## BOARD MEETING OF THE GOVERNING BODY
TO BE HELD ON TUESDAY, 12 JANUARY 2016
BOARDROOM, WHITE ROSE HOUSE
AT 1.00 PM
AGENDA

### PART 1

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<th>No.</th>
<th>Agenda Item</th>
<th>Lead officer</th>
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<tr>
<td>1.</td>
<td>Welcome and Chair’s Opening Remarks</td>
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<td>Apologies for Absence – Andrew Balchin, Dr Ann Caroll</td>
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<td>3.</td>
<td>Public Questions and Answers</td>
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<td>4.</td>
<td>Declarations of interest</td>
<td>All present</td>
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<tr>
<td>5.</td>
<td>a Minutes of the meeting held on 10 November 2015</td>
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<td>b Action sheet from the meeting held on 10 November 2015</td>
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<td>6.</td>
<td>Matters arising</td>
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<td>7.</td>
<td>Patient Story – Personal Health Budget (Presentation)</td>
<td>Jo Pollard/Laura Elliott</td>
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<td>8.</td>
<td>Chief Officer Briefing</td>
<td>Jo Webster</td>
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<td>9.</td>
<td>Integrated Quality and Performance Summary Report</td>
<td>Jo Pollard &amp; Andrew Pepper</td>
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<td>10.</td>
<td>[Report measuring the quality and performance of local services]</td>
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<td>11.</td>
<td>Annual Public Health Report 2015 (Presentation)</td>
<td>Dr Andrew Furber</td>
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<td>12.</td>
<td>Vanguard Programmes Update and delivery of the Forward View</td>
<td>Melanie Brown</td>
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<td>13.</td>
<td>Mid Yorkshire Health System Resilience Update (A co-ordinated approach across all areas of health and social care to ensure systems operate effectively in delivering year-round services for patients)</td>
<td>Jo Pollard</td>
</tr>
</tbody>
</table>
14. Finance Report Month 8 2015/16
   Andrew Pepper

15. Review of health services for Children Looked After and Safeguarding in Wakefield
   Jo Pollard

16. Receipt of minutes and items for approval
   a Audit Committee
      (i) Minutes of meeting held on 24 September 2015
      Sandra Cheseldine
   b Integrated Governance Committee
      (i) Minutes of meeting held on 15 October 2015
      (ii) Minutes of meeting held on 19 November 2015
   c Clinical Cabinet
      (i) Minutes of meeting held on 22 October 2015
      (ii) Minutes of meeting held on 26 November 2015
   d Connecting Care Executive
      (i) Minutes of meeting held on 10 September 2015
      (ii) Minutes of meeting held on 8 October 2015
      (iii) Minutes of meeting held on 5 November 2015
   e Probity Committee
      (i) Minutes of meeting held on 13 October 2015
   f Health and Well Being Board
      (i) Minutes of meeting held on 17 September 2015
   g Decisions of the Chief Officer – verbal update
      Jo Webster

17. Any other business

18. 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”).

19. Date and time of next Public meeting:
   Tuesday, 8 March 2016, 1pm in the Boardroom, White Rose House
NHS Wakefield Clinical Commissioning Group
GOVERNING BODY
BOARD MEETING

Minutes of the meeting held on 10 November 2015
Boardroom, White Rose House

Present
Andrew Balchin Corporate Director, Adults, Health & Communities – Wakefield Council
Dr Avijit Biswas GP, Pinfold Lane Surgery
Dr Ann Carroll GP, Outwood Park Medical Centre
Sandra Cheseldine Lay Member
Dr Phil Earnshaw Chair and Clinical Leader
Dr Andrew Furber Director of Public Health – Wakefield Council
Dr Deborah Hallott GP, New Southgate Surgery
Stephen Hardy Lay Member – Public Patient Involvement
Dr Pravin Jayakumar GP, Grove Surgery
Mr Hany Lotfallah Secondary Care Consultant
Rhod Mitchell Lay Member and Vice Chair
Andrew Pepper Chief Finance Officer
Jo Pollard Chief of Service Delivery and Quality
Alison Sugarman Practice Manager, Northgate Surgery
Jo Webster Chief Officer

In attendance
Jane Wilson Designated Nurse for Safeguarding Adults (item 15/192)
Melanie Brown Programme Commissioning Director Integrated Care (item 15/190, 15/191)
Katherine Bryant Governance & Board Secretary (items 15/195, 15/196)
Michele Ezro Associate Director Service Delivery & Quality
Edwina Harrison Independent Chair, Wakefield District Safeguarding Children Board (item 15/192)
Bill Hodson Independent Chair, Wakefield District Safeguarding Adult Board (item 15/192)
Richard Main Informatics Integration Lead (item 15/190)
Gemma Reed Minute taker
Mandy Sheffield Head of Safeguarding (item 15/192)
Jess Weatherill Planning & Performance Manager (item 15/189)
Catherine Wormstone Primary Care Commissioning Programme Manager (item 15/191)

15/181 Welcome and Chair’s Opening Remarks

Dr Earnshaw welcomed everyone to the meeting.

15/182 Apologies for Absence

Apologies for absence were received from:

Dr David Brown GP, Kings Medical Centre
Dr Clive Harries GP, Chapelthorpe Surgery
Dr Adam Sheppard GP, Lupset Health Centre & Assistant Clinical Leader
15/183 Public Questions and Answers

One question was asked from a member of the Public, Mick Griffiths:

Following attendance at a recent Overview and Scrutiny Committee, it was announced that additional cuts will be made to the Council’s public health funding. One option is to utilise funding from the Council’s reserves. Mr Griffiths expressed concern about an apparent decline in the Council’s reserves, from £100m to £20m.

Dr Andrew Furber confirmed that following an announcement from the Chancellor that £200m would be taken out of the public health grant, consultations have taken place and it was reported that this will be applied equally across Local Authorities. Work is taking place within Wakefield Council to address this.

Andrew Balchin offered to share information outlining the Council’s financial position regarding reserves and discuss this further with Mick Griffiths to follow up any further queries.

15/184 Declarations of Interest

All GP members and the Practice Manager member declared an interest in item 191 on the agenda; estates strategy. It was agreed that all members will be able to join in the discussion regarding this agenda item.

15/185 Minutes of the meeting held on 15 September 2015

The minutes of the meeting held on 15 September 2015 were agreed as an accurate record.

It was RESOLVED that:

(i) The minutes of the meeting of the NHS Wakefield Clinical Commissioning Group Governing Body Meeting held on 15 September 2015 were agreed as a correct record.

15/186 Action sheet from the meeting held on 15 September 2015

Katherine Bryant confirmed that all actions from the meeting held on 15 September 2015 were complete. It was noted that the conflicts of interest plain English guide is available on the CCG’s website.

15/187 Matters arising

There were no matters arising.

15/188 Patient Story

A video outlining a success story of a patient’s experience within the Wakefield District was presented showcasing the good work taking place across the health economy.
15/189  Chief Officer Update

Jo Webster presented the Chief Officer update; a number of items were highlighted within the report.

Nationally during Q3 2015/16 work will be completed to formally transfer commissioning responsibilities back to CCGs for outpatient Neurology (Adult Neuroscience Centres and Adult Neurology Centres) and Specialised Wheelchair Services. Responsibility for commissioning Morbid Obesity Surgery Services will transfer back to CCGs from April 2016. It was noted that specialised wheelchair services will form part of the integrated service provided by the Local Authority on the CCG’s behalf. Further information will form part of the planning guidance which is due to be published in December 2015. It was noted that no additional resource will be available to support this, therefore work is taking place across Yorkshire and Humber to address this including exploring the option of collaborative commissioning.

Successful work has taken place in taking forward the health and social care workforce development agenda. This work is being led by Dr Harris, Chief Executive of Spectrum.

An excellent event was held for nurses to support them through the process of “revalidation”. 149 nurses from across the district were in attendance.

An Older Peoples Thematic Review took place by the CQC; the Governing Body thanked all those involved for their hard work in preparing for this review. No formal feedback has been received to date.

A CQC inspection also took place for safeguarding children and looked after children. The Governing Body thanked the team who mobilised a quick response to this request. The reporting confirming the outcome from this is awaited.

Following the recent assurance process undertaken by NHS England, NHS Wakefield was rated as assured across all 6 domains. It was noted that no assessment against delegated functions has been made as this is a self-assessment process.

It was noted that significant work has taken place to take forward Community Anchors which will be built on in the new year.

In October 2015 the Integrated Governance Committee approved minor amendments to the Health and Safety policy for NHS Wakefield CCG. This was approved by the Governing Body.

It was RESOLVED that:

(i) To note the content for information and support on-going developments outlined in the content of the report; and
(ii) The Governing Body approved the updated Health and Safety Policy.

15/190  Integrated Quality and Performance Summary Report

Jo Pollard noted areas of success, this included the Sentinel Stroke National Audit Programme data for April – June 2015 which shows MYHT has made significant improvements. Following recent CQC visits to a number of practices across the district, the first two practices received a rating of ‘good’.
Following the recent CQC inspection at MYHT, Gate 42 at Pinderfields was highlighted as requiring improvement. It was noted that staffing challenges remain and MYHT are required to ensure that safe nurse staffing ratios are on each ward.

It was noted that there were 17 clostridium difficile cases assigned to the CCG in August 2015. The CCG is not on track to meet the clostridium difficile or MRSA targets. It was agreed that a deep dive is required to provide assurance regarding actions and interventions made.

Concerns were raised regarding hip fractures; MYHT is consistently failing to meet the national target which requires hip fracture patients to be operated on within 48 hours. Jo Pollard agreed that further developments are planned which will take account of falls, rehabilitation, therapy and intermediate care services including reablement across the health and social care economy. Further reports about this work will be reported to the Integrated Governance Committee.

Andrew Pepper updated members regarding performance. It was noted that there were no reported 12 hour Trolley waits and the CCG continues to meet all cancer standards for the second month running and for year to date.

It was noted that YAS Cat A (Red 1 & Red2) 8 minute response time have not met the operational standard. Andrew Pepper confirmed that significant investment has been made to support YAS. However, there is a need to consider which schemes will receive investment in 2016/17.

A&E performance at MYHT has not met the required standard for month 6 and the year to date position for the 9th month. The position has deteriorated from the previous month.

It was noted that additional investments have been made to support community paediatric autism assessments.

A whole system approach to improve performance is taking place to reduce the number of delayed transfers of care and a “Help Me Home” scheme is in place to help support the patient discharge process.

The CCG has not met the required standard for the 18 week RTT incomplete pathway for the first time this financial year. A performance notice has been issued to MYHT. The CCG has incurred two further breaches in the 52 week RTT pathway.

It was RESOLVED that the Governing Body:

(i) Note the current performance against the CCG strategic objectives and Quality Premium; and
(ii) Note the full unabridged versions have been presented at the Integrated Governance Committee in September and October 2015. Assurance has been provided verbally and through exception reporting.

15/191 Local Digital Road Maps

Richard Main informed the Governing Body that the NHS England programme is for Primary, Urgent and Emergency Care and for key transfers of care to be delivered using paper free integrated records by 2018 and that all publicly funded providers of health and care will have integrated digital care records by 2020 to enable health and care to be
“paper free at point of care”.

Further work is required to develop the local footprint, however it is determined that the most appropriate footprint is likely to be the Wakefield CCG and Wakefield Local Authority boundary. Work is taking place with providers to take this forward across the whole health and social care system. However this does not currently include GPs as further national guidance is awaited regarding General Practice IT.

It was noted that completed Roadmaps are to be submitted to NHS England by April 2016. Currently there is no funding associated with this work, although NHS England are seeking funding through the current Treasury Comprehensive Spending Review round.

Andrew Balchin confirmed that the Local Authority is supportive of this work and an internal review group has been established within the Local Authority to work alongside this to ensure there is no impact. Providers who are currently using SystmOne are encouraged to maintain to do so.

It was RESOLVED that the Governing Body:

(i) Note the submission of the Local Digital Roadmap footprint return to NHS England

15/192 Wakefield Estates Strategy

Andrew Pepper outlined the requirements for the CCG to have an estates strategy in place which requires submission to NHS England in December 2015. This will support the longer term vision to provide a framework for ensuring high quality, affordable accommodation in the most appropriate setting.

The CCG is required to demonstrate what estate is available, rationalise estate, improve patient experience, maximise use of facilities and ensure it provides value for money. To date, the CCG has secured support from NHS Property Services to provide a baseline report looking at GP and NHS estate and an outline draft is available.

It is essential to consider future investment in NHS Estate and further discussions are being held at the Integrated Governance Committee. It was noted that any future investment will need to align with new Models of Care.

Jo Webster informed members it is important to work with partners to determine the current NHS estate in order to form the basis of a potential submission to the primary care transformation fund. Future guidance about the primary care transformation funds is awaited. It was noted that there will be a need to work in collaboration across all layers of provision in health and social care in the future. Two sessions are planned with network chairs and members practices once guidance is available.

Assurance was sought that future planning of new doctor’s surgeries will take into consideration planned new housing developments. Work is taking place to link with the council’s planning team and a local estates forum to take this forward. It was noted that there is a need to identify key sites which will become enablers of change.

Andrew Balchin informed members that the Local Authority has taken stock of current estate. Price Waterhouse Coopers (PWC) is reviewing public sector estate across the district.
It was **RESOLVED** that the Governing Body:

(i) Note the progress to develop the NHS Wakefield CCG Estates Strategy; and
(ii) Delegate authority to the Integrated Governance Committee to approve the NHS Wakefield CCG Estates Strategy.

15/193 **Safeguarding Annual Report - Presentation**

Bill Hodson, Chair of Adults Safeguarding Board and Edwina Harrison, Chair of Childrens Safeguarding Board presented updates. Bill Hodson presented the Adults Safeguarding annual report and Edwina Harrison gave an update presentation on Childrens Safeguarding.

The Governing Body expressed their thanks to Jane Wilson and Mandy Sheffield for all their work in driving forward the safeguarding agenda.

These reports provide assurance about the CCG and provider organisations performance with regard to safeguarding adults and children. Prevention and awareness is essential to support this work.

Work is taking place to link better on joint issues between adults and children in circumstances which include Safer Places, hate crime and domestic abuse.

Edwina Harrison informed members that following the Rotherham publication, the intensity of work has not reduced. Work continues to ensure that learning and recommendations made within Serious Case Reviews are embedded.

It was noted that the role of Safeguarding Boards are increasing. Discussion took place regarding the need for a safeguarding impact assessment for children in Wakefield. Following the recent CQC inspection, initial feedback highlighted good practice. However there is inconsistency in approach from individual practitioners, there is a need for a consistent approach across all partnerships.

It was **RESOLVED** that the Governing Body:

(i) Note the content of the Wakefield and District Safeguarding Children Board presentation; and
(ii) Note the Wakefield and District Safeguarding Adult Board Annual Report 2014/15.

15/194 **Patient and Public Engagement Annual Report 2014/15**

Stephen Hardy presented the Patient and Public Engagement Annual Report 2014/15 which is a summary of the consultation and engagement activity taken place over the year. It outlines developments and service reviews which the engagement team have carried out system wide and at a local level.

It was noted that all GP practices across the district have a patient participation group. All groups have been offered training to develop and grow which has resulted in some patient groups taking on new roles.
Patient feedback is used to inform commissioning decisions. A 15 steps challenge in collaboration with HealthWatch has taken place, highlighting concerns regarding nursing levels and discharge planning within MYHT.

Val Pratt from the Deaf and Hard of Hearing Support Services shared service users experience regarding access to healthcare. Val informed members that awareness training was delivered for 80 GP and clinical staff. GP walkabouts to identify any areas of improvements have taken place and good feedback was received from this.

As a result, Network 3 has prepared an engagement plan for practices to be more accessible for patients with sensory impairments. A 43% response rate was received. Practices are making practical changes including font style on correspondence, signage and large print.

Improvements have been made where GPs share information when those who are deaf or hard of hearing are due to attend hospital appointments; this improves access and creates less anxiety for patients. However additional work is required to progress this further.

It was RESOLVED that the Governing Body:

(i) Note the content of the report for information; and  
(ii) Ensure public engagement is considered and undertaken for all commissioning intentions.

