved are some of the most vulnerable and the impacts of their experiences at this age can set the future for them as adults.

Commenting on the programme and supporting paper, BW advised:

- One of the risks of not proceeding with the programme is continuing to be at the mercy of the market; noting there is an increasing number of children who cannot find a placement and therefore on some rare occasions our system can be in a position of purchasing a complex area placement which can cost £10k a week;
- It is important for members to know there are commercial considerations, there is always a risk the plan for the child is not always the only thing which is at the centre of planning for those providers. In view of this BW would like to see, as part of the evaluation, all children’s plans being progressed and that children can move forward as their needs are being met;
- It is important to ensure that the whole package provided is the right one; adding this will accelerate a child’s ability to make progress within the
Regarding the rising numbers of children in care, BW suggested this was a temporary issue; feeling there is a legacy issue alongside a current issue. BW assured CCE members the position is being closely monitored adding colleagues do not want children in care unnecessarily, therefore other developments are running alongside this programme;

- If this programme works, we can theoretically have as many places as we like within a house environment. MG added there is a cohort of young people whose mental health difficulties are quite acute, however felt these young people could be looked after as part of this improved service. MG noted there is an element of staff confidence to deal in terms of managing children with mental health issues however suggested this could be addressed with some jointly commissioned nurses. In addition, children cannot be contained within homes forever therefore consideration needs to be given to how we can jointly commission a package of care which includes some nursing care.

CCE discussed how the older population in residential care and care homes are looked after, noting those residents have access to support. JoW asked how much additional support is given to children who are in care; noting the similarities within a cared environment and suggested a comparison may provide opportunities to consider enhanced models using our Primary Care Home (PCH) Networks; adding there is a one Practice, one home concept within adults and suggested this be considered for children. JoW also noted a model was developed in Airedale where there was a high proportion of children with learning disabilities and additional support was provided. With these and other models available, JoW suggested these could be reviewed and included as part of Wakefield’s Children’s Pledge to do something different to support young people in care and suggested this is given further consideration outside of CCE.

Discussing how the evaluation will be undertaken and noting the initial small cohort involved, MG would want to receive feedback from young people themselves in terms of their health, education and social outcomes i.e. have young people got life-long connections maintained, are young people engaged with education appropriately and accessing health services etc. In addition, MG suggested there will be a need to understand lived experience.

Noting this programme of work may provide the blueprint for future provision within the District and build Wakefield’s own services locally, JoW noted the importance of evaluation and suggested Healthwatch are involved in the evaluation process. MB confirmed conversations are underway regarding this. JoW also suggested the scope of the evaluation is presented at a future CCE to ensure it is correct and provides CCE with ownership. MB added GJ is beginning to pull together a proposal for 4 cohort areas of which one is children in care for mental health and this programme can be included as part of that piece of work.

Noting all the comments raised and additions, the CCE accepted the recommendations as outlined in the supporting paper.
6. FOR DISCUSSION: Wakefield Families Together New Ways of Working:

SC gave a presentation on some of the work taking place for Wakefield Families Together; advising on the vision (greater integration, co-location, locality based and responsive), the progress to date, new ways of working, early thinking to build a multi-agency, integrated and co-located team around a family, school pyramid clusters, governance and how partner agencies can help, adding:

- Learning will be taken from other areas including adult services; noting there is a lot which can be learnt from the way health and adult social care in Wakefield have better connected through the 3 hubs;
- New ways of working will be organised around schools, in view that schools is where most children can be found. School catchments and school pyramids are important when considering connections with schools;
- The six school cluster areas provide a close, but not exact match to the boundaries of the PCH Network areas;
- A Steering group for the programme met for the first time last week; chaired by BW, it includes membership from across the children’s partnership and will report to the Children and Young People Partnership Board.

During the presentation, CCE members raised the following:

- One element of Connecting Care was that Age UK and Carers Wakefield were an integral part of the core connecting care team; providing crucial early intervention prevention support which aided health and social care. AH suggested this programme should not just be about bringing people together, it is about people working in a different way; adding one of the biggest culture changes seen is the Voluntary Community Sector (VCS) becoming an equal partner and suggested VCS could contribute to the outcomes trying to be achieved and become a part of that core team. AH provided details of a staff evaluation, advising at the end of the 2.5 year evaluation period, the biggest improvement made which saw the largest difference was the involvement of Age UK and Carers;
- The requirement to not just include the statutory organisations but ensure the inclusion of VCS and acknowledging VCS are key players.

Noting the additions of VCS and PCH, the CCE discussed the school pyramid clusters and boundaries. DrS advised GPs deal regularly with schools and children’s services and suggested the clusters should be aligned to the 7 PCH networks.

CCE members also discussed the programmes vision; advising it is understood the vision is to provide the best universal health and commissioned services possible to all children and suggested this was not particularly clear in the presentation delivered.

Continuing discussions regarding boundaries, members acknowledged the need for schools and GP surgeries to know what is available when there is an extra need. DrC commented, with the exception to health visiting, midwifery services and services GP practices deliver themselves, GPs are not aware of what is
available either in voluntary or social care sectors for families who need more support. DrC noted the benefits of the introduction of an electronic referral within adult services to address problems based on referrals and suggested there should be ambition and consideration given to how a similar referral system could be implemented for children’s. DrC also suggested ensuring the skills used within adult services are included in delivering this programme; noting that IT and Governance were key factors when delivering the adult vision.

Discussing the map further and the differences between the school pyramid clusters and PCH boundaries, MB advised it is the Five Towns PCH; the seventh PCH, which has the largest boundary difference. JoW added finding a way of connecting the seventh to the map described would be ideal; adding the 3 PCH leads have previously been asked to demonstrate they can work across the districts which cover East of Wakefield and therefore suggested the cluster and network boundaries should be able to work together.

Acknowledging that getting all services to work within the same boundaries is not possible, CCE noted there needs to be an element of pragmatism despite the slight differences in footprints and suggested the PCH networks are reflected on the school pyramid cluster map and conversations take place with the clinical leads with regard to how this can work and what are the principles. SC advised the programme is still in its early stages and there are numerous conversations still to take place adding in conversation with Dominic Blaydon (DB) last week, DB was keen consideration be given to the fit with PCH networks and undertake some work to overlay on the map. JoW noted the importance of both schools and primary care and advised that all steps should be taken to make both work together.

BW added this piece of work is not about improvement, it is about what is our vision as a partnership to make it right for children living in Wakefield and giving them the best changes in life. BW suggested schools, teaching staff, early year providers etc. would advise they have these children all the time/5 days a week and are the people who know children best and therefore need to be at the centre of any discussion from the beginning. BW acknowledged the work to be undertaken is ambitious and it will be hard, however BW feels there is help within this room, examples of good practice who can help accelerate this programme of work.

MB highlighted this piece of work is in its early stages, advising the steering group have only met once to date and today’s conversation is an opportunity to shape the piece of work, build together and advise members that organisational representation will be required as part of the job groups moving forwards to ensure there is connectivity. JoW advised she would be happy to be Vice Chair of the steering group.

Following all discussion, CCE members were supportive of the principle and recognise the challenge faced, The following actions were suggested:
• Holding a conversation with the PCH Clinical Directors; asking them to work with the programme and the school pyramids cluster boundaries, noting what has taken place and worked in other places (Stockport) and acknowledging the involvement of PCH is key and such discussion is an important step;
• Making the presentation more expressive in terms of the model and wider vision to fit with the delivery of children’s services across Wakefield;
• Involvement of VCS and the crucial role they can play.

In final discussions, JoR suggested engagement is underpinned in all work areas as an enabler; not as a sole element.

JoW welcomed the approach described and the clear ownership of the programme with all partners being able to contribute. Once the PCH and school conversation has taken place and the design has been confirmed, DrC suggested details of this programme should also be presented at the Wakefield Integrated Care Board (ICP) with Network Chairs in attendance to ensure everyone understands what the model and direction of travel is for Wakefield. SC confirmed an update will be given at the next ICP meeting.