15/195 **Finance Report – Month 6**

Andrew Pepper outlined the financial position at month 6.

There are currently risks within the system and there are overspends in several areas e.g. continuing health care and children’s complex care. There has been a growth in procedures undertaken by Any Qualified Provider contractors and no reduction in activity at MYHT. It was noted that work is taking place with South West Yorkshire Partnership Foundation Trust (SWYPFT) to look at mental health out of area placements.

It was noted that there is an increasing financial pressure across the health system. Andrew informed members that following NHS England guidance relating to continuing health care risk pool to manage legacy claims. In previous years if there was an underspend then money was returned to CCGs. Going forward this will not be the case; discussions are taking place with NHS England to understand the implications of this.

It was RESOLVED that the Governing Body:

(i) Note the contents of the report

15/196 **NHS Wakefield CCG Declarations of Interest**

Katherine Bryant informed members that a quarterly update of conflicts of interest has taken place and this is presented twice a year to Governing Body.

It was noted that there is a register of interests for all network members which is available on skyline and is reported to the Audit Committee on a quarterly basis.
Following the recent review undertaken by Deloittes (on behalf of NHS England) looking at how the CCG manages conflicts of interest, no formal feedback has been received to date. It is expected that this will be presented to the Audit Committee in December 2015.

It was **RESOLVED** that the Governing Body:

(i) Note the declared interests of members of the NHS Wakefield CCG Governing Body and its Committees as at 26 October 2015.

15/197 Committee Terms of Reference Review

Katherine Bryant updated members following the annual review of all committee terms of reference. She highlighted a new requirement for all committees to refer items to Probit Committee if any conflicts of interest arise. In addition Katherine described a number of proposed changes to membership of the Governing Body’s committees.

It was **RESOLVED** that the Governing Body:

(i) Approved the proposed amendments to the terms of reference of the Integrated Governance Committee; Clinical Cabinet; Audit Committee and Probit Committee;
(ii) Approved the appointment of Governing Body members Dr Pravin Jayakumar and Alison Sugarman to the Integrated Governance Committee and Dr Deborah Hallott to the Audit Committee.

15/198 Minutes of the Audit Committee

Sandra Cheseldine presented minutes of the Audit Committee meeting held on 30 July 2015. Drew attention to Prompt Payment Code which the CCG is signed up to. This helps to ensure that the CCG is a good commissioner of services.

It was **RESOLVED** that the Governing Body:

i) Note the minutes of the Audit Committee held on 30 July 2015.

15/199 Minutes of the Integrated Governance Committee

Rhod Mitchell presented minutes of the Integrated Governance Committee meetings held on 20 August and 17 September 2015 and invited the Governing Body to consider the headline discussions.

It was **RESOLVED** that the Governing Body:

(i) Note the minutes of the Integrated Governance Committee held on 20 August and 17 September 2015.

15/200 Minutes of the Clinical Cabinet

Stephen Hardy presented minutes of the Clinical Cabinet meetings held on 27 August 2015 and invited the Governing Body to consider the headline discussions.

It was **RESOLVED** that the Governing Body:

(i) Note the minutes of the Clinical Cabinet held on 27 August 2015.
15/201 Connecting Care Executive

Andrew Balchin presented minutes of the Connecting Care Executive meetings held on 13 August 2015 and invited the Governing Body to consider the headline discussions.

It was RESOLVED that the Governing Body:

(i) Note the minutes of the Connecting Care Executive held on 13 August 2015.

15/202 Probity Committee

Rhod Mitchell presented minutes of the Probity Committee meetings held on 28 July and 22 September 2015 and invited the Governing Body to consider the headline discussions. Noting the excellent work taken place across practices resulting in an additional 34,000 appointments.

It was RESOLVED that the Governing Body:

(i) Note the minutes of the Probity Committee held on 28 July and 22 September 2015

15/203 Minutes of the Health and Well Being Board

Dr Phil Earnshaw presented the minutes from the Health and Well Being Board meeting held on 30 July 2015.

It was RESOLVED that the Governing Body:

(i) Note the minutes of the Health and Well Being Board held on 30 July 2015.

15/204 Decisions of the Chief Officer

There were no decisions of the Chief Officer to report.

15/205 Any other business

There were no other items of additional business.

it was RESOLVED that:

(i) 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).

15/206 Date and time of next meeting

Tuesday, 12 January 2016, 1.00 pm in the Boardroom, White Rose House.
## Action Points from the Meeting held on Tuesday 10 November 2015

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<thead>
<tr>
<th>Minute No</th>
<th>Topic</th>
<th>Action Required</th>
<th>Who</th>
<th>Date for Completion</th>
<th>Progress</th>
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<tbody>
<tr>
<td>15/183</td>
<td>Public Questions and Answers</td>
<td>Council reserves - Share information outlining the Council’s financial position.</td>
<td>Andrew Balchin</td>
<td>December 2015</td>
<td>Complete</td>
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<tr>
<td>15/190</td>
<td>Integrated Quality and Performance Summary Report</td>
<td>Reports to be shared at Integrated Governance Committee regarding hip fractures.</td>
<td>Jo Pollard</td>
<td>January 2016</td>
<td>National Hip Fracture Commissioner Audit Report summary to be included in the Integrated Quality and Performance report to be presented at January Integrated Governance Committee.</td>
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Paper 7

Patient Story

Presentation
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<th>Governing Body</th>
<th>Agenda Item:</th>
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<tr>
<td>Date of Meeting:</td>
<td>12 January 2016</td>
<td>Public/Private Section:</td>
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<tr>
<td>Paper Title:</td>
<td>Chief Officer Briefing</td>
<td>Public</td>
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<td>Private</td>
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<td>N/A</td>
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<tr>
<td>Purpose (this paper is for):</td>
<td>Decision ✓</td>
<td>Discussion</td>
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<tr>
<td>Report Author and Job Title:</td>
<td>Jo Webster, Chief Officer</td>
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<td>Responsible Clinical Lead:</td>
<td>Dr Phillip Earnshaw, Chair</td>
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<td>Responsible Governing Board Executive Lead:</td>
<td>Jo Webster, Chief Officer</td>
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<td>Recommendation:</td>
<td>To note the content for information and support on-going developments outlined in the content of the report.</td>
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<td>Executive Summary:</td>
<td>To provide a brief update to members of the Governing Body on areas not covered on the main agenda.</td>
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<td>Link to overarching principles from the strategic plan:</td>
<td>Citizen Participation and Engagement</td>
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<td>Wider Primary Care at Scale including Network development</td>
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<td>A Modern Model of Integrated Care</td>
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<td>Access to the Highest Quality Urgent and Emergency Care</td>
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<td>A Step Change in the Productivity of Elective Care</td>
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<td>Specialised Commissioning ✓</td>
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<td>Mental Health Service Transformation</td>
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<td>Maternity, Children and Young People Transformation</td>
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<td>Organising ourselves to deliver for our patients</td>
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<td>Outcome of Impact Assessments completed (e.g. Quality IA or Equality IA)</td>
<td>Not applicable</td>
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<tr>
<td>Outline public engagement – clinical, stakeholder and public/patient:</td>
<td>Not applicable</td>
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<td>Assurance departments/organisations who will be affected have been consulted:</td>
<td>CCG Leadership Team</td>
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<td>Previously presented at committee / governing body:</td>
<td>Not applicable</td>
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<td>Reference document(s) / enclosures:</td>
<td>None</td>
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<td>Risk Assessment:</td>
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<td>Finance/ resource implications:</td>
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Chief Officer Briefing

12 January 2016

Auditor Panel Establishment

Following the closure of the Audit Commission (in March 2015) a new local audit framework was developed. As a result early in 2016 every Clinical Commissioning Group (CCG) will need to appoint an ‘auditor panel’ (result of the Local Audit and Accountability Act 2014). The auditor panel will advise on the appointment of the CCG’s external auditors.

The CCG’s Governing Body must decide how it appoints its auditor panel. It is proposed that the CCG’s existing audit committees will be nominated to act as the panel. This is the most straightforward approach as audit committees are independent and members of the committee have the relevant experience and skills.

Further advice is awaited regarding the changes necessary to be made to the Audit Committee’s terms of reference, include the new role and responsibilities of the auditor panel. The draft terms of reference will be considered by the Audit Committee in February 2016 and presented to the Governing Body for approval in March 2016.

CCG Practice Agreement

NHS England require that all CCGs must sign up to a local Call Off Agreement with each GPSoC Supplier from whom they order GPSoC Services and agree a CCG Practice Agreement with each practice for which they arrange GPSoC and/or GP IT Services. Signing the agreement ensures the practice’s right to a choice of system is protected and that the practice and CCG each commit to specific responsibilities in relation to the delivery of GP IT services.

The practice agreement is a national standard. Appropriate due diligence and consultation was carried out with the support of Dr Pravin Jayakumar and Alison Sugarman, it was reviewed by the LMC management group. Some clarifications were provided and no subsequent challenges have been received.

As a result Wakefield CCG have completed the execution of the CCG Practice Agreement with all practices ahead of the deadline of 31 December 2015.

Care Quality Commission (CQC) Inspection – South West Yorkshire Partnership Foundation Trust (SWYPFT)

In October 2015, SWYPFT were notified that they will be inspected by the CQC week commencing 7 March 2016. This will be the first inspection of SWYPFT services against the five domains – Safe, Effective, Caring, Responsive and Well-led – and will last for at least five days.

At the Quality Board in early December 2015, SWYPFT colleagues described their preparations – they have established a CQC preparation task and finish group within their governance structure, developed a detailed action plan, and are ‘stepping up’ their established programme of mock CQC visits to service areas.

It was agreed at this meeting that NHS Calderdale CCG as lead commissioner would co-ordinate the submission of the CQC’s information request across Calderdale, Kirklees and Wakefield requesting input from each CCG (expected early January). This is in line with the approach we have adopted for
completion of the information request for other providers. It was also agreed that commissioners would share information with SWYPFT prior to submission to ensure they are fully cited on the commissioner’s view of their services.

The inspection preparation and outcome will now be a standing agenda item on future Quality Boards.

Yorkshire & Humber Clinical Support Transition

The CCG welcomed staff on the 1 December 2015 that have now transferred over, under TUPE from the YHCS. This was part of a transition process to in-house some of the services that have previously been provided by YHCS. The tender process to transfer some services to a new provider under the NHSE Lead Provider Framework (LPF) has also reached conclusion. A consortium company called eMBED were the successful bidder. Business Intelligence will be contracted for 4 years and PALs and Procurement contracted for 3 years in line with the agreed LPF procurement with a total value of £1.8m over the life of the contract. As part of the mobilisation phase, pre contractual due diligence is underway which will quickly move into implementation in order to be ready for business on 1 March 2016. Other services will be a shared model across CCGs with YHCS staff transferring to the host CCG. A Memorandum of Understanding between each CCG will be agreed over the next few months ready for implementation on 1 March 2016.
**Title of meeting:** Governing Body  
**Date of Meeting:** 12 January 2016  
**Paper Title:** Integrated Quality & Performance Report (Governing Body Summary)  
**Purpose (this paper is for):** Decision, Discussion, Assurance, Information  
**Public/Private Section:** Public

<table>
<thead>
<tr>
<th>Agenda Item:</th>
<th>9</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Report Author and Job Title:</strong></td>
<td>Andrew Singleton, Quality Co-ordinatorJess Weatherill, Planning and Performance Manager</td>
</tr>
<tr>
<td><strong>Responsible Clinical Lead:</strong></td>
<td>Dr David Brown, Quality lead</td>
</tr>
<tr>
<td><strong>Responsible Governing Board Executive Lead:</strong></td>
<td>Jo Pollard, Chief of Service Delivery and QualityAndrew Pepper, Chief Finance Officer</td>
</tr>
</tbody>
</table>

**Recommendations:**

It is recommended that the Governing Body:-

i. Note the current performance against the CCG strategic objectives and Quality Premium; and
ii. Note the full unabridged versions have been presented at the Integrated Governance Committee in November and December 2015. Assurance has been provided verbally and through exception reporting.

**Executive Summary:**

The Integrated Quality & Performance report is a key tool to provide assurance to the CCG that strategic objectives and NHS constitutional standards are being delivered and to direct attention to significant risk, issues, exceptions and areas for improvement. The report is aligned to the CCG’s six strategic priorities outlined in our Strategic Plan (NHS Wakefield – the next 5 years).

The report is a summary of the November and December Integrated Quality & Performance reports which have been presented to the two previous Integrated Governance Committee (IGC) meetings. The format of this summary report has been revised to highlight to Governing Body members the issues, actions and next steps discussed at the Integrated Governance Committee.

**Areas of attainment**

- Friarwood Surgery, White Rose Surgery and Ferrybridge Medical Centre were all rated as ‘outstanding’ by the CQC.
- Maybush Medical Centre, Drs DP Diggle & RE Phillips, Lupset Health Centre, South Hiendley Surgery, Rycroft Primary Care Centre and Crofton and Sharlston Medical Practice were all rated as ‘good’ by the CQC.
- The CCG has met all cancer standards for October and Year to Date (YTD).
- The CCG has met the Cat A (Red 1) Ambulance standard for October and YTD. At a Yorkshire and Humber level YAS did not achieve this standard.
- The CQC rated MYHT maternity & gynaecology, children & young people, outpatients & diagnostics services at MYHT as ‘good’. The CQC praised the reduction in the outpatient backlog.
- Patient satisfaction with MYHT A&E services continues to be much higher than the national average. 97% of inpatients would recommend MYHT services to friends and family.
- MYHT reported no slips, trips and falls Serious Incidents in November 2015, the first month since May 2014.
- Weekend Hospital Standardised Mortality Ratio data for August 2015 shows significant improvement.
- MYHT is one of fourteen trusts nationally to be categorised as having a lower than expected mortality rates in the latest Summary Hospital Mortality Indicator report. This is the third consecutive report where MYHT has achieved this rating.
Areas for improvement
- The Cat A (Red2) Ambulance operational standard has not been achieved.
- The Acute Trust and Ambulance turnaround targets continue not to meet the required standard.
- A&E performance at MYHT has not met the required standard for Month and the YTD Position.
- The CCG has not met the required standard for the 18 week RTT incomplete pathway.
- 7 clostridium difficile cases were assigned to the CCG in October 2015. It looks highly unlikely that the CCG will achieve this year’s target.
- MYHT received an overall rating of ‘requires improvement’ from the CQC, no change from the previous inspection in July 2014. MYHT received a rating of ‘good’ for caring from the CQC. Services at MYHT are still rated ‘inadequate’ for the safe category by the CQC.
- Community inpatient health services at MYHT (intermediate tier beds) received a rating of ‘inadequate’ from the CQC, previously they were rated as ‘requires improvement.’
- MYHT performance in the staff Friends and Family Test has shown improvement in 2015/16 but is still well below the national average.