7. FOR DISCUSSION: SEND Re-visit Update:

MB gave a verbal update following the SEND Re-visit on 3 and 4 June 2019 advising:
• Initial results have been released which detail sufficient progress. A draft letter received from CQC and Ofsted has been received asking for comments prior to the final version being released prior to schools closing for summer;
• Communications are being prepared for sign off by both CCG and WMDC in the coming days;
• There was great team and partnership working, not just in terms of the preparation and readiness, but also during the visit itself, with colleagues working together to defend and provide detail on the improving position;
• A meeting is taking place with all the clinicians from MYHT to discuss how to move beyond having a 14-18 ASD team, creating a 0-18 vision and how to move this forward. There is capacity within our system now to focus on moving the transformation conversation forward now that monitoring visits will formally cease;
• There are positives and areas for development noted within the draft letter including a request to progress 0-14 pathway and additional areas identified during the inspection (language used with families for example). The areas for development will be picked up and addressed to improve their position;
• On the whole, the re-visit generated a positive outcome.

BW thanked and congratulated MB, AL and members from all teams on this massive achievement. Although there are areas to be worked on, an overwhelming majority of the letter is very positive and testament to great leadership and the efforts of the teams. MB noted it was also good to see CQC and Ofsted comment on the relationship between WMDC and WCCG as strong
and that we’ve acted in a committed way to address a significant weakness and this is a positive for all.

JoW agreed with BW adding it is a great accolade to the leadership and all those involved in doing a fantastic job in turning the service around and managing the inspectors during the re-visit. There will be follow up meetings and discussions at the CAMHS Oversight and Assurance Group meetings in terms of learning and steps have already begun to consider next steps to continue to improvement this service; adding any child on a waiting list is a child too many. MB added further parent events are scheduled to take place in August and November which will provide opportunities to test the ideas for a 0-18 service with all our collective energies put towards local transformation.

8. **FOR DISCUSSION: Children’s Joint Commissioning Update/Project Team Report:**

MB gave an update presentation on bringing together children and young people commissioning; advising on the work taken place to date, findings, recommendations and discussion areas for CCE to consider; adding:

- Jane Hall and Charley Webster have conducted a series of interviews in order to sense check thoughts of colleagues regarding bringing children and young people commissioning together and how it can be done at pace;
- Recognising concerns raised by staff regarding loss of identity, OD sessions are to take place as teams come together, with some sessions already arranged for early September;
- Lots of work is taking place already including investigating estates and how best to bring staff (approximately 12 in total) together;
- It is hoped by October 2019 there will be a joint commissioning plan for children and young people services.

Reviewing the areas for CCE discussion, members discussed the phased approach and what the preferred approach would be. MB advised realistically it will be nice to get people working together; sharing a kettle, sharing fridge etc. in time for October 2019 with tools built from that point and noting there needs to be an element of pragmatism, a phased approach should provide the best solution to moving this programme forward. AH advised on the lessons learnt and experiences of the Connecting Care programme; adding these have been taking into consideration when deciding phased approach would provide a better outcome.

BW noted the progress made so far; advising it is a testament of the trust between the organisations to move this forward. SC added another positive is that there is a real willingness and openness between staff to work in a different way and staff do see a value in working together on this new approach.

JoW also supported the approach described recognising it is about people working together and developing relationships; adding it is these things which make a difference and the partnerships developed as a result of connecting care
is testament to such an approach. JoW advised colleagues should continue to progress this programme at pace and make it happen.

JW advised it would be good to see in 6 months’ time, the joint team advising the element which is preventing further development is budgets and make recommendations on how things should be done. JW also noted the pace of progress and asked if the approach could be replicated in other areas i.e. CHC Contracting, Business Intelligence etc. JoW advised she is leading a workstream on behalf of WMDC CMT regarding what commissioning opportunities there might be in the future; if this model can be lifted and replicated once tested, it might be helpful.

CCE members noted the examples of good co-working taking place with positive effect (i.e. KOOTH, Mental Health Provider Alliance) and the trusted relationships which have developed through CCE which allows members to talk freely and work together to find solutions.

BW noted the links required between jointly taking responsibility for the emotional health and wellbeing and matching that with the Wakefield Families Together New Model Pathway; adding these are two strands of work which have the potential to really come together. JoW added this programme is about doing the right thing and allowing people to develop in a different way; it is not about reducing running costs.

MB asked CCE members to confirm they are happy to proceed with JoR in a joint post and Clare Offer moving forwards with the logistic. JoW advised the programme can move forwards though there may be a simultaneous requirement to advise other forums what is taking place. BW and CCE members agreed with this approach.

9. **FOR ASSURANCE: Summary of 2018/19 BCF including Q4 Final Picture:**

   This agenda item was deferred until the next meeting.

10. **FOR INFORMATION: Mental Health Investment Proposal:**

    The CCE noted the paper was for information and the presentation had been delivered and supported at last weeks Integrated Care Partnership (ICP), however JoW noted the significant amount of resource and suggested this is raised at WMDC CMT; adding the paper is really good and shows the investment into mental health. BW has some comments regarding the paper, however will raise with JoW outside of CCE.

11. **FOR INFORMATION: Matters to be Referred to Governing Body, Health and Wellbeing Board and/or other Committee:**

    MB advised when the final SEND re-visit letter is released; a report will be written for WCCG Public Governing Body in September 2019.
12. **Any Other Business**

**Joint Commissioning Project CHC:**
MB advised Nichola Esmond was going to attend the next CCE meeting, however noting the conversation today regarding joint children and young people commissioning and moving at pace, MB asked if a PID could be circulated to members for virtual discussion regarding a similar programme of work to explore the contracting arrangements for CHC with Adult Social Care.

JoW supported the proposal, advising JoW has already had some discussion with AB where it was suggested it would be helpful to have some functions of CHC jointly commissioned however both JoW and AB acknowledged there will be some areas which will requiring working through via the PID. JoW believed AB would support this approach also. JWi added a meeting has already been set up with both contracting teams to consider what could work whilst also considering the concerns of staff.

13. **Date and Time of Next Meeting:**

The next meeting will take place on 12 September 2019 from 11.00 to 1.00pm in the Seminar Room at White Rose House.
NHS Wakefield Clinical Commissioning Group

PROBITY COMMITTEE

Minutes of the Meeting held on 21 May 2019

**Present:**
- Mel Brown: Programme Commissioning Director – Integrated Care
- Dr Greg Connor: Executive Clinical Advisor
- Suzannah Cookson: Chief Nurse
- Diane Hampshire: Registered Nurse
- Stephen Hardy: Lay Member (Deputy Chair)
- Richard Hindley: Lay Member (Chair)
- Mr Hany Lotfallah: Secondary Care Specialist
- Richard Watkinson: Lay Member
- Jonathan Webb: Chief Finance Officer

**In Attendance:**
- Neil Coulter: Deputy for Anna Ladd, NHS England representative
- Natalie Knowles: Primary Care Support Manager (item 19/033 only)
- Chris Skelton: Head of Primary Care Co-Commissioning
- Richard Sloan, MBE: Healthwatch representative
- Ruth Unwin: Director of Corporate Affairs
- Pam Vaines: Minute Taker

19/026 **Apologies**

Apologies were received from Dominic Blaydon, Anna Hartley, Cllr Faith Heptinstall, Anna Ladd (who was represented by Neil Coulter), and Amrit Reyat.

Richard Hindley welcomed Richard Sloan to the Committee.

19/027 **Declarations of Interest**

There were no declarations of interest made.

19/028 **(a) Minutes of the meeting held on 26 March 2019**

The minutes from the meeting held on 26 March 2019 were agreed as an accurate record subject to two minor amendments:

- Page 1 – Jonathan Webb’s job title was incorrectly shown as Interim Chief Finance Officer.
- Page 2 – comments made by Suzannah Cookson should be clarified to say ‘targets need to be sufficiently challenging’.

The minutes were amended accordingly.

19/028 **(b) Action sheet from the meeting held on 26 March 2019**
The action sheet was noted.

Chris Skelton confirmed that the Quality Team has written to Maybush Medical Centre to thank them for their hard work following the CQC inspection. This completed the action point from minute 18/133.