<table>
<thead>
<tr>
<th>Link to overarching principles from the strategic plan:</th>
<th>Citizen Participation and Engagement ✓</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Wider Primary Care at Scale including Network development ✓</td>
</tr>
<tr>
<td></td>
<td>A Modern Model of Integrated Care</td>
</tr>
<tr>
<td></td>
<td>Access to the Highest Quality Urgent and Emergency Care ✓</td>
</tr>
<tr>
<td></td>
<td>A Step Change in the Productivity of Elective Care</td>
</tr>
<tr>
<td></td>
<td>Specialised Commissioning</td>
</tr>
<tr>
<td></td>
<td>Mental Health Service Transformation ✓</td>
</tr>
<tr>
<td></td>
<td>Maternity, Children and Young People Transformation ✓</td>
</tr>
<tr>
<td></td>
<td>Organising ourselves to deliver for our patients ✓</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outcome of Impact Assessments completed (e.g. Quality IA or Equality IA)</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>The report contains the CQC report for Ferrybridge Medical Centre which may present a conflict of interest for Dr P. Earnshaw. The report contains the CQC report for Lupset Health Centre which may present a conflict of interest for Dr A. Sheppard.</td>
</tr>
<tr>
<td>Assurance departments/organisations who will be affected have been consulted:</td>
<td>Assurance on areas of underperformance or risks to safety and quality are discussed with providers through respective contractual and quality governance arrangements.</td>
</tr>
<tr>
<td>Previously presented at committee / governing body:</td>
<td>Integrated Governance Committee – 19 November and 17 December 2015</td>
</tr>
<tr>
<td>Reference document(s) / enclosures:</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Risk Assessment:</td>
<td>Mitigating actions have been included within the report and risks are captured as appropriate in the Board Assurance Framework and Corporate Risk Register.</td>
</tr>
<tr>
<td>Finance/ resource implications:</td>
<td>Mitigating actions required to improve performance or quality are assessed on an individual basis for any finance or resource implications.</td>
</tr>
</tbody>
</table>
Integrated Quality and Performance Report

January 2016

Governing Body Summary
Executive Summary

Items also included in the November and December IGC quality and performance reports

- Acute Trust Dashboard
- YAS Dashboard
- Complaints and Compliments
- CQUINs Q2 achievement
- Falls and Fragility Fracture National Audit
- Heart Failure National Audit
- MYHT Ward Dashboard
- MYHT Trust Dashboard
- MYHT Nurse Staffing
- National Reporting and Learning Management System
- Performance Exception Reports
- Serious Incidents (SI) summary
- Staff Friends and Family Test
- Specialty Exception Reports
- Summary Hospital Mortality Indicator (SHMI)

Summary of items discussed at Integrated Governance Committee (and previous)

The Integrated Quality and Performance Report is presented monthly at the Integrated Governance Committee (IGC). This page summarises the discussion on the items which members identified as areas for improvement.

IGC 19 November 2015

- It was highlighted to the Committee that the CCG met eight out of the nine cancer standards, with the ninth being missed by 0.1%.
- The Committee discussed the ongoing underperformance against the 18 week RTT pathway including actions in place at the Trust to address the position.
- The Committee noted the continuing underperformance against the 4 hour A&E target, which was highlighted as improving slightly on the position last month.
- Infection Control: The Head of Health Protection attended the meeting and provided details of how risks related to healthcare associated infection (HCAI) are being addressed, together with actions from Post Infection Reviews (PIRs). The number of clostridium difficile (CDI) cases was above the planned trajectory. A recovery plan has been developed to reinforce and build upon the CDI action plan for 2015/16, and a C.diff Summit will be held in early 2016.
- Nurse Staffing: The Interim Director of Nursing and Deputy Director of Nursing from MYHT attended the meeting to give a presentation on the staffing issues and the progress that has been made. They outlined a number of recruitment and retention initiatives that are being taken to improve staffing levels. It was recognised that the Care Quality Commission, Trust Development Authority and the CCG are assured with the processes that have been put in place, acknowledging that improvements have been made regarding the staffing challenges.
- GP CQC reports: To date, every practice has received an overall rating of outstanding or good. It was agreed that if a practice requires improvement in any area, a package of support will be made available from the CCG, based on the needs of the practice.

IGC 17 December 2015

- Discussion was held regarding the 18 week RTT Incomplete pathway which has not met the required standard for October. The Committee was informed that action plans were in place with the Trust and that the CCG was working with the Trust to improve performance. The Trust is maintaining that performance will be at the required standard by March 2016.
- It was identified to the Committee that the CCG had met all cancer targets for the month and year to date. Further discussion was held regarding the upcoming expected breach in trolley waits.
- Discussion took place regarding A&E. It was identified that the Trust had not met the standard and that the rectification plan had now been received from the Trust and was currently being reviewed.
- A verbal update was provided with regard to the trolley wait standard in November 2015.
- 111/GP Out of hours: Committee members requested further information about the performance against key contractual access indicators for the 111 contract. It was agreed to invite the lead commissioner and provider to a future meeting.
- GP Practice CQC inspections: The recently published ratings – which include ‘Outstanding’ for three practices and ‘Good’ for a further six practices – were acknowledged.
- Quality Premium (mental health indicator): The Committee discussed the patients that present with Mental Health issues in A&E who then breach the four hour target. It was queried why this would be the case as there is a Liaison Team within the department.
- Falls and Fragility Fracture Audit – Committee members were concerned about MYHT’s performance against the standards. It was acknowledged that this was the first time the national audit had been completed. A summary from the recent Falls Summit will be included in the January IQP and a clinical quality lead from North Kirklees CCG will be providing input and challenge to the falls improvement work at the Trust.
Wakefield CCG Strategic Objectives Balanced Scorecard - YTD Position

A step change in the productivity of elective care
Mental health service transformation
Access to the highest quality urgent & emergency care
Maternity, children and young people transformation
System wide quality measures
Citizen participation & empowerment

Cancer - Max 2 week wait urgent GP referral
Cancer - Max 2 week wait breast symptoms
Cancer - max 31 days wait from diagnosis to first definitive treatment for all cancer
Cancer - max 31 days for subsequent treatment where that treatment is surgery
Cancer - max 31 days for treatment where that treatment is a course of radiotherapy
*Cancelled operations offered re-admission date within 28 days
Improving Access to Psychological Therapies
Ambulance R1 8 min response
Smoking in pregnancy
Healthcare acquired infections - MRSA
FFT - A&E
Care Programme Approach
Ambulance R2 8 min response
Healthcare acquired infections - CDIFF
FFT - Inpatient
Ambulance 19 min transportation
AMBULANCE TO A&E HANDOVER
Crew clear delays
Diagnostic test waits - no more than 6 weeks
A&E waits no more than 4 hrs
Trolley waits - no more than 12 hrs
Mixed sex accommodation (MSA) breaches
FFT - Maternity

Arrow Key
↑ Target met, trend increased  ↑ Target not met, trend improving  ↔ No change  ↓ No target, trend decreasing
↓ Target met, trend deteriorated  ↓ Target not met, trend deteriorated  ↑ No target, trend increasing  ↓ No target, trend decreasing
## Executive Summary

### Quality Premium

<table>
<thead>
<tr>
<th>Domain</th>
<th>Quality Premium Measure</th>
<th>Target (Year End)</th>
<th>Percentage of quality premium</th>
<th>Potential value for CCG</th>
<th>Current YTD Performance</th>
<th>Current anticipated eligible QP Funding based on YTD/FOT Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventing people from dying prematurely</td>
<td>Potential years of life lost (PYLL)</td>
<td>Awaiting publication of figures/baseline</td>
<td>10%</td>
<td>£177,500</td>
<td>Awaiting publication of figures.</td>
<td>£177,500</td>
</tr>
<tr>
<td>Enhancing quality of life for people with long term conditions</td>
<td>Reduction in the number of patients attending an A&amp;E department for a mental health-related need who wait more than four hours to be treated and discharged, or admitted, together with a defined improvement in the coding of patients attending A&amp;E</td>
<td>95%</td>
<td>30%</td>
<td>£532,500</td>
<td>81.9% FOT (at September 2015)</td>
<td>£0</td>
</tr>
<tr>
<td>Enhancing quality of life for people with long term conditions</td>
<td>Avoidable emergency admissions</td>
<td>Awaiting data levels guidance</td>
<td>30%</td>
<td>£532,500</td>
<td>Awaiting data levels guidance.</td>
<td>£532,500</td>
</tr>
<tr>
<td>Treating and caring for people in a safe environment and protecting them from avoidable harm</td>
<td>Improving antibiotic prescribing (a combination of 3 measures): Reduction in the number of antibiotics prescribed in primary care, Reduction in the proportion of broad spectrum antibiotics prescribed in primary, Secondary care providers validating their total antibiotic prescription data</td>
<td>&lt;1.326, &lt;11.3%, Waiting information from MYHT</td>
<td>10%</td>
<td>£177,500, 1.35 (at September 2015), 7.50% (at September 2015)</td>
<td>1.35 (at September 2015), 7.50% (at September 2015)</td>
<td>£0</td>
</tr>
<tr>
<td>Local measure</td>
<td>Smoking in pregnancy</td>
<td>≤19%</td>
<td>10%</td>
<td>£177,500, 19.1% (Q1/FOT)</td>
<td>19.1% (Q1/FOT)</td>
<td>£0</td>
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<tr>
<td>Local measure</td>
<td>Percentages of lung cancers detected at stages 1&amp;2</td>
<td>25%</td>
<td>10%</td>
<td>£177,500</td>
<td>Awaiting publication of figures.</td>
<td>£177,500</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>100%</td>
<td>£1,775,000</td>
<td>Current anticipated value available for CCG (QP measures only)</td>
<td>£887,500</td>
</tr>
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</table>

### NHS Constitution Target

<table>
<thead>
<tr>
<th>NHS Constitution Target</th>
<th>YTD/Forecast Outturn Position</th>
<th>Percentage of QP Deducted if target not met</th>
<th>Value Deducted</th>
</tr>
</thead>
<tbody>
<tr>
<td>18 Week RTT Waiting Time Standard</td>
<td>90.7%</td>
<td>30%</td>
<td>£266,250</td>
</tr>
<tr>
<td>A&amp;E 4 Hour Waiting Time Standard</td>
<td>82.7%</td>
<td>30%</td>
<td>£266,250</td>
</tr>
<tr>
<td>Maximum 2 Week Wait from GP Referral to First Outpatient Appointment – All Cancer</td>
<td>96.9%</td>
<td>20%</td>
<td>£0</td>
</tr>
<tr>
<td>Cat A (Red 1) 8 Minute Response Time</td>
<td>75.8%</td>
<td>20%</td>
<td>£0</td>
</tr>
</tbody>
</table>

Total anticipated value available for CCG (QP measure and Constitution targets) Estimated : £355000
## Strategic Performance Monitoring

### Citizen participation and empowerment

<table>
<thead>
<tr>
<th>Provider</th>
<th>Indicator</th>
<th>Reporting Period</th>
<th>National Average</th>
<th>Actual</th>
<th>YTD</th>
<th>From previous Month</th>
<th>Previous months score card</th>
<th>D.A.</th>
<th>Clinical Lead</th>
<th>Comissioning Lead</th>
<th>Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>MYHT</td>
<td><strong>Friends and Family Test (FFT) - A&amp;E</strong> % of patients recommending the service</td>
<td>Sep</td>
<td>88%</td>
<td>95%</td>
<td>94.0%</td>
<td>↑</td>
<td>••••••</td>
<td>•</td>
<td>Dr AS</td>
<td>LE</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>FFT - Inpatient</strong> % of patients recommending the service</td>
<td>Sep</td>
<td>96%</td>
<td>97%</td>
<td>96.0%</td>
<td>↔</td>
<td>••••</td>
<td>•</td>
<td>Dr PW</td>
<td>LE</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>FFT - Maternity</strong> % of patients recommending the service</td>
<td>Sep</td>
<td>95%</td>
<td>92%</td>
<td>95.6%</td>
<td>↓</td>
<td>••••</td>
<td>•</td>
<td>Dr DH</td>
<td>LE</td>
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<tr>
<td></td>
<td><strong>Antenatal % of patients recommending the service</strong></td>
<td>Sep</td>
<td>97%</td>
<td>99%</td>
<td>98.8%</td>
<td>↑</td>
<td>••••</td>
<td>•</td>
<td>Dr DH</td>
<td>LE</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Labour Ward % of patients recommending the service</strong></td>
<td>Sep</td>
<td>93%</td>
<td>98%</td>
<td>92.8%</td>
<td>↑</td>
<td>••••</td>
<td>•</td>
<td>Dr DH</td>
<td>LE</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Postnatal Ward % of patients recommending the service</strong></td>
<td>Sep</td>
<td>98%</td>
<td>100%</td>
<td>98.2%</td>
<td>↔</td>
<td>••••</td>
<td>•</td>
<td>Dr DH</td>
<td>LE</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Postnatal Community % of patients recommending service</strong></td>
<td>Sep</td>
<td>95%</td>
<td>98%</td>
<td>97.0%</td>
<td>↔</td>
<td>••••</td>
<td>•</td>
<td>Dr PW</td>
<td>LE</td>
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</tr>
<tr>
<td></td>
<td><strong>FFT - Community</strong> % of patients recommending the service</td>
<td>Sep</td>
<td>95%</td>
<td>98%</td>
<td>97.6%</td>
<td>↔</td>
<td>••••</td>
<td>•</td>
<td>Dr PW</td>
<td>LE</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>FFT - Outpatients</strong> % of patients recommending the service</td>
<td>Sep</td>
<td>92%</td>
<td>97%</td>
<td>97.6%</td>
<td>↔</td>
<td>••••</td>
<td>•</td>
<td>Dr PW</td>
<td>LE</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>FFT - Staff</strong> % of staff recommending Trust as place to receive treatment</td>
<td>Q2</td>
<td>79%</td>
<td>58%</td>
<td>58%</td>
<td>↔</td>
<td>••••</td>
<td>•</td>
<td>Dr PW</td>
<td>LE</td>
<td></td>
</tr>
<tr>
<td>SWYPFT</td>
<td><strong>FFT - Mental Health</strong> % of patients recommending the service (Wakefield BDU)*</td>
<td>Q2</td>
<td>87%</td>
<td>94%</td>
<td>-</td>
<td>-</td>
<td>••••</td>
<td>•</td>
<td>Dr CH</td>
<td>LE</td>
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</tr>
<tr>
<td></td>
<td><strong>FFT – Staff</strong> % of staff recommending Trust as a place to receive treatment</td>
<td>Q2</td>
<td>79%</td>
<td>69%</td>
<td>71%</td>
<td>↓</td>
<td>••••</td>
<td>•</td>
<td>Dr CH</td>
<td>LE</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Wakefield FFT - GP</strong> % of patients recommending the service</td>
<td>Sep</td>
<td>89%</td>
<td>92%</td>
<td>91.5%</td>
<td>↓</td>
<td>•••••</td>
<td>•</td>
<td>Dr GC</td>
<td>LE</td>
<td></td>
</tr>
</tbody>
</table>

* This data is published by SWYPFT. Data for Wakefield BDU is not published by NHS England.
## Access to the Highest Quality Urgent and Emergency Care

<table>
<thead>
<tr>
<th>Provider</th>
<th>Indicator</th>
<th>Reporting Period</th>
<th>Target</th>
<th>2014/15 CCG Performance</th>
<th>2014/15 CCG Performance Trend Information</th>
<th>2014/15 CCG Performance Provider Trend Information</th>
<th>Trend from previous Month</th>
<th>Clinical Lead</th>
<th>Commissions Lead</th>
<th>Exception Report #</th>
</tr>
</thead>
<tbody>
<tr>
<td>MYHT</td>
<td>A&amp;E 4 hour waiting time standard</td>
<td>Oct 95%</td>
<td>-</td>
<td>Not reported at CCG Level</td>
<td>Not reported at CCG Level</td>
<td>82.7%</td>
<td>88.6%</td>
<td>88.6%</td>
<td>↓</td>
<td>Dr AS</td>
</tr>
<tr>
<td></td>
<td>Trolley Waits in A&amp;E</td>
<td>Oct 0</td>
<td>-</td>
<td>Not reported at CCG Level</td>
<td>Not reported at CCG Level</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>↔</td>
<td>Dr AS</td>
</tr>
<tr>
<td></td>
<td>Acute Trust - Turnaround Time</td>
<td>Oct 100%</td>
<td>-</td>
<td>Not reported at CCG Level</td>
<td>Not reported at CCG Level</td>
<td>65.2%</td>
<td>Not reported at Provider Level</td>
<td>↓</td>
<td>Dr AS</td>
<td>MJ</td>
</tr>
<tr>
<td>YAS</td>
<td>Ambulance - Turnaround Time</td>
<td>Oct 100%</td>
<td>-</td>
<td>Not reported at CCG Level</td>
<td>Not reported at CCG Level</td>
<td>85.9%</td>
<td>Not reported at Provider Level</td>
<td>↑</td>
<td>Dr AS</td>
<td>JF</td>
</tr>
<tr>
<td></td>
<td>Ambulance response times</td>
<td>Oct 75%</td>
<td>72.5%</td>
<td>81.9%</td>
<td>75.8%</td>
<td>75.8%</td>
<td>↑</td>
<td>73.7%</td>
<td>71.6%</td>
<td>71.6%</td>
</tr>
<tr>
<td></td>
<td>Cat A (Red 2) 8 min response time</td>
<td>Oct 75%</td>
<td>69.9%</td>
<td>75.9%</td>
<td>73.6%</td>
<td>73.6%</td>
<td>↑</td>
<td>72.5%</td>
<td>71.6%</td>
<td>71.6%</td>
</tr>
<tr>
<td></td>
<td>Cat A (Red 1 and 2) 19 min response time</td>
<td>Oct 95%</td>
<td>97.1%</td>
<td>97.9%</td>
<td>97.7%</td>
<td>97.7%</td>
<td>↑</td>
<td>95.3%</td>
<td>95.9%</td>
<td>95.9%</td>
</tr>
</tbody>
</table>