19/029 Matters Arising

There were no matters arising discussed.

19/030 Probity Committee Effectiveness Survey

Ruth Unwin reminded the Probity Committee that annual effectiveness surveys were carried out for all sub-committees of the Governing Body.

The results showed that the Probity Committee members felt that overall the committee was effective. However, in common with other committees, further work was needed regarding the sharing of information with other groups and committees. This was a recommendation from the Capacity and Capability Review.

Ruth Unwin confirmed that work would be undertaken with all Committee Chairs in order to improve communication and sharing of information.

Dr Connor commented that the findings of the survey were encouraging and reflected the strong role of the Chair. He noted that the structure of the agenda may be improved by employing subject headings, similar to those used for Integrated Governance Committee agendas.

Ruth Unwin reminded members of the newly implemented ‘Committee Minutes – Items for Escalation’ paper which is completed by Committee Chairs and is presented to the Governing Body together with the meeting minutes.

Richard Hindley reminded members that each meeting agenda includes an item to raise any matters to be referred to other committees or Governing Body. He commented that Probity Committee had been delegated authority to prevent conflicts of interest arising at Governing Body.

Stephen Hardy congratulated officers for clear and focused papers, commenting that the front sheets provide an explanation of the required action or decision for each paper.

It was RESOLVED that:
   i) The Probity Committee noted the findings of the Probity Committee Effectiveness Survey
   ii) The Probity Committee agreed that future agendas would include section headings.

19/031 Probity Committee Annual Report 2018/19

Ruth Unwin presented the Probity Committee Annual Report in line with NHS
Wakefield CCG’s governance arrangements.

The report showed good attendance rates by members and effective communication. All elements of the work plan have been delivered.

Ruth Unwin explained that the paper would then be presented to the Governing Body in July 2019.

Suzannah Cookson noted that the report detailed Clare Linley’s involvement with Probity Committee until August 2018 and suggested that the report be amended to show her own involvement after that date.

It was RESOLVED that:

i. The Probity Committee commented on the annual report and subject to the necessary amendments, recommended the annual report to Governing Body in July 2019.

19/032 Probity Committee Annual Work Plan 2019/20

Ruth Unwin presented the proposed work plan for 2019/20 and reminded the Committee that the work plan would be amended throughout the year to reflect new and developing issues and topics.

It was RESOLVED that:

i. The Probity Committee approved the work-plan for 2019/20

19/033 Wakefield Practice Premium Contract 2018/19 Performance Report

Chris Skelton presented the annual summary of the Wakefield Practice Premium Contract for 2018/19.

The report provided assurance against performance under several contractual domains. Chris Skelton highlighted several, including:

Access Domain:

29 of the 37 practices had achieved compliance with the access domain requirements. The remaining practices are being supported to achieve the recommended level.

Medicines Domain:

Nine practices did not make any improvements in line with contract requirements within the medicines domain. They are being supported by the Medicines Optimisation team.

Only one practice did not meet the electronic prescribing target. This was as a result of the high number of dispensing patients registered within the practice, a higher number than the requirements of the standard contract.
Learning Disability Domain:

KPI requirements were for a 50% improvement in the number of LD health checks. Three practices did not meet the target and reported recording issues. These will be addressed once the final data is available.

Cancer Domain:

93.91% of patients in the cancer cohort have now been contacted. This is a baseline figure and will continue to be worked on in future.

Diabetes Domain:

Prevention remains the main focus of work within this domain. However, there was an increase of 1641 newly diagnosed patients in the previous 12 months. Overall the CCG performed well in comparison to peer organisations in the area and work will continue with practices to improve the situation further.

Heart Domain:

Hypertension will remain a focus for 2019/20. 87% of newly diagnosed hypertensive patients in Wakefield have had an assessment of risk in regard to cardiovascular disease.

Respiratory Domain:

96% of patients considered to be at high risk have been contacted for a review. Work is continuing regarding steroids. This is a moving cohort of patients and the number of new diagnosis increases year on year.

Chris Skelton informed the Committee that the practices with the highest number of outliers have been contacted to provide assurance of the work they are undertaking to improve the situation.

All practices have completed the requirements relating to the GP Incentive Scheme (70p Scheme) and will be included in the commissioning intentions for 2019/20.

Diane Hampshire asked for clarification of the repeat dispensing target. Chris Skelton explained that the results of one practice were affected because they had a significant number of patients that they dispense to but are not eligible to re-dispense.

Diane Hampshire also enquired whether the action plan for improving performance of Learning Disabilities Health Checks will reflect the quality of assessments. Chris Skelton confirmed that this had been done as part of premium contract. Practices were asked to provide evidence during Quarter 2 and the Committee will receive a report regarding the quality of the assessment at a future date.

Mr Lotfallah sought assurance that the Committee will continue to be informed of the progress of the practices which have not currently achieved the KPIs. Chris
Skelton confirmed that the Committee would receive regular reports.

Mel Brown noted the good work of all practices in relation to Learning Disabilities Health Checks and that a SEND visit is expected shortly. Chris Skelton stated that data relating to patient ages and comparator information regarding other CCGs will be received from NHS Digital in the future.

Chris Skelton commented that South West Yorkshire Partnerships NHS Foundation Trust will be supporting practices regarding Learning Disabilities, particularly in regards to the quality element.

Susannah Cookson asked how practices communicate with LD patients, noting that this cohort of patients can be difficult to engage.

Mel Brown responded that some practices are going out to see patients in their own homes to conduct the LD Health Check.

Richard Hindley commented that the report was very positive and asked whether there were any actions the Committee could take to support this work.

Chris Skelton responded that the relationship between the CCG and practices is very open and supportive. Practices fully understand what is expected of them and they are supported by Natalie Knowles.

It was RESOLVED that:

i. Received the final performance report against the Wakefield Practice Premium Contract for 2019/20 and 70p Incentive Scheme.

ii. Agreed the KPI payments in regard to the KPI002 for Quarter 4.

19/034 Wrenthorpe Branch Closure – Assurance Report

Chris Skelton noted that the paper was provided as part of the assurance required by Probity Committee regarding patient access at Outwood Medical Centre following the closure of the Wrenthorpe branch surgery.

Chris Skelton explained that the additional doctors and senior nurses employed at Outwood Park were now fully in place and providing additional GP appointments and a home visiting service led by a former community matron now employed by the practice.

The Practice has undertaken a patient access survey following on from the national patient survey results in July 2018. The practice has implemented an action plan on their areas for improvements which included how easy it was to get an appointment. The practice conducted a seconded survey following the changes which showed an improvement with 67% of the 102 respondents indicated that it was easy to book an appointment.

Another mitigation agreed as part of the branch closure approval process was the offer of transport for patients who would otherwise be unable to get to the surgery for medical reasons and might therefore need a home visit. During the time period detailed in the report, 15 patients out of the 229 who were offered the service
agreed to use it. The practice has requested support to end the transport service given the low level of utilisation. The practice has consulted with its Patient Participation Group (PPG) about the service and the uptake. The request to discontinue the service has the support of the PPG.

Stephen Hardy commented that the transport service was an important part of the branch closure decision process. However in view of the low up-take it did not seem to be a valued resource. He asked whether the local ward councillors had been informed of the possible withdrawal of the service.

Ruth Unwin commented that as we are currently in a period of Purdah due to local and European elections, this had not yet been done. However Ruth Unwin will ensure that the Council Overview and Scrutiny Committee and local ward councillors will be informed as soon as is appropriate.

Mel Brown asked whether the reason for the low uptake is known. Chris Skelton explained that the service is offered to patients requesting a home visit. The low up-take indicates some assurance that home visits are being provided.

Richard Sloan enquired whether the number of requests for home visits had increased since the branch closure. Chris Skelton commented that this information is not known. Further information was requested before a final decision could be made, although it was acknowledged that the PPG accepted the withdrawal of the service, which was an indicator that the rationale was sound. Chris Skelton confirmed that he would obtain this information and report to a future Committee.

Richard Hindley commented that the transport service was an important element of the assurance process and that the Overview and Scrutiny Committee had taken this into account when accepting the branch closure decision.