**Note:** The table displays performance metrics and trends for various indicators related to urgent and emergency care services. The data includes actual performance, year-to-date (YTD) figures, and performance over the previous month. Trends are indicated with arrows (↑ for improvement, ↓ for decline, ↔ for no change), and exception reports are marked with 'Y' for intervention.
# Strategic Performance Monitoring

## Mental Health Service Transformation

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Reporting Period</th>
<th>Target</th>
<th>2014/15 CCG Performance</th>
<th>Trend Information</th>
<th>SWYPFT</th>
<th>Clinical Lead</th>
<th>Commissions Lead</th>
<th>Exception Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Programme Approach (CPA)</td>
<td>Q2</td>
<td>95%</td>
<td>97.9%</td>
<td>97.9%</td>
<td>↑</td>
<td>Not reported at Provider Level</td>
<td>Dr CH</td>
<td>MEz</td>
</tr>
<tr>
<td>The proportion of people under adult mental illness specialties on CPA who were followed up within 7 days</td>
<td></td>
<td></td>
<td>97.9%</td>
<td>97.9%</td>
<td>↑</td>
<td>Not reported at Provider Level</td>
<td>Dr CH</td>
<td>MEz</td>
</tr>
<tr>
<td>Improving Access to Psychological Therapies</td>
<td>Q2</td>
<td>3.75%</td>
<td>2.77%</td>
<td>No previous data</td>
<td>Not at Provider Level</td>
<td>n/a</td>
<td>Dr CH</td>
<td>MEz</td>
</tr>
<tr>
<td>People entering psychological therapies from prevalent population</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improving Access to Psychological Therapies</td>
<td>Q2</td>
<td>75%</td>
<td>4.92%</td>
<td>Not currently reported – target date of March 2016 for implementation</td>
<td>n/a</td>
<td>Dr CH</td>
<td>MEz</td>
<td></td>
</tr>
<tr>
<td>Patients treated within 6 weeks of referral</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Patients treated within 18 weeks of referral</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Early Intervention in Psychosis</td>
<td>Q2</td>
<td>50%</td>
<td>50%</td>
<td>Not currently reported – target date of March 2016 for implementation</td>
<td>n/a</td>
<td>Dr CH</td>
<td>MEz</td>
<td></td>
</tr>
<tr>
<td>Maximum 2 week wait from referral to treatment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment delivered in accordance with NICE guidelines for psychosis and schizophrenia</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Liaison Psychiatry</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Achieving better access to mental health services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Service in place – no measurable target described in the NHS Constitution to date</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
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</table>

**Notes:**
- ↑ indicates an increase.
- n/a signifies not applicable.
- Service in place – no measurable target described in the NHS Constitution to date.
## Strategic Performance Monitoring

### A step change in the productivity of elective care

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Reporting Period</th>
<th>Target</th>
<th>2014/15 CCG Performance</th>
<th>Trend from previous Month</th>
<th>MYHT</th>
<th>Trend from previous Month</th>
<th>Clinical Lead</th>
<th>Commissioning Lead</th>
<th>Exception Report</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cancer Waits - 2 Weeks</strong></td>
<td>Oct</td>
<td>93%</td>
<td>95% 96.8% 96.9% 96.9%</td>
<td>↑ 96.9% 96.9% 96.9%</td>
<td>↑</td>
<td>Dr AM MA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Max 2 week wait from GP referral to first outpatient appointment - all cancer</td>
<td>Oct</td>
<td>93%</td>
<td>97.4% 98.5% 97.7% 97.7%</td>
<td>↑ 96.4% 97.1% 97.1%</td>
<td>↓</td>
<td>Dr AM MA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Max 2 week wait for patients referred with breast symptoms - cancer not suspected</td>
<td>Oct</td>
<td>96%</td>
<td>98.2% 99.3% 98.9% 98.9%</td>
<td>↓ 100% 99.1% 99.1%</td>
<td>↑</td>
<td>Dr AM MA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Max 31 day wait from diagnosis to first definitive treatment - all cancers</td>
<td>Oct</td>
<td>96%</td>
<td>96.6% 97.8% 98.9% 98.9%</td>
<td>↓ 100% 98.8% 98.8%</td>
<td>↑</td>
<td>Dr AM MA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Max 31 day wait for subsequent treatment where treatment is surgery</td>
<td>Oct</td>
<td>94%</td>
<td>100.0% 98.8% 99.6% 99.6%</td>
<td>↓ 100.0% 100.0% 100.0%</td>
<td>↔</td>
<td>Dr AM MA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Max 31 day wait for subsequent treatment where treatment is an anti-cancer drug regime</td>
<td>Oct</td>
<td>98%</td>
<td>99.3% 100.0% 98.9% 98.9%</td>
<td>↔ Not Reported at Provider Level</td>
<td></td>
<td>Dr AM MA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Max 31 day wait for subsequent treatment where treatment is a course of radiotherapy</td>
<td>Oct</td>
<td>94%</td>
<td>100% 98.9% 100% 100%</td>
<td>↔</td>
<td></td>
<td>Dr AM MA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Max 62 day wait for first definitive treatment following a consultant decision to upgrade priority of patient</td>
<td>Oct</td>
<td>90%</td>
<td>83.3% 100.0% 95.8% 95.8%</td>
<td>↔ 100% 89.8% 89.8%</td>
<td>↑</td>
<td>Dr AM MA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Max 62 day wait from referral linked to the NHS Screening Program to start 1st treatment for all cancers</td>
<td>Oct</td>
<td>90%</td>
<td>91.5% 91.7% 97.3% 97.3%</td>
<td>↓ 92.3% 97.1% 97.1%</td>
<td>↓</td>
<td>Dr AM MA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Max 62 day wait from urgent GP referral to first definitive treatment for cancer</td>
<td>Oct</td>
<td>85%</td>
<td>84.2% 86.3% 86.1% 86.1%</td>
<td>↑ 83.7% 88.2% 88.2%</td>
<td>↓</td>
<td>Dr AM MA Y</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
A step change in the productivity of elective care

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Reporting Period</th>
<th>Target</th>
<th>2014/15 CCG Performance</th>
<th>Trend Information</th>
<th>MYHT</th>
</tr>
</thead>
<tbody>
<tr>
<td>18 Week RTT Waiting Time Standard</td>
<td>Oct</td>
<td>92.0%</td>
<td>91.6% 88.1% 90.7% 90.7%</td>
<td>↓ 86.4% 89.7% 89.7%</td>
<td>↓ Dr PW PK Y</td>
</tr>
<tr>
<td>Number of 52 week Referral to treatment pathways</td>
<td>Oct</td>
<td>0</td>
<td>22 0 7* 7</td>
<td>↔ 0 8 8</td>
<td>↑ Dr PW PK Y</td>
</tr>
<tr>
<td>Diagnostic test waiting times</td>
<td>Oct</td>
<td>99%</td>
<td>99.7% 97.5% 98.8% 98.8%</td>
<td>↓ 97.5% 98.9% 98.9%</td>
<td>↓ Dr PW PK Y</td>
</tr>
<tr>
<td>Cancelled Operations</td>
<td>Oct</td>
<td>0</td>
<td>0 0 0 0</td>
<td>↔ 0 2 2</td>
<td>↓ Dr PW PK</td>
</tr>
</tbody>
</table>

* BI data showing seven 52 week breaches; however verbal confirmation from MYHT has confirmed there are eight 52 week breaches all attributable to WCCG. This is due to a time lag in the update of Unify data available for viewing by the CCG which in turn updates the BI data.
### Strategic Performance Monitoring

#### System Wide Quality Measures

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Reporting Period</th>
<th>Target</th>
<th>2014/15 CCG Performance</th>
<th>Wakefield CCG Actual</th>
<th>YTD</th>
<th>FOT</th>
<th>MYHT Actual</th>
<th>YTD</th>
<th>FOT</th>
<th>Trend from previous Month</th>
<th>D.A.</th>
<th>Clinical Lead</th>
<th>Commissions Lead</th>
<th>Exception Report</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mixed sex accommodation breaches</strong></td>
<td>Oct</td>
<td>0</td>
<td>0</td>
<td>↔ 0</td>
<td>0</td>
<td>0</td>
<td>↔ 0</td>
<td>0</td>
<td>0</td>
<td>↔</td>
<td>•</td>
<td>Dr PW</td>
<td>PK</td>
<td></td>
</tr>
<tr>
<td><strong>Healthcare Associated Infections</strong></td>
<td>Oct</td>
<td>0</td>
<td>2</td>
<td>↑ 2</td>
<td>0</td>
<td>2</td>
<td>↑ 3</td>
<td>0</td>
<td>1</td>
<td>↑</td>
<td>•</td>
<td>Dr AF</td>
<td>JO'D</td>
<td>✓</td>
</tr>
<tr>
<td><strong>Clostridium Difficile</strong></td>
<td>Oct</td>
<td>6/72 (CCG) 2/27 (MYHT)</td>
<td>67</td>
<td>↑ 67</td>
<td>7</td>
<td>65</td>
<td>↑ 111</td>
<td>1</td>
<td>22</td>
<td>↑</td>
<td>•</td>
<td>Dr AF</td>
<td>JO'D</td>
<td>✓</td>
</tr>
</tbody>
</table>

#### Maternity, Children and Young People Transformation

<table>
<thead>
<tr>
<th>Provider</th>
<th>Indicator</th>
<th>Reporting Period</th>
<th>Target</th>
<th>2014/15 CCG Performance</th>
<th>Wakefield CCG Actual</th>
<th>YTD</th>
<th>FOT</th>
<th>Provider</th>
<th>Trend from previous Quarter</th>
<th>Clinical Lead</th>
<th>Commissions Lead</th>
<th>Exception Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>MYHT</td>
<td>Smoking in pregnancy</td>
<td>Q1</td>
<td>≤ 19%</td>
<td>19.7% 19.1% 19.1%19.1%</td>
<td>↑ 19.7%</td>
<td>19.1%</td>
<td>19.1%</td>
<td>↑</td>
<td>Dr AF</td>
<td>MEz</td>
<td></td>
<td>✓</td>
</tr>
</tbody>
</table>
**Quality Intelligence Group:** The Group represents every team within the CCG, plus colleagues from Public Health, the Local Authority, Healthwatch and the Commissioning Support Unit working in relevant functions, such as complaints, PALS, engagement and communications. At each meeting a template captures and triangulates ‘soft’ intelligence from sources such as Patient Opinion, feedback from member practices, PALS enquiries, media reports, staff observations (including patient safety walkabouts) and staff/family experiences. From this key themes are identified and any actions agreed dependent on the strength of evidence, link with ‘hard’ data sources, and judgement on the level of concern. 81 items of intelligence gathered at October’s meeting and 60 at November’s meeting.

<table>
<thead>
<tr>
<th>Theme Identified</th>
<th>Previous times as key theme in 2015</th>
<th>Key actions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GP Access – accessing appointments</strong></td>
<td>1</td>
<td>1. Examples of outstanding practice pertaining to GP access identified by the CQC will be collated and shared with practices.</td>
</tr>
<tr>
<td><strong>Communication between different services</strong></td>
<td>0</td>
<td>1. System-wide communications and engagement work is ongoing through Connecting Care.</td>
</tr>
<tr>
<td>Audiology not referring to ENT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GP to GP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GP not aware of Waterton Hub</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Theme Identified</td>
<td>Previous times as key theme in 2015</td>
<td>Key actions</td>
</tr>
<tr>
<td>------------------</td>
<td>-------------------------------------</td>
<td>-------------</td>
</tr>
</tbody>
</table>
| **A&E**<br>Long waits for admission and to see a doctor<br>Praise for staff attitude and quality of care received | 1 | 1. Rapid Clinical Assessment at Triage started in Pinderfields ED which is intended to ensure patients get seen by a doctor sooner.  
2. Patient Safety Walkabouts undertaken in November at Dewsbury and Pinderfields Emergency Departments.  
3. MYHT has started earlier ward rounds to help increase the number of discharges which happen earlier in the day.  
4. Breaking the Cycle Week held at MYHT from 11-18 November 2015 to improve patient flow. |
| **Waiting times for appointments and procedures**<br>MAT<br>LTHT (cardiology and vascular)<br>GP<br>SWYPFT | 2 | 1. MYHT provided action plans for each specialty failing the 18 week pathway standard.  
2. Examples of outstanding practice pertaining to GP access identified by the CQC will be collated and shared with practices.  
3. Discussion at relevant contracting boards. |
| **Maternity**<br>Staff attitude and treatment (positive and negative) | 1 | 1. Maternity clinical audit results to be shared at a future MYHT Executive Quality Board (EQB).  
2. MYHT EQB requested that data from the Trust’s Maternity Dashboard is shared at EQB to enhance monitoring of maternity services.  
3. Contrast with CQC Maternity Survey, which will be published in December 2015.  
4. Patient Safety Walkabout to Pinderfields maternity ward in December highlighted only positive patient experiences. |
<table>
<thead>
<tr>
<th>Provider</th>
<th>Outcomes</th>
<th>Current Status</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Toffee Medical Centre, Wakefield</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date of Inspection</td>
<td>Safe</td>
<td>Good</td>
</tr>
<tr>
<td>Review Type</td>
<td>Announced</td>
<td>Effective Good</td>
</tr>
<tr>
<td>Link to Report</td>
<td>Caring</td>
<td>Good</td>
</tr>
<tr>
<td></td>
<td>Responsive Good</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Well-led Good</td>
<td></td>
</tr>
<tr>
<td><strong>Overall rating</strong></td>
<td></td>
<td>Good</td>
</tr>
<tr>
<td><strong>Grapebridge Medical Centre</strong></td>
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</tr>
<tr>
<td>Date of Inspection</td>
<td>Safe</td>
<td>Good</td>
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<tr>
<td>Review Type</td>
<td>Announced</td>
<td>Effective Good</td>
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<tr>
<td>Link to Report</td>
<td>Caring</td>
<td>Good</td>
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<tr>
<td></td>
<td>Responsive Outstanding</td>
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<td>Well-led Outstanding</td>
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</tr>
<tr>
<td><strong>Overall rating</strong></td>
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<td>Outstanding</td>
</tr>
<tr>
<td><strong>The Friarwood Surgery, Pontefract</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date of Inspection</td>
<td>Safe</td>
<td>Good</td>
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<td>Review Type</td>
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<td>Well-led Outstanding</td>
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<tr>
<td><strong>Overall rating</strong></td>
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<td>Outstanding</td>
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<tr>
<td><strong>Lupset Health Centre, Wakefield</strong></td>
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<tr>
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</tr>
<tr>
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<tr>
<td></td>
<td>Responsive Good</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Well-led Good</td>
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<tr>
<td><strong>Overall rating</strong></td>
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## System Wide Quality Measures – Wider Primary Care
### CQC Inspection Report