Mel Brown commented that the decision to provide transport was one factor that the committee considered and critical to the decision was the increased clinical capacity to support patients at the practice through new posts such as ANPs and additional GP appointments.

Dr Connor and Chris Skelton have attended the practice to ensure that the additional GP time and transport has been promoted to patients. Dr Connor was able to confirm that the branch closure had impacted positively on patient access at the practice main site which had not previously compared very well with other practices. The practice continues to work to improve its access and patient satisfaction with the appointment system and this is to be commended.

Richard Hindley suggested that the Probity Committee support the recommendation in principle, subject to comment from the June Overview and Scrutiny committee and data regarding any changes to the number of home visit requests.

Dr Connor confirmed that the practice would maintain the transport offer until a final decision is taken by the Probity Committee.

It was RESOLVED that:

i. The Probity Committee received assurance in regards to the implementation
of the mitigating actions of the branch surgery at Wrenthorpe

ii. The Probity Committee supported the practice’s application to end the transport service subject to confirmation in the July meeting following the receipt of data on home visits and communication with local elected members and the Overview and Scrutiny Committee.

19/035 Primary Care Network Configuration

Chris Skelton explained that the paper expanded on the information provided in the presentation to the March 2019 Probity Committee.

The new GP contract states that all practices must be part of a Network. Chris Skelton commented that Wakefield had a strong history of Networks and is at an advantage now that this has become a national programme.

The Review Panel, comprising CCG Primary Care Commissioners and Wakefield Local Medical Committee, considered the application process for Primary Care Networks, which will continue until 30 June 2019, in line with national requirements.

Diane Hampshire commented that the paper was very helpful.

Dr Connor commented that the CCG has asked existing Networks to work together to ensure complete coverage of the population and to identify any overlapping areas. The Five Towns and the Wakefield Health Alliance North Networks were based on historical agreements between practices and had agreed to work together on the overlap areas to make sure that local people’s needs are considered together, services are equitable and partner organisations avoid duplication of effort – eg a single district nurse team working in the overlap area. This configuration of networks will continue to evolve in the light of experience.

Jonathan Webb acknowledged this as assurance that Networks were willing to work together.

Mel Brown commented that the Executive Team has discussed this matter and that she had been part of the panel that looked at registration.

Mel Brown confirmed that work was progressing satisfactorily and confirmed that other areas are not currently as advanced in the process as NHS Wakefield CCG.

Mel Brown provided assurance that all Wakefield patients are in areas covered by Networks.

Richard Hindley asked members for recommendations regarding the appropriate way for Probity Committee to continue to monitor this works.

Mel Brown suggested that a member of Probity Committee could sit on the Primary Care Steering Group in order to represent the committee.

Dr Connor reminded the Committee that reports regarding the implementation of network contracts will be presented at future meetings. Primary care networks are an important feature of the emerging integrated health and care system and will...
work with the CCG and other partners both in Wakefield District and at West Yorkshire and Harrogate level.

Work on this topic will continue and papers will be presented at future Probity Committee meetings.

It was **RESOLVED** that:

i. The Probity Committee noted the process undertaken by the CCG in line with the Primary Care Networks DES guidance for the sign-off of Primary Care Networks.

ii. The Probity Committee accepted the recommendation of the Panel to sign-off the Primary Care Network configuration for Wakefield.

### 19/037 Improvement Performance of Learning Disability Health Checks – For Information Only

Chris Skelton provided the Improvement Performance of Learning Disability Health Checks for information only to provide additional assurance of improvement.

Stephen Hardy commented that the previous SEND report had identified areas for improvement and he had been assured by discussions at previous Committees that real improvements had been made. He asked whether the change was taking place fast enough.

Chris Skelton responded that a target of 75% LD health check completion was appropriate as the target needs to reflect that some patients will decline to take part.

Mel Brown asked if NHS England had any expectation regarding an appropriate target. Neil Coulter was uncertain and would seek advice and respond to Mel Brown.

Dr Connor acknowledged that some people with mild learning difficulties may not benefit from a Health Check. However, he felt it would be beneficial to be able to identify why some people were not offered an LD health check or why they declined one. Dr Connor requested further assurance that no patient had been overlooked.

Stephen Hardy asked if it was clear why some practices reported 100% compliance whilst others only 40%.

Richard Hindley commented on the difficulties of placing a definitive figure on the number of patients with learning difficulties due to the wide varieties and impact of disabilities.

Dr Connor suggested that work be undertaken to ensure that practices, the Local Authority and SWYPFT were all applying the same definition to identify the correct cohort of patients.
Richard Sloan voiced his concern that data was not currently available regarding the reasons for patients declining LD Health Checks.

Mel Brown provided assurance that the Health and Wellbeing Board would review this topic of LD Health Checks in the June 2019 meeting.

Mel Brown and Richard Hindley both acknowledged the amount of work already completed and commented that further work continues.

It was RESOLVED that:

i. The Probity Committee noted the content of the report

19/038 Matters to be referred to other committees or Governing Body

The following papers were to be referred to other Committees:

i. The minutes of this meeting would be shared with the Governing Body.
ii. The Probity Committee effectiveness survey and work plan will be presented to Governing Body
iii. The Probity Annual Report will be shared with the Governing Body, subject to the amendments discussed.
iv. The Improvement Performance of Learning Disabilities Check List will be shared at the New Models of Care Board.

19/039 Any Other Business

No items were raised.

19/040 Date and Time of Next Meeting

Tuesday 23 July 2019, 3pm, Boardroom, White Rose House (Meeting cancelled. Next meeting 24 September 2019)
HEALTH AND WELLBEING BOARD

Thursday, 19 September 2019

Present:

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Councillor Mrs F Heptinstall</td>
<td>The Chair</td>
</tr>
<tr>
<td>Dr A Sheppard, CCG</td>
<td>The Deputy Chair</td>
</tr>
<tr>
<td>Councillor M Ward</td>
<td>WMDC</td>
</tr>
<tr>
<td>Ms B Wagner</td>
<td>Corporate Director, WMDC</td>
</tr>
<tr>
<td>Mr A Balchin</td>
<td>Corporate Director, WMDC</td>
</tr>
<tr>
<td>Ms A Hartley</td>
<td>Director of Public Health</td>
</tr>
<tr>
<td>Ms M Brown</td>
<td>Programme Commissioning Director of Integrated Care, CCG</td>
</tr>
<tr>
<td>Dr D Hallott</td>
<td>CCG representative</td>
</tr>
<tr>
<td>Mr S Hardy</td>
<td>Non-executive member of CCG</td>
</tr>
<tr>
<td>Mr M England</td>
<td>Mid Yorkshire NHS Trust</td>
</tr>
<tr>
<td>Ms S Roxby</td>
<td>Wakefield and District Housing</td>
</tr>
<tr>
<td>Mr S Rayner</td>
<td>South West Yorkshire Partnership NHS Foundation Trust</td>
</tr>
<tr>
<td>Chief Superintendent Mark McManus</td>
<td>West Yorkshire Police</td>
</tr>
<tr>
<td>Ian Cockerill</td>
<td>Chief Executive, NOVA</td>
</tr>
</tbody>
</table>

13. APOLOGIES FOR ABSENCE
Apologies for absence submitted prior to the meeting were accepted on behalf of Merran McRae, Councillor Forster, Jo Webster, Dr R Sloan MBE, Dr L Harris, Suzannah Cookson, Ms M Bradley and David Teggart.

14. MINUTES
Resolved – That the Minutes of the meeting of the Health and Wellbeing Board held on 18 July 2019 be approved as a correct record.

15. CHAIR’S ANNOUNCEMENTS
The Chair, Councillor Mrs Heptinstall, thanked Members of the Board for extending their diaries to accommodate a longer meeting. She asked Members for feedback on the new meeting style.

The Chair reminded the Board that the wellness summit would be taking place on 10 October 2019 and encouraged everyone to be involved.

Members were informed that the outstanding vacancy on the Board from the CCG had been filled by Suzannah Cookson, Chief Nurse for NHS Wakefield CCG.

At the previous meeting, Shane Mullen had been asked to provide some analysis in respect of the quality of employment, type of employment and pay levels of people in employment with learning disabilities. The Chair requested that this information, along with an update on the progress being made on a number of actions identified at the last meeting, be submitted to the November meeting of the Board.

For future meetings, a detailed action log would be presented outlining all existing actions and progress made.
16. MEMBERS DECLARATIONS OF INTEREST
No Declarations of Interest were made.

17. PUBLIC QUESTIONS
No public question had been received.

BUSINESS ITEMS

18. WEST YORKSHIRE AND HARROGATE HEALTH AND CARE PARTNERSHIP FIVE YEAR STRATEGY
Consideration was given to a report of Ian Holmes, Director, West Yorkshire and Harrogate (WY&H) Health and Care Partnership detailing the draft five year strategic narrative for the Partnership and the process for further developing and refining it. The process to develop the five year strategy began in early Spring and had continued throughout the year with drafts being shared with Health and Wellbeing Boards throughout this period.

At the meeting of the WY&H Partnership Board on 4 June 2019, it was agreed that a new Children and Young People’s priority programme would be established alongside an expansion of the existing prevention programme into a new improving population health programme.

NHS England and NHS Improvement published the NHS Long Term Plan in January 2019. This was supplemented by the NHS LTP Implementation Framework at the end of June 2019 which provided further detail and specific asks of systems. One such ‘ask’ was for each Sustainability and Transformation Partnership (STP)/Integrated Care System (ICS) to agree a plan for delivery of the NHS Long Term Plan through to 2023/24. The plan would include:

- A System Narrative: describing how the required transformation activities would enable the necessary improvements for patients and communities as set out in the NHS LTP.
- A System Delivery Plan: setting the aggregate plan for delivery of finance, workforce and activity along with the basis for the 2020/21 operational plans for providers and CCG’s. The system delivery plan would also cover the NHS LTP ‘Foundation Commitments’.

Wakefield’s Health and Wellbeing Plan was approved in November 2018 and is aligned with the priorities within the NHS Long Term Plan and the WY&H ICS five year system narrative in particular the recent inclusion of the priority of ‘Giving every child the best start in life’.

The timeline for the planning process was provided in Appendix A of the report. A draft copy of the ICS system narrative was attached at Appendix B of the report.

Ian Holmes explained that the draft strategy was considered at a recent Partnership Board meeting where it was acknowledged that the draft was a lengthy document which could potentially be shortened. A summary document was currently being developed which would also include a small number of ambitions for the Partnership. Comments on the draft plan were requested as soon as possible before commencement of the design stage. Members were informed that the first draft would be sent to NHS England on 27 September 2019. Refinement would take place during October ready for
consideration at the Partnership meeting on 3 November followed by a final submission by 15 November.

Andrew Balchin, Corporate Director, Adults, Health and Communities acknowledged that the Local Authority’s perspective needed to be strengthened, that workforce challenges needed to be highlighted and that prevention needed to be a priority for all partners.

Resolved – (1) That the draft Five Year Strategy be noted.

(2) That the timescale and sign-off process for the document be noted.

19. BETTER CARE FUND
A report of Andrew Balchin, Corporate Director, Adults, Health and Communities and Jo Webster, Accountable Officer, Wakefield CCG detailed the Better Care Fund (BCF) for Wakefield for the financial year 2019/20.

The Health and Wellbeing Board is responsible for review of the performance and oversight of the Better Care Fund. The on-going management of the BCF is managed via the Connecting Care Executive as an Executive Sub-Committee of the Health and Wellbeing Board.

On 18 July 2019, the Department of Health and Social Care (DHSC) and the Ministry of Housing, Communities and Local Government (MHCLG) published the Policy Framework for the implementation of the BCF in 2019/20.

The Framework formed part of the NHS mandate for 2019/20. The BCF Policy Framework for 2019/20 provided continuity from the previous round of the programme, however, the current structure of the BCF was under review. In June 2018, the Government announced a review of the ‘current functioning and structure of the BCF’ to ensure it supported the integration of health and social care. There would be an update later this year.

Martin Smith, Head of Connecting Care Commissioning, Wakefield CCG explained that he was responsible for consolidating the fund to ensure integration of services between both organisations. He explained performance of the BCF for 2018/19 which included a 26% reduction in long stay patients which was one of the key aims. During the year, both the adult community nursing team and community therapy team received more referrals than the previous year. The adult community nursing team had around 2,500 referrals a month and the therapy team around 950.

The Board were informed that the Connecting Care Hub model was funded via the BCF providing health, social and voluntary sector services. The Personal Integrated file (PIC) was fully rolled out to all GP practices during 2018/19 ensuring that patient’s history was contained within one system. In addition, the creation of a shared IT platform (SysmOne) enabled secure data sharing. A total of nearly 4,000 referrals were made in 2018/19 using PIC which had enhanced working relationships and efficiencies. In addition, 18,823 contacts were made to Age UK Wakefield Care and Support Workers and 11,260 made to Carers Wakefield.

The Specialist Stop Smoking Service was contained within the BCF and was about offering support and advice for those who wanted to quit.
HEALTH AND WELLBEING BOARD - THURSDAY, 19 SEPTEMBER 2019

The care home sector was also supported through BCF and supported through dedicated support works from both Carers Wakefield and Age UK Wakefield.

The Board were informed that the BCF for 2019/20 required submission to NHS England by the deadline of 27 September 2019.

Members of the Board congratulated both the Local Authority and CCG for the excellent services provided through the BCF.

Resolved – (1) That the Better Care Fund 2019/20 methodology applied by Wakefield be noted.

(2) That the increased Better Care Fund Pooled Fund be noted.


(4) That the sign off of the Better Care Fund 2019/20 be delegated to the Corporate Director, Adults, Health and Communities (WMDC) and the Commissioning Director for Integrated Care (WCCG).

FOCUSSED DISCUSSION - BUILDING SUSTAINABLE COMMUNITIES

20. CREATING AND DEVELOPING SUSTAINABLE PLACES AND COMMUNITIES FOR WAKEFIELD DISTRICT

Consideration was given to a report of Anna Hartley, Director of Public Health which explained that the Wakefield District’s Health and Wellbeing Plan, led by the Health and Wellbeing Board, had chosen to focus on the four priorities:-

- Healthy Standard of Living for All
- Give every child the best start in life
- Strengthen the role and impact of ill health prevention
- Create and develop sustainable places and communities

The report set out to describe possible actions for the "sustainable places and communities" outcome by:-

- Summarising where we were in regards to this outcome
- Suggesting a future approach for Wakefield District

Currently lots of activity was happening in the district which potentially fell under the 'healthy and sustainable communities' outcome but there was no overarching structure bringing it together. In order to tackle this outcome effectively, there was also a need to bring together a wider partnership than currently existed, moving beyond health and social care organisations and engaging with transport, regeneration and housing.

The report captured some of the existing work happening in the District and outlined a proposed three strand approach to structure the work going forward. It was suggested that this outcome could sit under a newly created 'healthy and sustainable communities' sub-group reporting then to the Board.

The three strands identified were:-
1. Creating health by promoting physical environments; for example, green space, community centres, footpaths
2. Creating health by promoting social environments; for example, social groups, befriending, person centred approaches
3. Bringing the sustainable communities agenda together; for example, embedding community development approaches, community engagement mechanisms and system-wide training such as Making Every Contact Count

Resolved – (1) That the Health and Wellbeing Board approve the creation of a sub-group to create priority work streams for each of the three strands as detailed in the report.

(2) That the Director of Public Health co-ordinate the sub-group with strategic input from NOVA and provide regular reports back to the Health and Wellbeing Board.

21. 'TALKING HEADS' FILM - WHAT DO LOCAL RESIDENTS THINK ABOUT WHAT GIVES THEM A HEALTHY COMMUNITY?
Anna Hartley, Director of Public Health introduced a talking heads video which was filmed locally detailing what local residents thought about what would give them a healthy community.

Resolved – That the talking heads video be noted.