<table>
<thead>
<tr>
<th>Provider</th>
<th>Outcomes</th>
<th>Current Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crofton and Sharlston Medical Practice</td>
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<td>Good</td>
</tr>
<tr>
<td>Date of Inspection</td>
<td>6 October 2015</td>
<td></td>
</tr>
<tr>
<td>Review Type</td>
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</tr>
<tr>
<td></td>
<td>Responsive</td>
<td>Good</td>
</tr>
<tr>
<td></td>
<td>Well-led</td>
<td>Good</td>
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<tr>
<td></td>
<td>Overall rating</td>
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<table>
<thead>
<tr>
<th>Provider</th>
<th>Outcomes</th>
<th>Current Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drs DP Diggle &amp; RE Phillips, South Kirkby</td>
<td>Safe</td>
<td>Good</td>
</tr>
<tr>
<td>Date of Inspection</td>
<td>29 September 2015</td>
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<td>Outstanding</td>
</tr>
<tr>
<td></td>
<td>Responsive</td>
<td>Good</td>
</tr>
<tr>
<td></td>
<td>Well-led</td>
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<td></td>
<td>Overall rating</td>
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<table>
<thead>
<tr>
<th>Provider</th>
<th>Outcomes</th>
<th>Current Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>White Rose Surgery, South Elmsall</td>
<td>Safe</td>
<td>Good</td>
</tr>
<tr>
<td>Date of Inspection</td>
<td>2 September 2015</td>
<td></td>
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<td>Link to Report</td>
<td>Caring</td>
<td>Good</td>
</tr>
<tr>
<td></td>
<td>Responsive</td>
<td>Outstanding</td>
</tr>
<tr>
<td></td>
<td>Well-led</td>
<td>Good</td>
</tr>
<tr>
<td></td>
<td>Overall rating</td>
<td>Outstanding</td>
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</table>

<table>
<thead>
<tr>
<th>Provider</th>
<th>Outcomes</th>
<th>Current Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>South Hiendley Surgery</td>
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<td>Good</td>
</tr>
<tr>
<td>Date of Inspection</td>
<td>3 September 2015</td>
<td></td>
</tr>
<tr>
<td>Review Type</td>
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<tr>
<td>Link to Report</td>
<td>Caring</td>
<td>Good</td>
</tr>
<tr>
<td>South Hiendley</td>
<td>Responsive</td>
<td>Good</td>
</tr>
<tr>
<td></td>
<td>Well-led</td>
<td>Good</td>
</tr>
<tr>
<td></td>
<td>Overall rating</td>
<td>Good</td>
</tr>
</tbody>
</table>

South Hiendley is part of White Rose Surgery and Rycroft Primary Care Centre, but registered with the CQC separately.
## System Wide Quality Measures – Wider Primary Care CQC Inspection Report

<table>
<thead>
<tr>
<th>Provider</th>
<th>Rycroft Primary Care Centre</th>
<th>Outcomes</th>
<th>Current Status</th>
</tr>
</thead>
<tbody>
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<td>Date of Inspection</td>
<td>3 September 2015</td>
<td>Safe</td>
<td>Good</td>
</tr>
<tr>
<td>Review Type</td>
<td>Announced</td>
<td>Effective</td>
<td>Good</td>
</tr>
<tr>
<td>Link to Report</td>
<td>Rycroft</td>
<td>Caring</td>
<td>Good</td>
</tr>
</tbody>
</table>

Rycroft is part of White Rose Surgery and South Hiendley Surgery, but registered with the CQC separately.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Responsive</th>
<th>Good</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Well-led</td>
<td>Good</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Overall rating</td>
<td>Good</td>
</tr>
</tbody>
</table>

The overall rating is Good.
## Access to the highest quality urgent and emergency care
### Additional support measures

<table>
<thead>
<tr>
<th>Provider</th>
<th>Indicator</th>
<th>Reporting Period</th>
<th>Target</th>
<th>2014/15 CCG Performance</th>
<th>Actual</th>
<th>YTD</th>
<th>FOT</th>
<th>From previous Month</th>
<th>Actual</th>
<th>YTD</th>
<th>FOT</th>
<th>Trend from previous Month</th>
<th>Clinical Lead</th>
<th>Commissioning Lead</th>
<th>Exception Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>MYHT</td>
<td>Emergency Readmissions</td>
<td>May</td>
<td>&lt;4.05%</td>
<td>Not reported at CCG Level</td>
<td>Not reported at CCG Level</td>
<td>Not reported at CCG Level</td>
<td>4.40%</td>
<td>4.05</td>
<td>4.05</td>
<td>↓</td>
<td>Dr AS</td>
<td>JF</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Emergency readmissions within 30 days following an elective or emergency spell</td>
<td>May</td>
<td>&lt;9.38%</td>
<td>Not reported at CCG Level</td>
<td>Not reported at CCG Level</td>
<td>Not reported at CCG Level</td>
<td>9.32%</td>
<td>9.28</td>
<td>9.28</td>
<td>↓</td>
<td>Dr AS</td>
<td>JF</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stroke</td>
<td>% patients scanned within 1 hour of arrival</td>
<td>Q1</td>
<td>50%</td>
<td>-</td>
<td>34.3%</td>
<td>34.3%</td>
<td>34.3%</td>
<td>↑</td>
<td>34.7%</td>
<td>34.7%</td>
<td>34.7%</td>
<td>↑</td>
<td>Dr AB</td>
<td>GR</td>
<td>Nov</td>
</tr>
<tr>
<td></td>
<td>% of patients admitted to stroke ward within 4 hours of arrival</td>
<td>Q1</td>
<td>58.7% nat av</td>
<td>-</td>
<td>63%</td>
<td>63%</td>
<td>63%</td>
<td>↑</td>
<td>61%</td>
<td>61%</td>
<td>61.0%</td>
<td>↑</td>
<td>Dr AB</td>
<td>GR</td>
<td>Nov</td>
</tr>
<tr>
<td>YAS 111 Performance</td>
<td>% of clinical call backs within 2 hours</td>
<td>Oct</td>
<td>95%</td>
<td>90.7%</td>
<td>83.2%</td>
<td>88.3%</td>
<td>88.3%</td>
<td>↓</td>
<td>84.1%</td>
<td>88.2%</td>
<td>88.2%</td>
<td>↓</td>
<td>Dr CJ</td>
<td>SR</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>% calls answered within 60 seconds</td>
<td>Oct</td>
<td>95%</td>
<td>92.7%</td>
<td>Not reported at CCG Level</td>
<td>Not reported at CCG Level</td>
<td>88.6%</td>
<td>92.9%</td>
<td>92.9%</td>
<td>↓</td>
<td>Dr CJ</td>
<td>SR</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>% of warm transfers or clinical call backs within 10 minutes</td>
<td>Oct</td>
<td>65%</td>
<td>49.9%</td>
<td>35.1%</td>
<td>37.5%</td>
<td>37.5%</td>
<td>↓</td>
<td>35%</td>
<td>36.4%</td>
<td>36.4%</td>
<td>↓</td>
<td>Dr CJ</td>
<td>SR</td>
<td>✓</td>
</tr>
<tr>
<td>YAS Out of Hours Performance</td>
<td>% Definitive Clinical Assessments in time</td>
<td>Oct</td>
<td>95%</td>
<td>87.2%</td>
<td>100%</td>
<td>97.6%</td>
<td>97.2%</td>
<td>↑</td>
<td>99.4%</td>
<td>98.9%</td>
<td>98.9%</td>
<td>↑</td>
<td>Dr AS</td>
<td>JF</td>
<td></td>
</tr>
<tr>
<td></td>
<td>% Emergency within 1 hour</td>
<td>Oct</td>
<td>95%</td>
<td>58.6%</td>
<td>58.2%</td>
<td>57.8%</td>
<td>57.8%</td>
<td>↓</td>
<td>55.1%</td>
<td>51.2%</td>
<td>50.5%</td>
<td>↑</td>
<td>Dr AS</td>
<td>JF</td>
<td></td>
</tr>
<tr>
<td></td>
<td>% Urgent within 2 hours</td>
<td>Oct</td>
<td>95%</td>
<td>76.9%</td>
<td>69.3%</td>
<td>72.4%</td>
<td>72.4%</td>
<td>↓</td>
<td>61.7%</td>
<td>64.7%</td>
<td>64.7%</td>
<td>↓</td>
<td>Dr AS</td>
<td>JF</td>
<td></td>
</tr>
<tr>
<td></td>
<td>% Less Urgent within 6 hours</td>
<td>Oct</td>
<td>95%</td>
<td>92.4%</td>
<td>95.3%</td>
<td>95.5%</td>
<td>95.5%</td>
<td>↓</td>
<td>92.3%</td>
<td>92.7%</td>
<td>92.7%</td>
<td>↓</td>
<td>Dr AS</td>
<td>JF</td>
<td></td>
</tr>
<tr>
<td>ST-elevation myocardial infarction</td>
<td>% of patients with STEMI who received an appropriate care bundle</td>
<td>Jun</td>
<td>78.1%</td>
<td>82.7%</td>
<td>Not reported at CCG Level</td>
<td>Not reported at CCG Level</td>
<td>85.1%</td>
<td>85.3%</td>
<td>85.3%</td>
<td>↑</td>
<td>Dr AS</td>
<td>JF</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>% of patients receiving primary angioplasty within 150 minutes.</td>
<td>Jun</td>
<td>85.5%</td>
<td>83.9%</td>
<td>Not reported at CCG Level</td>
<td>Not reported at CCG Level</td>
<td>84.8%</td>
<td>81.6%</td>
<td>81.6%</td>
<td>↑</td>
<td>Dr AS</td>
<td>JF</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiac arrest</td>
<td>% of patients who were discharged from hospital alive following resuscitation by ambulance service following a cardiac arrest</td>
<td>Jun</td>
<td>8.8%</td>
<td>10.6%</td>
<td>Not reported at CCG Level</td>
<td>Not reported at CCG Level</td>
<td>12.7%</td>
<td>10.6%</td>
<td>10.6%</td>
<td>↑</td>
<td>Dr AS</td>
<td>JF</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stroke</td>
<td>% of FAST positive patients potentially eligible for stroke thrombolysis arriving at a hyperacute stroke unit within 60 minutes of the call being received</td>
<td>Jun</td>
<td>59.8%</td>
<td>55.6%</td>
<td>Not reported at CCG Level</td>
<td>Not reported at CCG Level</td>
<td>53.6%</td>
<td>56.7%</td>
<td>56.7%</td>
<td>↓</td>
<td>Dr AS</td>
<td>JF</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff absence (YAS)</td>
<td>Trust absence rate</td>
<td>Oct</td>
<td>&lt;5%</td>
<td>5.9%</td>
<td>Not reported at CCG Level</td>
<td>Not reported at CCG Level</td>
<td>5.69%</td>
<td>5.79% (Sep 14-Oct 15)</td>
<td>↑</td>
<td>Dr AS</td>
<td>JF</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Access to the highest quality urgent and emergency care: Exception Report

<table>
<thead>
<tr>
<th>NHS Constitution Indicator</th>
<th>A&amp;E 4 hour waiting time standard - % Patients who spent 4 hours or less in A&amp;E</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator</td>
<td>Reporting Period</td>
</tr>
<tr>
<td>A&amp;E 4 hour waiting time standard</td>
<td>Oct</td>
</tr>
</tbody>
</table>

Description of underperformance identified:
Against the 95% target for patients waiting less than 4 hours in A&E there has been reported achievement of 82.7 % for October and 88.6% YTD.

Reason for underperformance:
A&E Attendances: MYHT continue to report increases and spikes in attendances during October 2015. There were a number of days that saw over 600 attendances and one day rose to almost 750 attendances.

Staffing: Nurse staffing recruitment remains an issue.

Intermediate care capacity in Wakefield: During a CQC visit to Kingsdale (28 bedded intermediate care unit) a number of concerns were raised in relation to; leadership on the unit, clinical oversight of patients and staffing levels and high agency usage. As a result of these concerns the unit has been closed to new admissions. This has resulted in reduced intermediate care capacity and an increase in delayed discharges for patients awaiting rehab or a step down bed. Waits for these beds remains to be the largest category of DTOC within the Trust. The Trust continues to have low numbers of daily discharges and regularly does not meet their internal target of 33% discharges by lunchtime. DTOC is showing signs of improvement.

Actions taken:
A&E Performance escalated within the CCG. Performance work stream underway between CCG's, MYHT and public health. A shared understanding of the data has now been developed and was presented to the System Resilience Group on 20 October. The SRG have asked for further work to be carried out on this by the Systems Intelligence Group. Work in ongoing on this data.

Trust Safe Staffing Policy
Implementation of Safe Staffing Escalation Policy which is recorded and actioned throughout daily bed meetings to ensure safety and continues to be reported monthly to the Trust Board. The safe staffing work stream is being implemented at pace following recommendations from the CQC visit. Recruitment is in progress and by February 2016 there should be an improvement in the number of vacancies (i.e. more registered nurses in post). Mechanisms have been put in place to ensure safe nurse staffing levels are achieved for Intermediate Care beds. All of the staffing levels were linked to the key Quality Improvement Strategy projects including falls and pressure ulcers.

Intermediate care: MYHT and Wakefield CCG have been working together to develop an intermediate care model to address reduced capacity. This was highlighted as a risk at the SRG meeting. An intermediate care workshop was also delivered by ECIST. Following surge teleconferences between MYHT, Wakefield CCG and wider SRG partners Wakefield CCG agreed to fund 10 step down beds for 28 days to facilitate flow. MYHT will be responsible for the case managements of patients with support from Wakefield Council social care.

Addressing delayed transfers of care work stream: This work stream continues to gain pace with a number of key actions; the fast track of an integrated discharge model between Mid Yorkshire Hospitals Trust and Wakefield Council. SRG funding has been provided to extend to 7 days service. A Standard Operating Procedure is being agreed between partners. - Completion and implementation of the Moving on Policy (support the reduction in choice patients waiting in hospitals) - source step down capacity for DTOC while Moving on Policy is implemented - rapid utilisation review of existing community stet down/up provision - implement the Care Closer 2 Home contract in North Kirklees CCG to mobilise increase flexible bed bases - mobilise the care home vanguard in Wakefield Delivery of SAFER care bundle: The Trust are implementing the SAFER care bundle which includes; - All patients to have a senior review before midday - All patients will have a clinically agreed expected date of discharge - 33% of patients to be discharged before midday - Develop a process for the systematic review of patients with and extended length of stay (>14 days)

MY SRG Winter Preparedness: The Mid Yorkshire SRG Surge and Escalation plan has been reviewed. System wide responses to surges in demand have been agreed. The Mid Yorkshire SRG winter plan is currently being finalised. The Breaking the Cycle project took place in November with all SRG involved partners, with review to follow. Further resilience actions are reported below.

The CCG has received the action plan to address underperformance from the Trust and this is being reviewed by the CCG.
The Emergency Care Improvement Programme (ECIP) is a clinically-led programme designed to offer challenged emergency care systems practical guidance and support to help them identify and implement actions to improve patient flow during the winter period and beyond.

Clinical research has shown that improving patient flow through emergency care systems can improve patient safety, access and outcomes this winter. Performance against the 4 hour standard can also be driven by performance at any stage along the emergency care pathway therefore during Q3 2015 the ECIP team have been working with all key stakeholders across the Mid Yorkshire footprint to systematically review all aspects of the local Urgent Care Pathway.

The team are in the process of finalising their preliminary report with a view to this being circulated to all members of the Mid Yorkshire Systems Resilience Group week commencing 14 December 2015. ECIP leads will also be attending the next meeting of the Mid Yorkshire Systems Resilience Group to further discuss their findings, review progress to date and to agree the priorities for action which are critical to improving patient flow. In advance of this examples of areas the team have highlighted which require further improvement are as follows:

- Agree and finalise Emergency Department primary care stream model and implement as soon as possible;
- Emergency Department clinics need to be phased out as soon as possible;
- Access to on site Psychiatric liaison is extremely efficient but the pathway for admission to a bed requires further review in order to minimise delays;
- System wide review of intermediate tier capacity is required; and
- The SAFER care bundle needs to be systematically implemented across all sites and wards with a view to significantly increasing the number of discharges before mid day;

It is important to note the above list is not exhaustive and some of the ECIP team recommendations are already underway. The ECIP report, recommendation and progress will also be shared with members for consideration at their next meeting.