22. JOINT STRATEGIC NEEDS ASSESSMENT OVERVIEW - WHAT DOES THE DATA TELL US?
Shane Mullen, Public Health Intelligence Manager presented the Wakefield Joint Strategic Needs Assessment (JSNA) overview to the Board. The assessment included a comparison of areas in terms of the health of residents within those areas. The Board were informed that a ward by ward profile was currently being produced. Further insight through the use of a survey had provided information on the activities of both children and adults and provided a Health Impact Assessment and excellent planning tool. There was a drive to help people help themselves and it was recognised that this produced a 50% improvement for participating residents.

Resolved – That the presentation be noted.

23. LOCAL RESIDENT'S PERSPECTIVE - HEARING FROM A VOLUNTEER WALK LEADER
Anna Hartley, Director of Public Health introduced David Sayer, a volunteer Nordic walking leader. David Sayer gave a detailed presentation to the Board about how walking had vastly improved his life, his wellbeing and his health. Nordic walking was rising in popularity and he recommended anyone to try it.

The Chair thanked David Sayer for an interesting presentation.

Resolved – That the presentation be noted.

24. EXPERT WITNESS - HEALTHY AND SUSTAINABLE COMMUNITIES IN WAKEFIELD DISTRICT
Amy Sharp, Health and Wellbeing Manager gave a presentation to the Board on how healthy communities could be created in Wakefield. It was acknowledged that by creating and developing sustainable places and communities it helped support an improvement in health for all residents within the District.
Wakefield had been a member of the UK Healthy Cities Network since 2013; key aspects of which being healthy people, healthy places and healthy practice. In 2017/18, a new approach focused on three areas of deprivation. Building on existing assets to improve health outcomes were also described for Members of the Board.

The Board were given examples of successful programmes which included Room on the Broom, a story trail at Angler's Country Park and Health by Stealth roll out. They were also informed about developments currently being worked on.

The establishment of a Healthy Wakefield Charter would protect and improve the health and wellbeing of the people living and working within it, reducing inequalities and providing all residents with opportunities to prosper and flourish. Some healthy practices were described which included Environmental Health developing the Workplace Wellbeing Chartermark and the Eatwell award for businesses. Some of the benefits from having a healthy and sustainable community were detailed for the Board.

The Chair thanked Amy Sharp for her presentation.

Resolved – That the presentation be noted.

PRESENTATIONS

25. 'EXPLORING A HEALTH LED APPROACH TO INFRASTRUCTURE'
Paul Simkins, Associate Strategic Director from Arup gave a presentation to the Board which explored a health-led approach to infrastructure. He stated that health and wellbeing could be a powerful lens and catalyst to build shared value, create ideas and prioritise investment. Understanding all of the assets that support health and wellbeing could help to build on existing strengths, communicate priorities and ideas, and create shared value for neighbourhoods, cities and regions.

The Chair thanked Paul Simkins for his presentation.

Resolved – That the presentation be noted.

26. KNOTTINGLEY - STEP UP PROGRAMME
Sharon Marshall, Step Up Skills Strategy Manager explained that the programme was a Council led brokerage service which connected residents to employment and skills opportunities and provided businesses with local recruits with the appropriate skills and attitudes.

From July 2019, a pilot was undertaken in Knottingley and Ferrybridge based in Kellingley Club. It developed a blue print to inform future district wide roll-out and worked with a range of stakeholders. It was hoped to roll-out the programme across the district within 12-18 months’ time but ESF funding had been awarded enabling an earlier roll-out.

Members of the Board were asked to provide feedback on how the programme could support residents back to work or onto progression pathways, areas of particular deprivation and what interventions would work best. Thirty people had used the service since July with five gaining employment and as many taking up community education. Examples of case studies were detailed for Members.
The Chair thanked Sharon Marshall for her presentation.

**Resolved** – That the presentation be noted.

**27. THIRD SECTOR STRATEGY**

Ian Cockerill, Chief Executive from NOVA gave a presentation on the Wakefield District Third Sector Strategy ‘Meeting the Challenge’. He explained that the third sector in Wakefield was made up of 1500 charities and community groups.

The vision for a stronger third sector strategy described for Members was one which made best use of the social, economic and environmental opportunities to improve the quality of life for local people, a sector which people trusted and supported, was just and fair, creative and innovative and which was passionate and resilient.

The aims of the strategy were:-

- Enabling the local third sector to strengthen its financial resilience and to grow and become more enterprising in the process
- Growing active citizenship and voluntary activity in local communities
- Maximising the third sector’s contribution to improving health and wellbeing of the community reducing inequalities
- Helping communities feel safe

A Third Sector Strategy Group would be meeting in September, followed by consultation with partners and stakeholders and formal adoption of the strategy was planned for October/November.

The Chair thanked Ian Cockerill for his presentation.

**Resolved** – That the presentation be noted.

**28. CHANGING HEALTH BEHAVIOURS**

A telephone conferencing call took place with Dr Nat Wright, Clinical Research Director for Transform Research Alliance from Spectrum who explained the work undertaken so far in changing health behaviours and described what needed to be done in the future. Dr Wright welcomed the opportunity to have input into the new sub-group.

The Chair thanked Dr Wright.

**Resolved** – That the presentation be noted.

**29. NEXT STEPS FOR THE HEALTH AND WELLBEING BOARD**

Members felt that the new sub-group should pick up the areas highlighted, engage with partners who had not previously had an input and bring a report back to the Board for information once the group had had time to establish.

**Resolved** – That a report of the new sub-group be brought back to the Board at a future date.

**ITEMS FOR INFORMATION**
30. CONNECTING CARE EXECUTIVE MINUTES  
Resolved – That the Minutes of the Connecting Care Executive meeting held on 9 May 2019 be noted.

31. OUTCOMES FRAMEWORK  
Consideration was given to the Wakefield District Health and Wellbeing Board Outcomes Framework produced by Shane Mullen, Public Health Intelligence Manager.  
Resolved – That the Outcomes Framework be noted.

32. DATE AND TIME OF NEXT MEETING  
Resolved – That the next meeting of the Health and Wellbeing Board be held on 14 November 2019 at 1.30pm in St Catherine's, Wakefield.
West Yorkshire & Harrogate (WY&H) Joint Committee of Clinical Commissioning Groups
Summary of key decisions - Meeting in public, Tuesday 1 October 2019

Shoulder policy
As part of the Elective Care/Standardisation of Commissioning Policies Programme, the Committee considered a WY&H policy covering surgical and non-surgical procedures for a range of conditions relating to shoulder pain and instability. The policy requires conservative management options to be tried and to have shown no benefit before referral for MSK assessment. The Committee noted that an increase in demand for physiotherapy services was anticipated and that the pace of implementation in each place would depend on local workforce capacity.

The Joint Committee: Agreed to adopt the shoulder policy across WY&H, with a three year timescale for full implementation.

NHS England/Improvement (NHS E/I) Low Priority Prescribing Programme
The Committee considered a report on the NHS E/I Medicines Value Programme. The programme aimed to increase value from the prescribing budget and reduce unwarranted variation in prescribing practice. Recommendations had been published on 29 June 2019 for implementation across England. Primary care prescribers should not initiate and in many cases should deprescribe a number of items, mainly relating to skin and cardiac conditions. Items were considered if they were of low clinical effectiveness, or were clinically effective but where more cost-effective products were available. Clear guidance would be developed to support prescribers.

The Joint Committee: Agreed to adopt the NHS E/I low value prescribing programme recommendations for implementation across WY&H.

Bariatric surgery - implementation
The Committee received an update on implementation of the commissioning policy for surgery for severe and complex obesity. In March 2019, the Joint Committee had agreed to adopt a new commissioning policy and service specification to support the CCGs’ aspiration to commission more activity, based on strong clinical evidence. The Committee noted that activity targets were not yet being met consistently across WY&H. There was a need to allow time for the new commissioning approach and collaborative work between providers to take full effect. Representatives from each place would explore what action had been taken locally to ensure effective implementation of the policy, including awareness raising and clinical briefing about the service and the policy.

The Joint Committee: Noted the update and requested a further update in 12 months.