A&E - 4hr target

![A&E - 4hr target chart](chart-image-url)
Access to the highest quality urgent and emergency care: Exception Report

**NHS Constitution Indicator**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Reporting Period</th>
<th>Target</th>
<th>2014/15 CCG Performance</th>
<th>Actual</th>
<th>YTD</th>
<th>FOT</th>
<th>From previous Month</th>
<th>Actual</th>
<th>YTD</th>
<th>FOT</th>
<th>Trend from previous Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Trust - Turnaround Time</td>
<td>All handovers between ambulance and A&amp;E should take place within 15 mins</td>
<td>Oct</td>
<td>100%</td>
<td>-</td>
<td>Not reported at CCG Level</td>
<td>Not reported at CCG Level</td>
<td>-</td>
<td>65.2%</td>
<td>Not Reported at Provider Level</td>
<td>Not Reported at Provider Level</td>
<td>↓</td>
</tr>
</tbody>
</table>

**Description of underperformance identified**

There were a total of 3,889 handovers across the three MYHT A&E locations in October, achieving 65.2% a worsened position on previous months. There were 7 handovers waiting over 2 hours.

**Reason for Underperformance**

The individual site performance within MYHT identifies Pinderfields as a significant contributor to the Trust level performance not being achieved. However, October saw a worsening performance at all three sites.

Dewsbury – 82.2%
Pinderfields – 57%
Pontefract – 92%

The four main reasons for the majority of the breaches are as follows:

- Clinical staff availability for handovers
- No available cubicles (specifically in Pinderfields and Dewsbury)
- Difficulty in achieving the 100% target
- Data capture

The reasons for low performance levels are multi-faceted and are strongly linked to reduced patient flow through the acute trust, which causes overcrowding and pressure in A&E. This affects their ability to support YAS with handover, both in terms of clinical availability and cubicle space. Subsequently there is a link between this area of performance and the MYHT recovery plan for A&E performance which they have submitted to the Trust Development Agency (TDA).

**Actions taken**

MYHT, in particular Pinderfields, has been identified by lead commissioners and YAS as a site requiring extra support. Actions are being developed which build on the previous work undertaken by the lead consultant for emergency medicine and lead paramedic. That work consisted of a review of over 60 cases attending PGH and the design of a more detailed self-handover protocol to be undertaken at PGH.

There are further and sustained attempts, within the context of A&E performance, for:

- YAS to improve the use of the new self-handover, a protocol to improve the number of patients this relates to has been approved through YAS governance arrangements.
- Identification of cases which could be handed-over in a wheel chair to nurses – therefore not limited by waiting for a cubicle, and free up crews to make them selves ready
- Encourage staff to proactively liaise with each other from both MYHT and YAS to facilitate smoother process
- YAS to work with paramedics on education around alternative pathways e.g. falls pathways, to increase their utilisation and avoid transfer to Emergency Department altogether
- YAS and ED to reinforce with staff the need to complete the handover screen to capture data accurately
- YAS have set up remote tracking of the number of crews waiting at Pinderfields, once this escalates supervisors attend to assist with improving the position
- As available YAS are providing hospital liaison officers on site at PGH to support the handover process
- Over winter locality team leaders will be on operational only duty as part of the winter plan and will have a greater presence on site.

Recognition of issues with patient flow which impact on flow through ED and therefore availability of nursing staff and cubicles for handover will be picked up through the Health economy wide action plan and through patient safety walk about in ED being organised as part of the ECST work and Help me Home week.
Access to the highest quality urgent and emergency care: Exception Report

**NHS Constitution Indicator**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Reporting Period</th>
<th>Target</th>
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<th>YTD</th>
<th>FOT</th>
<th>From previous Month</th>
<th>Actual</th>
<th>YTD</th>
<th>FOT</th>
<th>Trend from previous Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance - Turnaround Time</td>
<td>Oct</td>
<td>100%</td>
<td>-</td>
<td>Not reported at CCG Level</td>
<td>Not reported at CCG Level</td>
<td>85.9%</td>
<td></td>
<td>Not Reported at Provider Level</td>
<td>Not Reported at Provider Level</td>
<td>↑</td>
<td></td>
</tr>
</tbody>
</table>

**Description of underperformance identified:**

There were a total of 3,574 completed handovers completed across the three MYHT A&E locations. ‘Wrap-up’ times remain high compared to some other areas in Yorkshire and Humber.

**Reason for Underperformance**

The individual site performance is shown below;

- Dewsbury – 80.4%
- Pinderfields – 88.3%
- Pontefract – 88.0%

The individual site performance has improved from last month. This is probably as a result of the longer waits for handover.

**Actions taken**

See previous exception report for details.

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**All crews should be ready to new accept calls**

- **Action Plan in Place**: Yes
- **Risk Register ID**: 427
- **Clinical Lead**: Dr Adam Sheppard
- **Commissioning Lead**: Jenny Feeley
- **CCG Assurance**: MYHT Executive Contract Board
Access to the highest quality urgent and emergency care: Exception Report

### NHS Constitution Indicator

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Reporting Period</th>
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<th>YTD</th>
<th>FOT</th>
<th>Trend from previous Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance response times</td>
<td>Oct</td>
<td>75%</td>
<td>72.5%</td>
<td>81.8%</td>
<td>75.8%</td>
<td>75.8%</td>
<td></td>
<td>73.7%</td>
<td>71.6%</td>
<td>71.6%</td>
<td>↑</td>
</tr>
<tr>
<td>Cat A (Red 2) 8 min response time</td>
<td>Oct</td>
<td>75%</td>
<td>69.9%</td>
<td>75.9%</td>
<td>73.6%</td>
<td>73.6%</td>
<td></td>
<td>72.5%</td>
<td>71.6%</td>
<td>71.6%</td>
<td>↑</td>
</tr>
</tbody>
</table>

### Description of underperformance identified

Position October 2015, the CCG achieved a performance of 81.8% and 75.9% against a target of 75% for Cat A Red 1 and Red 2 (8 Minute) response times respectively. This is an improvement on previous months.

### Reason for Underperformance

The Trust have been unable to deliver YTD the operational performance standard, at the contract or at an individual WCCG level.

There are two main factors that the Trust cite as contributing to the underperformance:
- An employee resource gap
- The impact of rota changes

For information Cat A (Red 1) relates to patients with cardiac or breathing symptoms; Cat A (Red 2) relates to other all emergencies.

### Actions taken

The CCG continue to support YAS to review and implement their workforce plan, to minimise staffing gaps. YAS performance is negatively affected by lack of staff resource and paramedic attrition. Recruitment drive has seen some increase in staffing but workforce numbers will still fall short of planned establishment. This is due to there being a lack of paramedics trained nationally. YAS are also addressing the paramedic shortage by internally upskilling other clinical staff. Rotas are currently supported by overtime and management covering shifts.

Commissioners requested formal remedial action plan linked to the improvement trajectory which was supplied in September. This plan did not show a performance increase to 75%, and therefore a performance summit was held on 19th October. Discussion occurred around the ongoing schemes and recruitment plans to help with meeting performance. In addition it was noted that Red demand has increased; further analysis of this shows a specific increase in HC red calls. An action was taken away by commissioners and YAS to review this demand in detail, which is currently being undertaken.

Throughout the year commissioners have supported YAS through:-
- Financial investment in clinical ‘floor-walkers’ in NHS 111, frequent callers scheme and mental health professionals with the EOC
- Invested growth monies of £5.8m to support existing initiatives to manage ambulance demand.

YAS have progressed with the contracting of additional independent sector resource (additional 30 paramedic crews and vehicles). YAS have put in place a stringent processes to ensure high governance and safety standards. These crews undertake green activity, releasing YAS crews to concentrate on the red activity. Locally these have been deployed in Wakefield, Leeds and Bradford.

Winter resilience plans have been developed and shared with all CCG SRG leads. This plan includes actions for managing days known to have exceptional pressures (E.G Friday before Christmas).

YAS are now a pilot site for the national Ambulance Response Programme system which allows call handlers to ensure an appropriate resource is sent based on the patients condition. As this is a national pilot the impact on performance is not yet known but this could be a contributing factor to improved performance.
Mental Health Service Transformation: Exception Report

NHS Constitution Indicator

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Reporting Period</th>
<th>Target 2014/15 CCG Performance</th>
<th>2014/15 CCG Performance</th>
<th>Actual</th>
<th>YTD</th>
<th>FOT</th>
<th>Description of underperformance identified:</th>
<th>Reason for Underperformance</th>
<th>Actions taken</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improving Access to Psychological Therapies</td>
<td>Q1</td>
<td>3.75% per/q</td>
<td>2.15%</td>
<td>4.92%</td>
<td>4.92%</td>
<td>No previous data</td>
<td>A total of 1156 people entered treatment during Q2, against a target of 1567. On a cumulative basis the total target of those entering treatment has fallen short by 2.58% of the required Q1-2 total.</td>
<td>Underperformance has occurred due to the following reasons:</td>
<td>The following mitigating actions have been put in place:</td>
</tr>
<tr>
<td>Improving Access to Psychological Therapies</td>
<td>Q2</td>
<td>3.75% per/q</td>
<td>2.77%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Reduced number of referrals being received at an early stage of intervention</td>
<td>• Development of a rolling workshop programme</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Low attendance at direct access workshops during the quarter</td>
<td>• Drop in workshops every month in Wakefield all day at the Elizabethan Gallery</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Lack of capacity to deliver Step 3 therapy</td>
<td>• Increased advertising of the service including leaflets, radio slots and targeted events</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Maximising staff contacts</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Promoting and maximising links with GPs</td>
</tr>
</tbody>
</table>

These actions are currently in place and are starting to produce the required improved access, as can be seen from the improvement against the Q1 position above.

IAPT – Entering Treatment (By Quarter)

IAPT – Entering Treatment (Cumulative)
A step change in the productivity of elective care: Exception Report

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Reporting Period</th>
<th>Target</th>
<th>2014/15 CCG Performance</th>
<th>Actual</th>
<th>YTD</th>
<th>FOT</th>
<th>From previous Month</th>
<th>Actual</th>
<th>YTD</th>
<th>FOT</th>
<th>Trend from previous Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>18 Week RTT Waiting Time Standard</td>
<td>Oct</td>
<td>92.0%</td>
<td>91.6%</td>
<td>88.1%</td>
<td>90.7%</td>
<td>90.7%</td>
<td>↓</td>
<td>86.4%</td>
<td>89.7%</td>
<td>89.7%</td>
<td>↓</td>
</tr>
</tbody>
</table>

**Description of underperformance identified:**
18 week RTT incomplete pathways has not met the required standard for the fourth month this year and is below target YTD.

**Reason for Underperformance**
Underperformance has been reported in a number of specialties as follows (arrows indicate whether performance is higher or lower than previous month):
- General Surgery: 85.7% ↑
- Urology: 83.1% ↓
- T&O: 80.8% ↓
- ENT: 77.4% ↓
- Ophthalmology: 86.5% ↓
- Oral Surgery: 86.7% ↑
- Plastic Surgery: 81.7% ↓
- General Medicine: 83.1% ↓
- Gastroenterology: 91.7% NEW
- Cardiology: 91.7% NEW
- Thoracic Medicine: 87.9% ↓
- Neurology: 75.4% ↓
- Rheumatology: 90.2% NEW
- Gynaecology: 89.7% ↑
- Other: 90.9% NEW

Geriatric Medicine has recovered the position in the October data. Reason for underperformance cited as demand and capacity issues, as well as the inability to close down and complete pathways. The data reported by MYHT indicates that the same specialties continue to fail the required standard.

**Actions taken**
Response received from MYHT with detailed action plans for each specialty currently failing the 18 week pathway standard. These include trajectories for recovery and actions to improve performance. Update on these action plans is being confirmed with MYHT. Recovery to 92% is forecast for March 2016. Trauma and Orthopaedics are yet to submit a trajectory. Regular meetings are ongoing with MYHT to monitor the activity and discuss the implementation of the actions. However, the impact of the NHSE/TDA requirement to improve winter capacity for three weeks commencing 21st December 2015 by reducing elective activity is still being worked through.

**RTT Incomplete**

![RTT Incomplete Chart](image)
A step change in the productivity of elective care: Exception Report

NHS Constitution Indicator | Number of 52 Week Referral to Treatment Pathways

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Reporting Period</th>
<th>Target</th>
<th>2014/15 CCG Performance</th>
<th>Actual</th>
<th>YTD</th>
<th>FOT</th>
<th>From previous Month</th>
<th>Actual</th>
<th>YTD</th>
<th>FOT</th>
<th>Trend from previous Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of 52 Week Referral to Treatment Pathways</td>
<td>Oct</td>
<td>0</td>
<td>22</td>
<td>0</td>
<td>7*</td>
<td>7</td>
<td>↔</td>
<td>0</td>
<td>8</td>
<td>8</td>
<td>↑</td>
</tr>
</tbody>
</table>

Description of underperformance identified:
Although there have been no further 52 week pathway breaches in October 2015, there have been 7 breaches year to date. However verbal update from MYHT indicates that there have been 8 breaches all attributable to WCCG. The difference in data is due to a time lag in the update of Unify data.

Reason for Underperformance
Seven breaches have been formally identified as being attributable to the CCG, with a further one confirmed verbally. Details are as follows:

- One patient in Trauma and Orthopaedics; patient treated and discharged
- One patient in Plastics; patient treated
- Six patients in Community Paediatrics (awaiting Autism Assessment); all patients now treated

All patients have now been treated. All patients were identified as belonging to WCCG.

Actions taken
Full waiting list validation has been undertaken on patients within Community Paediatrics and no further breaches are anticipated.

52 Week Waits

Action Plan in Place: Yes
Risk Register ID: 734
Clinical Lead: Dr Patrick Wynn
Commissioning Lead: Pat Keane
CCG Assurance: MYHT Executive Contract Board

BI data showing seven 52 week breaches; however verbal confirmation from MYHT has confirmed there are eight 52 week breaches all attributable to WCCG. This is due to a time lag in the update of Unify data available for viewing by the CCG which in turn updates the BI data.
### NHS Constitution Indicator: Diagnostic test waiting times

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Reporting Period</th>
<th>Target</th>
<th>2014/15 CCG Performance</th>
<th>Actual CCG Performance</th>
<th>YTD CCG Performance</th>
<th>FOT CCG Performance</th>
<th>From previous Month</th>
<th>Actual MYHT Performance</th>
<th>YTD MYHT Performance</th>
<th>FOT MYHT Performance</th>
<th>Trend from previous Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic test waiting times</td>
<td>Oct</td>
<td>99%</td>
<td>99.7%</td>
<td>97.5%</td>
<td>98.8%</td>
<td>98.8%</td>
<td>↓</td>
<td>97.5%</td>
<td>98.9%</td>
<td>98.9%</td>
<td>↓</td>
</tr>
</tbody>
</table>

### Description of underperformance identified:

The diagnostic test waiting time standard has not been met for the third month this financial year. YTD position is also showing as not achieved.

### Reason for Underperformance

Although a number of Trusts are contributing to the underperformance, the majority of breaches have occurred at MYHT:

- **Mid Yorkshire:** Audiology; 19 breaches
  - Neurophysiology; 78 breaches
  - Cystoscopy; 4 breaches
- **Leeds Teaching Hospitals:** Magnetic Resonance Imaging; 2 breaches
  - Colonoscopy; 1 breach
- **Sheffield Teaching Hospitals:** Colonoscopy; 1 breach
  - Gastroscopy; 1 breach

The majority of the underperformance is from breaches at MYHT. Reasons cited for this are consultant vacancies, specifically within the neurophysiology division. The issues associated with the MYHT diagnostic performance have been raised through the Executive Contract Board and rectification plans requested. Further to this, WCCG colleagues are seeking similar assurances from associate contractors that are also reporting underperformance.