Healthy Hearts project
The Committee considered standardised and simplified treatment guidance for patients with high cholesterol, which supported Phase 2 of the Healthy Hearts project. The Partnership had set a target to reduce cardiovascular incidents by 10% by 2021. Approximately 175,000 people in WY&H have a 20% risk of a heart attack or stroke in the next 10 years, and if the project identified and treated just 10% of these people not currently treated with statins, between 250 and 400 strokes and heart attacks would be prevented over 5 years. Shared decision making and self-management were essential. Phase I of the project had already led to 4,000 new patients being added to hyper tension registers. To enable the successful Phase 1 work to be fully embedded in general practice, it was proposed to allow more flexibility in the timescales for implementing Phase 2.

The Joint Committee: Approved the use of the Cholesterol Treatment Guidance across WY&H and supported the amended timeframes for implementing phases two and three of the project.

The Joint Committee has delegated powers from the WY&H CCGs to make collective decisions on specific, agreed WY&H work programmes. It can also make recommendations to the CCGs. The Committee supports the wider HCP, but does not represent all of the partners. Further information is available on the Joint Committee web pages: https://wyh-jointcommitteeccgs.co.uk/ or from Stephen Gregg, stephen.gregg@wakefieldccg.nhs.uk.
West Yorkshire & Harrogate Joint Committee of Clinical Commissioning Groups
Minutes of the meeting held in public on Tuesday 1 October 2019
Kirkdale Room, Junction 25 Conference Centre, Armytage Road, Brighouse, HD6 1QF

<table>
<thead>
<tr>
<th>Members</th>
<th>Initials</th>
<th>Role and organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marie Burnham</td>
<td>MB</td>
<td>Independent Lay Chair</td>
</tr>
<tr>
<td>Richard Wilkinson</td>
<td>RW</td>
<td>Lay member</td>
</tr>
<tr>
<td>Stephen Hardy</td>
<td>SH</td>
<td>Lay member</td>
</tr>
<tr>
<td>Dr James Thomas</td>
<td>JT</td>
<td>Chair, NHS Airedale, Wharfedale and Craven CCG</td>
</tr>
<tr>
<td>Dr Sohail Abbas</td>
<td>SA</td>
<td>Chair, Bradford City CCG</td>
</tr>
<tr>
<td>Dr Andy Withers</td>
<td>AW</td>
<td>Chair, NHS Bradford Districts CCG</td>
</tr>
<tr>
<td>Helen Hirst</td>
<td>HH</td>
<td>Chief Officer, Bradford District and Craven CCGs</td>
</tr>
<tr>
<td>Dr Steven Cleasby</td>
<td>SC</td>
<td>Chair, NHS Calderdale CCG</td>
</tr>
<tr>
<td>Dr Matt Walsh</td>
<td>MW</td>
<td>Chief Officer, NHS Calderdale CCG</td>
</tr>
<tr>
<td>Dr Steve Ollerton</td>
<td>SO</td>
<td>Chair, NHS Greater Huddersfield CCG</td>
</tr>
<tr>
<td>Dr David Kelly</td>
<td>DK</td>
<td>Chair, NHS North Kirklees CCG</td>
</tr>
<tr>
<td>Carol McKenna</td>
<td>CMc</td>
<td>Chief Officer, NHS Greater Huddersfield CCG and NHS North Kirklees CCG</td>
</tr>
<tr>
<td>Dr Alistair Ingram</td>
<td>AI</td>
<td>Chair, NHS Harrogate &amp; Rural District CCG</td>
</tr>
<tr>
<td>Amanda Bloor</td>
<td>ABI</td>
<td>Chief Officer, NHS Harrogate &amp; Rural District CCG</td>
</tr>
<tr>
<td>Tim Ryley</td>
<td>TR</td>
<td>Chief Executive, NHS Leeds CCG</td>
</tr>
<tr>
<td>Dr Adam Sheppard</td>
<td>AS</td>
<td>Chair, NHS Wakefield CCG</td>
</tr>
<tr>
<td>Jonathan Webb</td>
<td>JWb</td>
<td>Chief Finance Officer/ Deputy Chief Officer, NHS Wakefield CCG</td>
</tr>
</tbody>
</table>

**Apologies**

Dr Gordon Sinclair | GS | Chair, NHS Leeds CCG |
Jo Webster         | JW | Chief Officer, NHS Wakefield CCG |
Matthew Groom      | MG | Assistant Director, Specialised Commissioning, NHS England |

**In attendance**

Karen Coleman      | KC | Communication Lead, WY&H Health and Care Partnership (HCP) |
Stephen Gregg      | SG | Governance Lead, Joint Committee of CCGs (minutes) |
Shane Hayward-Giles | SHG | NHS Rightcare Delivery Partner |
Ian Holmes         | IH | Director, WY&H HCP |
Anthony Kealy      | AKe | Locality Director WY&H, NHS England & NHS Improvement |
Michelle Turner    | MT | Director of Quality and Nursing, Bradford District and Craven CCGs |
Catherine Thompson | CT | Programme Director - Elective care/standardisation of commissioning policies |

7 members of the public were present.
<table>
<thead>
<tr>
<th>Item No.</th>
<th>Agenda Item</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>43/19</td>
<td>Welcome, introductions and apologies</td>
<td></td>
</tr>
<tr>
<td>44/19</td>
<td>Open Forum</td>
<td></td>
</tr>
<tr>
<td>45/19</td>
<td>Declarations of Interest</td>
<td></td>
</tr>
<tr>
<td>46/19</td>
<td>Minutes of the meeting in public – 2 July 2019</td>
<td></td>
</tr>
<tr>
<td>47/19</td>
<td>Actions and matters arising – 2 July 2019</td>
<td></td>
</tr>
</tbody>
</table>

**Welcome, introductions and apologies**

Apologies were noted. The Chair welcomed Dr Sohail Abbas, who had taken over as Chair of Bradford City CCG from Dr Akram Khan. On behalf of the Committee, the Chair thanked Akram Khan for his contribution to its work.

**Open Forum**

The Chair invited questions from members of the public:

**48/19 – Shoulder policy**

- What arrangements are in place to support shared decision-making and ensure that it delivers better outcomes for patient experience and quality?

JT advised that shared decision-making was an important part of the MSK pathway. Key patient outcomes would be monitored as part of the management of the pathway.

**50/19 – Bariatric surgery**

- Why are they considering bariatric surgery for people of Asian family (are they from Indian sub-continent?) origin who have recent-onset of type 2 diabetes at a lower BMI than other population who have been reviewed by a Tier 3 service or been referred for consideration?

- Why commission more bariatric surgery over the next 2-5 years than treating these illnesses with diet and lifestyle change?

With the agreement of the questioner, the Chair proposed that the questions would be answered as part of the presentation. Written answers would be provided to any questions not answered during the meeting.

**Declarations of Interest**

MB asked Committee members to declare any interests that might conflict with the business on today’s agenda. (Note: under 48/19 Shoulder policy, JT noted that GP members of the Committee received payments for providing shoulder injections. The Chair noted the declaration and agreed that no mitigating action was needed.)

**Minutes of the meeting in public – 2 July 2019**

The Committee reviewed the minutes of the last meeting.

The Joint Committee: Approved the minutes of the meeting on 2 July 2019, subject to adding an action to item 40/19 Flash Glucose monitoring, setting out the timescales for Leeds and Harrogate CCGs to report back to the Clinical Forum and Joint Committee on the evaluation for their specific patient cohorts.

**Actions and matters arising – 2 July 2019**

The Joint Committee reviewed the action log.

The Joint Committee: Noted the action log.
Dr James Thomas (JT) presented a Shoulder policy for WY&H as part of the Elective Care/Standardisation of Commissioning Policies Programme.

The proposed policy covered surgical and non-surgical procedures for a range of conditions relating to shoulder pain and instability. The policy required conservative management options to be tried, and to have shown no benefit before referral for MSK assessment. Conservative treatment would usually be tried for around 3 months before considering referral for MSK assessment.

All patients referred for shoulder pain should have an assessment of their BMI and smoking status, as well as other lifestyle factors that may influence their long term health outcomes, as part of a ‘making every contact count’ approach. A shared decision making conversation was a key part of the referral process and any decision to proceed with an invasive intervention. Many people with shoulder pain would not benefit from surgical intervention. Referral to pain management services was needed for this cohort of people.

JT noted the engagement and consultation processes that had taken place. Further information would be provided to support the roll-out of the policy. A comprehensive Quality and Equality Impact Assessment had been carried out.

The policy required that following a steroid injection, the patient started physiotherapy within 2 weeks and following a hydrodistension injection within 72 hours. Work would be needed to co-ordinate services. An increase in demand for physiotherapy services was anticipated with implementation of the policy. The scale of this would depend on the place, the service model and the local approach to implementation.

SH asked how a ‘level playing field’ for pain management services would be established across WY&H. JT said that this has been highlighted as part of the MSK pathway work, but currently was an issue for individual places. MW said that pain management might need to be considered as a future priority for the Joint Committee. In response to a question from SC, JT advised that shoulder injections could be done by a range of providers as long as they held appropriate validation.

SA highlighted the need to engage with and support patients to self-care, particularly in areas of high deprivation. DK and AW questioned whether providing physiotherapy within 2 weeks was deliverable within existing resources. JT advised that seeing a physiotherapist was the ‘gold standard’ approach and that a range of other options was available, including self-management, leaflets and video. MW acknowledged that physiotherapy capacity presented a significant challenge, but would deliver the best patient outcomes. He proposed that implementation take place over 3 years, with each place moving at a pace in line with local workforce capacity. The Committee noted that inequalities in access would be addressed over the 3 year period.

The Joint Committee:
1. **Agreed** to adopt the shoulder policy in the nine CCGs of West Yorkshire and Harrogate.
2. **Agreed** a three year timescale for full implementation.
**49/19 NHS England low priority prescribing programme**

Dr James Thomas (JT) presented a report on the NHS England and Improvement Medicines Value Programme. The programme aimed to increase value from the prescribing budget and reduce unwarranted variation in prescribing practice.

Recommendations had been published on 29 June 2019 for implementation across England. Primary care prescribers should not initiate and in many cases should deprescribe a number of items, mainly relating to skin and cardiac conditions. Items were considered if they were of low clinical effectiveness, or were clinically effective but where more cost-effective products were available.

Engagement and consultation had been done nationally along with a Quality and Equality Impact Assessment. The WY&H Pharmacy Leadership Group (PLG) and the Elective Care Programme Board had also considered the recommendations.

For the majority of items the new prescribing policy represented minimal change for most places. The greatest challenge for implementation would be around deprescribing. The PLG and Area Prescribing Committees would support clinicians on this.

In response to a question from DK, CT said that cardiologists were being consulted about how best to manage the deprescribing of aliskiren. MW confirmed that clear guidance would be developed to support prescribers.

SC highlighted that some patients who were not able to self-administer insulin may need more expensive needles, but with support from nursing staff could be helped to self-administer. JT acknowledged this and said that audit and review should be used to ensure best practice.

---

**The Joint Committee:**

1. **Agreed** to adopt the NHS E/I low value prescribing programme recommendations for implementation in the nine CCGs of West Yorkshire and Harrogate.

---

**50/19 Bariatric surgery implementation update**

Michelle Turner (MT) presented an update on implementation of the commissioning policy for surgery for severe and complex obesity (bariatric surgery).

In March 2019, the Joint Committee had agreed to adopt a new commissioning policy and service specification for bariatric surgery. This supported the aspiration agreed by the CCGs to aspire to commission the surgery at the rate of 4% of the eligible population – the level of the best performing CCG in WY&H. The WY&H Clinical Forum had supported the strong clinical case to commission more bariatric surgery, which reduced the risk of heart attacks and strokes.

It had been agreed that each lead commissioner would include the new service specification and commissioning policy in their main provider contracts from 1st April 2019. The report outlined progress in implementing the policy and levels of commissioning activity against the ambition.

MT noted that the activity targets were not yet being met consistently across WY&H as at July 2019. There was a need to more fully understand the reasons for this, as it could lead to inequitable access to services.
HH advised that the Partnership’s Organisational Development programme was supporting collaborative work between providers to understand capacity issues and meet future activity levels. MW added that work was also needed in place to explore how referral processes were working locally and whether the ambition to commission more surgery had been widely and effectively communicated.

In response to the public question about how the policy related to people of Asian origin with onset of type 2 diabetes, MT confirmed that this related to people of South Asian origin, who were disproportionately at risk.

In response to the public question about prevention, MW agreed that supporting lifestyle change was the preferred approach. Bariatric surgery was very much a ‘last resort’, but the evidence showed that it was highly effective in changing people’s lives by reducing life threatening health risks.

The questioner confirmed to the Chair that she was satisfied with the responses to her questions.

The Committee noted the need for time for the new commissioning approach and collaborative work between providers to take effect.

Action: To inform a further update in 12 months, each CCG to evaluate the action that had been taken locally to implement the policy. This would include the effectiveness of referral practices, awareness raising and clinical briefing about the service and the policy.

The Joint Committee:
1. Noted the update on implementation in place of the commissioning policy for surgery for severe and complex obesity.
2. Requested a further update in 12 months.

51/19 Healthy hearts project

Dr Steve Ollerton presented standardised and simplified treatment guidance for patients with high cholesterol, which supported Phase 2 of the Healthy Hearts project. Amanda Bloor presented an update on implementation of the project.

SO noted the Partnership’s target to reduce cardiovascular incidents by 10% by 2021. He added that 175,000 people in WY&H had a 20% risk of a heart attack or stroke in the next 10 years. If the project identified and treated just 10% of these people not currently treated with statins, between 250 and 400 strokes and heart attacks would be prevented over 5 years.

Shared decision making and self-management were essential parts of the WY&H approach. SO outlined the areas where the WY&H approach differed from NICE guidance. In WY&H, the aim was to support patients to self-manage and make their own, informed decisions about their diet, lifestyle and medication.

The Cholesterol Treatment Guidance had been developed following extensive clinical, patient and public engagement across WY&H and had been reviewed by the Elective Care Programme Board, Pharmacy Leadership Group and Area Prescribing Committees. The results of the Quality and Equality Impact Assessment were attached to the report. Alongside significant patient benefits, financial savings were envisaged from reducing the number of avoidable heart attacks and strokes.
AB reported that Phase I had already delivered significant successes, including 4,000 new patients being added to hyper tension registers. To enable the successful Phase 1 work to be fully embedded in general practice, it was proposed to allow more flexibility in the timescales for implementing Phase 2.

SH welcomed that feedback from patient and public involvement (PPI) and input from the PPI Assurance Group had been reflected in the materials which would support the Phase 2 work. He asked whether there was an ‘optimum’ cholesterol level for people to aim for, as this might help self-management.

SO advised that the aim was for people to be below 4. However, this was a broad aim – the important thing was for people to lower their level, not necessarily to get below 4. He agreed that it would be helpful to include some simple, but carefully worded guidance on this in information for patients.

SHG noted that the project was based on strong collaborative working across all partners and that an interim review would be reported to the Clinical Forum in December. The Chair congratulated the project team on the success of the project to date.

**The Joint Committee:**
1. **Approved** the use of the Cholesterol Treatment Guidance across the whole of the West Yorkshire and Harrogate Health and Care Partnership.
2. **Supported** the amended timeframes for implementing phases two and three of the Healthy Hearts project.

**52/19 Risk Management**

Stephen Gregg (SG) presented the significant risks to the delivery of the Joint Committee’s work plan.

5 risks were currently scored at 12 or above after mitigation, including 2 new risks which had been raised by the Elective care programme since the Joint Committee meeting in July 2019.

The scores for 2 Elective care/SCP programme risks had been reduced to below 12. These risks were shown on the register, but would be removed from future versions unless the risk level increased.

**The Joint Committee:**
1. **Noted** the risk management framework and the actions being taken to mitigate the risks identified.

**53/19 Any other business**

There was none.

**Next Joint Committee in public** – Tuesday 5th November 2019, Kirkdale Room, Junction 25 Conference Centre, Armytage Road, Brighouse, HD6 1QF.