### Actions taken

Action plans are in place at MYHT with consultant posts expected to be filled in the next few months. MYHT have projected that the standard will be met in January 2016.
A step change in the productivity of elective care: Exception Report
NHS 111

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Period</th>
<th>Target</th>
<th>2014/15</th>
<th>Month</th>
<th>YTD</th>
<th>Previous Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>% calls answered within 60 seconds – (Trust, not reported at CCG level)</td>
<td>Oct-15</td>
<td>95%</td>
<td>92.7%</td>
<td>88.6%</td>
<td>92.9%</td>
<td>✔️ ✔️ ✔️ ✔️ ✔️</td>
</tr>
<tr>
<td>% warm transfer or clinical call back within 10 minutes (NHS Wakefield CCG)</td>
<td>Oct 15</td>
<td>65%</td>
<td>49.9%</td>
<td>35.1%</td>
<td>37.5%</td>
<td>✔️ ✔️ ✔️ ✔️ ✔️</td>
</tr>
<tr>
<td>% clinical call backs within 2 hours (NHS Wakefield CCG)</td>
<td>Oct-15</td>
<td>95%</td>
<td>90.7%</td>
<td>83.2%</td>
<td>88.3%</td>
<td>✔️ ✔️ ✔️ ✔️ ✔️</td>
</tr>
</tbody>
</table>

**Description of underperformance:** The percentage of calls answered within 60 seconds in October dipped to its lowest level since December 2014. Since January 2015 YAS has performed better than the national average in 7/10 months on this measure. A warm transfer is when a call is transferred directly to a 111 clinician, rather than being placed in a call back queue. The targets for warm transfer or call back within 10 minutes and clinical call back within 2 hours have been locally agreed with commissioners. 80% of patients are managed in one call by a non-clinical handler. The remaining calls need to be transferred to a 111 clinician.

**Reason for underperformance**
Staffing issues have contributed to a dip in performance. Available time of call handlers and clinicians working in the call centre was 9.2% below planned levels in October 2015. This was largely due to 20 whole time equivalent staff receiving induction training throughout the month. This downward trend started in September 2015 when the total handling time worked by call handlers reduced to 769,243 minutes, which coincided with a significant dip in the percentage of calls answered within 60 seconds. This was the lowest total handling time worked by called handlers since February 2014. Recruiting and retaining clinical staff to meet warm transfer and call back targets is challenging for YAS. Prior to the start of the current recruitment campaign YAS were 15 whole time equivalent clinical advisors short of the budgeted levels. When patients are waiting longer for a clinical call back, there is often results in more patients phoning 111 to chase the call back, which consumes the time of call handlers.

**Data sources:** NHS England 111 Dashboard, YAS Integrated Performance Report, YAS 111 Dashboard

**Actions to be taken**
YAS has created Band 6 Clinical advisor roles to aid recruitment and retention. YAS has launched a campaign for clinical advisors, including radio advertisements. Urgent calls are prioritised for call backs. This was discussed at the NHS 111 West Yorkshire Clinical Quality Group on 17 December 2015. YAS confirmed that performance improved in November 2015.

---

**Action Plan in Place**
- **Clinical Lead**: Dr Chris Jones
- **Commissioning Lead**: Simon Rowe
- **Executive Lead**: Jo Pollard
- **CCG Assurance**: 111 West Yorkshire Clinical Quality Group
## Mental Health service transformation

### Provider - SWYPFT

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Reporting Period</th>
<th>Target</th>
<th>2014/15 Performance</th>
<th>From previous Month</th>
<th>Clinical Lead</th>
<th>Commissioning Lead</th>
<th>Exception Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access Source: SWYPFT</td>
<td>Sep</td>
<td>7.5%</td>
<td>4.0%</td>
<td>1.8%</td>
<td>1.9%</td>
<td>↓</td>
<td>Dr CH</td>
</tr>
<tr>
<td>Care Programme Approach (CPA) Source: SWYPFT</td>
<td>Sep</td>
<td>95%</td>
<td>99.4%</td>
<td>96.1%</td>
<td>96.5%</td>
<td>↑</td>
<td>Dr CH</td>
</tr>
<tr>
<td>Friends and Family Test – Staff Source: NHS England</td>
<td>Sep</td>
<td>95%</td>
<td>98.1%</td>
<td>98.4%</td>
<td>95.1%</td>
<td>↑</td>
<td>Dr CH</td>
</tr>
<tr>
<td>Staffing (SWYPFT)</td>
<td>Jul</td>
<td>&lt;4.4%</td>
<td>4.8%</td>
<td>4.9%</td>
<td>4.9%</td>
<td>↓</td>
<td>Dr CH</td>
</tr>
<tr>
<td>Premature Mortality Source: NHS England</td>
<td>2012/13</td>
<td>&lt;1316</td>
<td>1,560</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NHS Safety Thermometer</td>
<td>Oct</td>
<td>&lt;3% (nat av)</td>
<td>3.2%</td>
<td>2.4%</td>
<td>3.5%</td>
<td>↑</td>
<td>Dr CH</td>
</tr>
<tr>
<td>NHS Safety Thermometer</td>
<td>Oct</td>
<td>84.8% (nat av)</td>
<td>83.9%</td>
<td>88.7%</td>
<td>86.4%</td>
<td>↑</td>
<td>Dr CH</td>
</tr>
<tr>
<td>NHS Safety Thermometer</td>
<td>Oct</td>
<td>&lt;1.4% (nat av)</td>
<td>1.4%</td>
<td>0.8%</td>
<td>1.3%</td>
<td>↑</td>
<td>Dr CH</td>
</tr>
<tr>
<td>NHS Safety Thermometer</td>
<td>Oct</td>
<td>&lt;12.5% (nat av)</td>
<td>12.9%</td>
<td>15.4%</td>
<td>12.2%</td>
<td>↓</td>
<td>Dr CH</td>
</tr>
<tr>
<td>NHS Safety Thermometer</td>
<td>Oct</td>
<td>88.1% (nat av)</td>
<td>90.7%</td>
<td>92.5%</td>
<td>90.3%</td>
<td>↑</td>
<td>Dr CH</td>
</tr>
</tbody>
</table>

The Safety Thermometer is a point of care survey carried out on a single day each month on all appropriate patients.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Reporting Period</th>
<th>Target</th>
<th>2013/14 Performance</th>
<th>From previous Month</th>
<th>Clinical Lead</th>
<th>Commissioning Lead</th>
<th>Exception Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dementia Diagnosis rate</td>
<td>Mar</td>
<td>67%</td>
<td>68.4%</td>
<td></td>
<td></td>
<td>↑</td>
<td>Dr CH</td>
</tr>
</tbody>
</table>

### WCCG

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Reporting Period</th>
<th>Target</th>
<th>2013/14 Performance</th>
<th>From previous Month</th>
<th>Clinical Lead</th>
<th>Commissioning Lead</th>
<th>Exception Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dementia Diagnosis rate</td>
<td>Mar</td>
<td>67%</td>
<td>68.4%</td>
<td></td>
<td></td>
<td>↑</td>
<td>Dr CH</td>
</tr>
</tbody>
</table>

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**NHS Safety Thermometer**

- Proportion of patients that have self harmed in the last 72 hours
- Proportion of patients that report feeling safe at the point of survey
- Proportion of patients that have been the victim of violence/aggression in the last 72 hours
- Proportion of patients that have had an omission of medication in the last 24 hours
- Proportion of patients with 'harm free' care (patients that did not self harm, do not feel unsafe, have not been a victim of violence or aggression and in Inpatient settings have not been restrained)

**WCCG Trend Information**

- **Dementia Diagnosis rate**: % of people with formal diagnosis of estimated number of people with dementia
Mental Health service transformation

• The CQC has published the results of the Community Mental Health Survey for SWYPFT. People who received care or treatment for a mental health condition from September 2014 – November 2014 were eligible. People only seen once for an assessment, current inpatients and people receiving treatment for primary conditions such as drug and alcohol abuse, learning disability services and specialist forensic services were excluded.

• 850 surveys were distributed to SWYPFT service users. 232 responses were received. 33 questions were asked and grouped in the categories listed below.

<table>
<thead>
<tr>
<th>Category</th>
<th>Score 2014</th>
<th>Score 2015</th>
<th>Compared with other trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health and social care workers</td>
<td>7.9/10</td>
<td>8.0/10</td>
<td>About the same</td>
</tr>
<tr>
<td>Organising care</td>
<td>8.6/10</td>
<td>8.5/10</td>
<td>About the same</td>
</tr>
<tr>
<td>Planning care</td>
<td>7.1/10</td>
<td>7.3/10</td>
<td>About the same</td>
</tr>
<tr>
<td>Reviewing care</td>
<td>7.3/10</td>
<td>7.7/10</td>
<td>About the same</td>
</tr>
<tr>
<td>Changes in who people see</td>
<td>6.3/10</td>
<td>6.5/10</td>
<td>About the same</td>
</tr>
<tr>
<td>Crisis care</td>
<td>6.8/10</td>
<td>6.2/10</td>
<td>About the same</td>
</tr>
<tr>
<td>Treatments</td>
<td>7.5/10</td>
<td>7.4/10</td>
<td>About the same</td>
</tr>
<tr>
<td>Other areas of life</td>
<td>4.9/10</td>
<td>5.3/10</td>
<td>About the same</td>
</tr>
<tr>
<td>Overall views and experience</td>
<td>7.7/10</td>
<td>7.7/10</td>
<td>About the same</td>
</tr>
<tr>
<td>Overall experience</td>
<td>7.5/10</td>
<td>7.3/10</td>
<td>About the same</td>
</tr>
</tbody>
</table>

• SWYPFT performed better than other trusts on the following questions:
  – for those told who is in charge of organising their care, that this person organises the care and services they need well
  – for feeling that they were treated with respect and dignity by NHS mental health services

• SWYPFT received scores of 5/10 or less on the following questions:
  – Help finding support for financial advice or benefits
  – Help finding support for finding or keeping work
  – Help finding support for finding or keeping accommodation
  – Local activities
  – Information on support from others

Action: The survey findings will be discussed at the next SWYPFT Quality Board on 12 February 2016 and at the local Mental Health Transformation Board,
## Maternity, children and young people transformation

<table>
<thead>
<tr>
<th>Provider</th>
<th>Indicator</th>
<th>Reporting Period</th>
<th>Target</th>
<th>2014/15 CCG Performance</th>
<th>Trend Information</th>
<th>Provider Indicator Reporting</th>
<th>Previous months score card</th>
<th>Actual</th>
<th>YTD</th>
<th>FOT</th>
<th>Trend</th>
<th>D.A.</th>
</tr>
</thead>
<tbody>
<tr>
<td>MYHT</td>
<td>C-section (MYHT Integrated Performance Report)</td>
<td>Oct</td>
<td>&lt;16%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>16%</td>
</tr>
<tr>
<td></td>
<td>Emergency C-section rate (%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>15%</td>
</tr>
<tr>
<td></td>
<td>Breast Feeding Initiation (NHS England)</td>
<td>Q1</td>
<td>60%</td>
<td>63.9% 62.1% 62.1% 62.1%</td>
<td>↓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>66.2%</td>
</tr>
<tr>
<td></td>
<td>Initiation of breast feeding</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>66.2%</td>
</tr>
<tr>
<td></td>
<td>Breast Feeding at 6 weeks (NHS England)</td>
<td>Q1</td>
<td>36%</td>
<td>32.8% 32.6% 32.6% 32.86%</td>
<td>↓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>66.2%</td>
</tr>
<tr>
<td></td>
<td>% infants totally or partially breast fed at 6 weeks</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>66.2%</td>
</tr>
</tbody>
</table>
System Wide Quality Measures - organising ourselves

Exception Report: Smoking at the time of delivery

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Period</th>
<th>Target</th>
<th>2014/15</th>
<th>Month</th>
<th>YTD</th>
<th>Previous Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of mothers smoking at the time of delivery (NHS Wakefield CCG)</td>
<td>Q1</td>
<td>&lt;19%</td>
<td>19.7%</td>
<td>19.1%</td>
<td>19.1%</td>
<td></td>
</tr>
</tbody>
</table>

**Description of underperformance:** In 2015/16 the target reduced to <19% from <23% in 2014/15. Performance improved to 19.1% in Q1 from 21.7% in the previous quarter. In Q1 174/911 women were smoking at the time of delivery.

**Reason for underperformance**

Smoking in pregnancy was identified as a priority for 6 out of 7 Networks in 2015/16 and a CQUIN has been put in place with MYHT midwifery services however, work undertaken may not yet have impacted on the figures and there is evidence that referrals to the stop smoking service have in fact decreased.

**Actions to be taken**

- Establishment of an active District task group and action plan
- 55 new Carbon monoxide monitors were purchased for the midwifery service in April.
- Midwives have received additional refresher training on smoking cessation over the summer.
- An information leaflet targeted at young women has been produced following research commissioned by Diva – these leaflets have recently been distributed to GP practices
- Practices have all been offered training from the Stop Smoking service

**Actions Plan in Place**

<table>
<thead>
<tr>
<th>Action Plan in Place</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commissioning Lead</td>
<td>Michelle Ezro</td>
</tr>
<tr>
<td>Executive Lead</td>
<td>Andrew Furber</td>
</tr>
<tr>
<td>CCG Assurance</td>
<td>MYHT Executive Quality Board</td>
</tr>
</tbody>
</table>
## System Wide Quality Measures - organising ourselves

### Additional support measures

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Reporting Period</th>
<th>Target</th>
<th>2014/15 Performance</th>
<th>MYHT</th>
<th>Trend Information</th>
<th>D.A.</th>
<th>Clinical Lead</th>
<th>Commissioing Lead</th>
<th>Exception Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>System Wide Quality Measures</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Organising ourselves</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td><strong>Additional support measures</strong></td>
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<td>MYHT Trend Information</td>
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<td>Information</td>
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<tr>
<td>Indicator (Source: MYHT Trust Board Performance Report unless indicated)</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Venous Thromboembolism % patients risk assessed</td>
<td>Sep</td>
<td>95%</td>
<td>95.80%</td>
<td>95.1%</td>
<td>95.4%down</td>
<td></td>
<td>Dr PW</td>
<td>LE</td>
<td></td>
</tr>
<tr>
<td>Harm free care % patients receiving harm free care</td>
<td>Oct</td>
<td>95%</td>
<td>92.94%</td>
<td>94.16%</td>
<td>94.23%down</td>
<td></td>
<td>Dr PW</td>
<td>LE</td>
<td></td>
</tr>
<tr>
<td>Harm free care % of patients suffering new harm</td>
<td>Oct</td>
<td>&lt;2.8%</td>
<td>-</td>
<td>2.44%</td>
<td>2.49%down</td>
<td></td>
<td>Dr PW</td>
<td>LE</td>
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</tr>
<tr>
<td>Never Events Number of never events</td>
<td>Nov</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td></td>
<td>Dr PW</td>
<td>LE</td>
<td></td>
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<tr>
<td>Serious Incidents Number of open serious incidents</td>
<td>Nov</td>
<td>-</td>
<td>-</td>
<td>78</td>
<td>down</td>
<td></td>
<td>Dr PW</td>
<td>LE</td>
<td></td>
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<tr>
<td>Serious Incidents Number of new serious incidents for month</td>
<td>Nov</td>
<td>-</td>
<td>276</td>
<td>3</td>
<td>113</td>
<td>down</td>
<td>Dr PW</td>
<td>LE</td>
<td></td>
</tr>
<tr>
<td>Patient Safety Incidents (acute services) Proportion of patient safety incidents that are harmful</td>
<td>Oct</td>
<td>&lt;29%</td>
<td>-</td>
<td>21.7%</td>
<td>27.2%up</td>
<td></td>
<td>Dr PW</td>
<td>LE</td>
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<tr>
<td>Patient Safety Incidents (community services) Proportion of patient safety incidents that are harmful</td>
<td>Oct</td>
<td>&lt;29%</td>
<td>-</td>
<td>54.4%</td>
<td>63.8%up</td>
<td></td>
<td>Dr PW</td>
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<tr>
<td>Summary Hospital Mortality Indicator SHMI score (Source: Health and Social Care Information Centre)</td>
<td>Apr 14 – Mar 15</td>
<td>&lt;1</td>
<td>-</td>
<td>0.887</td>
<td>down</td>
<td></td>
<td>Dr PW</td>
<td>LE</td>
<td>✓</td>
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<tr>
<td>Hospital Standard Mortality Rate HSMR (elective and emergency admissions)</td>
<td>Aug</td>
<td>&lt;100</td>
<td>-</td>
<td>92.62</td>
<td>98.90down</td>
<td></td>
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<tr>
<td>Hospital Standard Mortality Rate HSMR - weekend</td>
<td>Aug</td>
<td>&lt;100</td>
<td>118.2</td>
<td>79.67</td>
<td>103.66up</td>
<td></td>
<td>Dr PW</td>
<td>LE</td>
<td></td>
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<tr>
<td>Absence Total sickness rate</td>
<td>Sep</td>
<td>&lt;4%</td>
<td>4.80%</td>
<td>4.36%</td>
<td>4.66%up</td>
<td></td>
<td>Dr PW</td>
<td>JP</td>
<td></td>
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<tr>
<td>MYHT nurse vacancies WTE Registered Nurse vacancies</td>
<td>Oct</td>
<td>37 (5%)</td>
<td>-</td>
<td>107.99</td>
<td>WTE</td>
<td>up</td>
<td>Dr PW</td>
<td>JP</td>
<td>✓</td>
</tr>
<tr>
<td>Surgery nurse vacancies WTE Registered Nurse vacancies</td>
<td>Oct</td>
<td>&lt;15 (5%)</td>
<td>-</td>
<td>15.17 WTE</td>
<td></td>
<td>up</td>
<td>Dr PW</td>
<td>JP</td>
<td>✓</td>
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<tr>
<td>Medicine nurse vacancies WTE Registered Nurse vacancies</td>
<td>Oct</td>
<td>&lt;22 (5%)</td>
<td>-</td>
<td>88.12 WTE</td>
<td></td>
<td>down</td>
<td>Dr PW</td>
<td>JP</td>
<td>✓</td>
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<tr>
<td>Staff turnover Turnover rate (monthly)</td>
<td>Sep</td>
<td>&lt;1%</td>
<td>-</td>
<td>0.9</td>
<td>up</td>
<td></td>
<td>Dr PW</td>
<td>JP</td>
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<tr>
<td>CQC Rating</td>
<td>Dec</td>
<td>95%</td>
<td>Requires improvement</td>
<td></td>
<td>Requires improvement</td>
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<td>Dr PE</td>
<td>JW</td>
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System Wide Quality Measures - organising ourselves
Exception Report: Clostridium Difficile

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Period</th>
<th>Target</th>
<th>2014/15</th>
<th>Month</th>
<th>YTD</th>
<th>FOT</th>
<th>Previous Performance</th>
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<tbody>
<tr>
<td>Clostridium difficile cases: NHS Wakefield CCG</td>
<td>Oct-15</td>
<td>&lt;6 month &lt;72 annual</td>
<td>67/92</td>
<td>7</td>
<td>65</td>
<td>111</td>
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<tr>
<td>Clostridium difficile cases: MYHT post 72 hour cases</td>
<td>Oct-15</td>
<td>&lt;2 month &lt;27 annual</td>
<td>33/42</td>
<td>1</td>
<td>22</td>
<td>38</td>
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</table>

**Description of underperformance:** There were 7 reported clostridium difficile cases in October 2015. 6 were pre 72 hour cases (2 GP samples, 1 LTHT and 3 MYHT). There was 1 post 72 hour case at MYHT. Based on current projections it looks likely that there will be over 100 clostridium difficile cases in 2015/16, a significant increase from the 67 cases in 2014/15.

**Reason for underperformance**
7 of the pre and post 72 hour cases have been reviewed. Cases were registered with different GP practices across Wakefield District.

Of the 6 pre 72 hour cases;
- 2 specimens were requested by the GP, 3 specimens were obtained on admission to MYHT and 1 on admission to LTHT.
- 2 of the cases had a previous history of clostridium difficile infection toxin and Glutamate Dehydrogenase positive.
- 3 had recent antibiotics prescribed. Prescribing was in line with the Antimicrobial Guidelines for Primary and Community Care Organisations.
- 2 cases resided in care homes and 1 case was in intermediate care in Queen Elizabeth.
- 3 cases had recent inpatient episodes.

Of the 1 post 72 hour cases reported by MYHT;
- 1 was deemed non preventable following post infection review. Learning identified development of ward education on the use of IV Vancomycin for oral use for the management of CDI.

**Actions to be taken**
MYHT Infection Control Doctor is meeting with the Consultant Urologists and Elderly Medicine Consultants to discuss a change in antibiotic prescribing for urinary tract infections. Kirklees and Wakefield IPC Team continue to undertake enhanced surveillance to determine common themes to enable targeted work.

A CDI summit is being planned across the health economy in early 2016.
System Wide Quality Measures - organising ourselves
Exception Report: MRSA

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Period</th>
<th>Target</th>
<th>2014/15</th>
<th>Month</th>
<th>YTD</th>
<th>Previous Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRSA: NHS Wakefield CCG</td>
<td>Sep-15</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>•••••</td>
</tr>
<tr>
<td>MRSA: MYHT assigned</td>
<td>Sep-15</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>•••••</td>
</tr>
</tbody>
</table>

**Description of underperformance:** 1 pre 48 hour MRSA case was assigned to Wakefield CCG in September 2015. YTD position for Wakefield assigned cases = 2. This is the third MRSA cases in a Wakefield resident YTD.

**Reason for underperformance**
The patient was admitted with a urinary tract infection and cellulitis to right leg and necrotic toes were noted. The patient was known to have a history of MRSA in 2013. Blood culture was taken on 30 September 2015. Suppression treatment was prescribed and undertaken.
District Nurses attended every 12 weeks for skin integrity assessment, however the patient was non compliant and frequently refused entry. The patient resided in their own home and poor living conditions observed. The case was deemed unavoidable, final assignment to be determined via the arbitration process.

**Actions to be taken**
No lapse in quality of care was identified following the post infection review process.
System Wide Quality Measures - organising ourselves
Exception Report: MYHT Registered Nurse Staffing

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Period</th>
<th>Month</th>
<th>Indicator</th>
<th>Period</th>
<th>Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicine WTE Registered Nurse vacancies</td>
<td>Oct</td>
<td>82.51 WTE</td>
<td>Care Closer to Home</td>
<td>Oct</td>
<td>4.71 WTE</td>
</tr>
<tr>
<td>Surgery WTE Registered Nurse vacancies</td>
<td>Oct</td>
<td>15.17 WTE</td>
<td>Trust</td>
<td>Oct</td>
<td>107.99 WTE</td>
</tr>
</tbody>
</table>

Source: MYHT Safe Nurse and Midwifery Staffing Report 3 December 2015

**Description of underperformance:** Registered Nurse (RN) staffing vacancies reduced to 107.99 WTE in October from 114.29 WTE in September. RN vacancies in the Division of Medicine increased to 88.12 WTE in October from 82.51 WTE in September. This equates to 20.3% of the budgeted RN complement. RN vacancies in the Division of Surgery reduced to 15.17 WTE, the lowest number in the past 12 months. The number of vacancies equates to 5.3% of the budgeted RN complement. The Care Closer to Home (intermediate care) vacancy position reduced to 4.71 WTE. However, this equates to 22% of the RN complement.

**Reason for underperformance**
The projections for registered nursing numbers set in September 2015 for January 2015, enabled the Trust to be in a position that the inpatient wards would be fully recruited to. The projection position changed week commencing 2 November, after taking into account the length of time it is currently taking for new recruits to obtain NMC registration.
MYHT is now forecasting that it will be February 2015 when inpatient wards will be fully recruited to

**Actions to be taken**
MYHT is widening their target recruitment pool. Underway is a ‘Return to the NHS’ programme where MYHT is targeting nurses working in other sectors who wish to return to NHS practice.
MYHT is implementing a requirement for corporate nurses, management role nurses and non-clinical facing nurses to work a minimum of two 6.5 hour shifts per month within ward areas. This has released approximately 5 WTE nurses equivalent, to support ward areas.
Ward managers will reduce their supernumerary time from 37.5 hours to 15 per week and will allocate 22.5 hours clinically to the wards and to cover the staffing bleep function, resulting in the equivalent of 11.33 WTE hours to support the ward areas.
Nurse staffing is one of the work streams in the economy-wide CQC action plan

**Number of MYHT WTE Registered Nurse Vacancies in Medicine and Surgery**

<table>
<thead>
<tr>
<th>Action Plan in Place</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Lead</td>
<td>Dr Patrick Wynn</td>
</tr>
<tr>
<td>Commissioning Lead</td>
<td>Laura Elliott</td>
</tr>
<tr>
<td>Executive Lead</td>
<td>Jo Pollard</td>
</tr>
<tr>
<td>CCG Assurance</td>
<td>MYHT Executive Quality Board</td>
</tr>
</tbody>
</table>
This summarises the findings from the Patient Safety Walkabout that took place at Pinderfields General Hospital on 24 September 2015 and 6 October 2015. Walkabouts involve a small team of clinical and non-clinical staff walking onto ward areas to note their first impressions and talk to patients and staff to identify areas of good practice and areas for improvement. Representatives from Healthwatch in Wakefield and Kirklees regularly participate in the walkabouts. All of the wards listed below were visited on both walkabouts, with the exception of Gate 41 which was visited once.

**Gate 20 (respiratory)**
Patients spoken to stated that staff were ‘hard working’ and that call bells were answered promptly. Patient feedback included the suggestion that patients would like to administer their own medication as they would at home rather than through the drugs round. A review of a small number of records demonstrated good quality care plans and nursing risk assessments. However, gaps in intentional rounding, nutritional and fluid balance documentation were observed. Staff stated they welcomed the ward based discharge team who supported more complex discharge planning.

**Gate 41 (elderly care)***
One patient and their relative felt well informed about their care. DNACPR forms were filed at the front of the medical notes and fully completed. One family felt communication from medical staff could have been better. Staff felt the Discharge Support Worker enabled effective discharge of patients. Staff said they care for a number of patients with dementia. They felt it would be better for these patients if the ward design was made a dementia friendly ward, similar to Gate 43.

**Gate 42 (elderly care)**
Staff were proud of their bay tagging system which had contributed to a large reduction in the number of patients who suffered an inpatient fall. Staff said they are struggling to admit fracture neck of femur patients to the ward within 4 hours of arrival at hospital. Staff said there are issues with getting hip fracture patients to theatre within 48 hours of admission. There was a sense of calm on the ward. This seemed to be due to there always being staff in the bays and near the side rooms.

**Gate 43 (elderly care)**
Patients praised the care received. The ward had a band 6 discharge nurse with band 3 administration support. Staff felt this increased the number of discharges. Most patients were aware of their discharge plans including a patient with dementia. Nursing staff said they had excellent support from the consultants, including at weekends. Patients and staff felt the ward needed more nurses and healthcare assistants, the ward was not meeting recommended levels at the time of the visit. Reducing the number of inpatient falls was identified as an area of improvement.

**Key Actions**
All immediate issues were shared with the ward on the day of the Patient Safety Walkabout. A debrief took place immediately after the Walkabout which was attended by a Trust Director. The full report and MYHT response was shared at MYHT Executive Quality Board on 19 November 2015.
System Wide Quality Measures - organising ourselves
Patient Safety Walkabouts

This summarises the findings from the Patient Safety Walkabouts that took place at Dewsbury and District Hospital on 11 November 2015 and Pinderfields General Hospital on 12 November 2015. These walkabouts took place as part of the ‘Breaking the Cycle’ week at MYHT, which ran from 11-18 December 2015.

Emergency Department – Dewsbury and District Hospital
Patients were very complimentary about the care they received. The department was well staffed. A dementia patient had a ‘Forget Me Not’ sticker on their notes. Information about allergies and drug sensitivities was clearly documented in the patient notes and on the patient’s medical chart. There were no patients in the Walk-In centre during the visit. Walk -In centre staff reported that they have to wait for patients to be filtered from the Emergency Department.

Diagnostics – Dewsbury and District Hospital
In all areas; X-ray, Ultrasound and CT scanning in-patients and Emergency Department patients reported that staff were friendly and that they had good care from nursing and medical staff. The clinicians were very responsive and kept their patients calm.

Ward 4 (stroke / neurology rehabilitation) – Dewsbury and District Hospital
Patients were very complimentary of the care given by all staff groups. They felt well looked after and involved in their ongoing care. Involving patients with their discharge plan was identified as an area for improvement.

Acute Assessment Unit – Pinderfields General Hospital
The ward was extremely busy and staffing was below establishment. However, the ward was clean, tidy and well ordered. Patients gave positive feedback about the quality of care they received. Privacy and dignity was promoted. Two patients were unsure if their endoscopy procedure would be going ahead. Due to patient flow issues some patients remain on the ward for longer than 48 hours.

Emergency Department – Pinderfields General Hospital
This visit highlighted many positives including effective leadership, improved facilities, staff dedication and successful innovation. These included specialist facilities to care for patients exposed to hazardous substances and bariatric patients. The electronic drug storage system which worked on finger print recognition has contributed to a reduction in drug errors by 50%. Further improvements to the department were imminent including a Rapid Assessment at Triage system, which entails a senior doctor assessing patients at triage. The biggest frustration amongst staff centred on patient flow. The department struggles to admit patients onto other wards within 4 hours due to bed availability in the hospital, resulting in ED having to care for patients for longer.

The PSW team felt the department was dealing with this challenge admirably. The department has taken a number of actions including medical reviews, waterlow assessments and providing food and drink to those patients waiting for a bed. The patient flow challenges were resulting in ambulance crews struggling to handover patients within 15 minutes. Staff raised a concern that planned registered nurse staffing levels did not allow the department to provide 1:1 care when Resuscitation was full.

Key Actions: All immediate issues were shared with the ward on the day of the Patient Safety Walkabout. The full report and MYHT response will be shared at MYHT Executive Quality Board in January 2016.
The CQC published their inspection reports of MYHT on 3 December 2015. Reports are available for the Trust overall, each of the 3 hospital sites and all core services that were reviewed at [http://www.cqc.org.uk/provider/RXF](http://www.cqc.org.uk/provider/RXF).

The Trust was inspected between 23-25 June 2015. This was to follow up on improvements required as a result of the CQC’s previous inspection in 2014. Inspectors made further planned and unannounced visits in August and September at Pontefract General Infirmary and Pinderfields Hospital. During the further visit at Pinderfields, the CQC found that the Trust had taken action to provide additional nursing support on the acute respiratory care unit (Gate 20) and on the three acute elderly wards (Gates 41, 42 and 43). The CQC state that MYHT have made some clear improvements to improve the safety and quality of services since the previous inspection in June 2014. However, the CQC report that there is still work to do and ask the Trust to monitor and sustain action taken.

- **What services and sites has the CQC inspected and rated?**
  - All 3 hospital sites were inspected.
  - Services inspected at Pinderfields and Dewsbury Hospitals; urgent & emergency care, medical care, surgery, maternity & gynaecology, children & young people’s services, end of life care, outpatients & diagnostic imaging.
  - Services inspected at Pontefract General Infirmary; urgent & emergency care, medical care, surgery, maternity & gynaecology, outpatients & diagnostic imaging.
  - Community health (intermediate tier) inpatients service at Queen Elizabeth House and Monument House (located at Gate 1 Pinderfields).

The table below shows that there has been no change in the overall ratings against each domain for the three sites. The tables overleaf show the breakdown by service area for each of the three sites.

<table>
<thead>
<tr>
<th></th>
<th>Dewsbury and District Hospital</th>
<th>Pinderfields General Hospital</th>
<th>Pontefract General Infirmary</th>
<th>MYHT</th>
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</thead>
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<tr>
<td><strong>Overall</strong></td>
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<td>Requires Improvement</td>
<td>Requires Improvement</td>
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<tr>
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<td>Inadequate</td>
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<td>Requires Improvement</td>
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## System Wide Quality Measures - organising ourselves

### MYHT CQC Inspection Report - Summary of hospital sites and services

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<tr>
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<td>Outpatients &amp; Diagnostic Imaging</td>
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<td>Good</td>
<td>Not rated</td>
<td>Good</td>
<td>Not rated</td>
</tr>
<tr>
<td></td>
<td>Overall rating</td>
<td>Requires improvement</td>
<td>Requires improvement</td>
<td>Good</td>
<td>Requires improvement</td>
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</tr>
<tr>
<td>Pinderfields</td>
<td>Safe</td>
<td>Effective</td>
<td>Caring</td>
<td>Responsive</td>
<td>Well-led</td>
<td>Overall</td>
</tr>
<tr>
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<tr>
<td>Urgent &amp; Emergency Services</td>
<td>Requires improvement</td>
<td>Requires improvement</td>
<td>Not rated</td>
<td>Requires improvement</td>
<td>Good</td>
<td>Not rated</td>
</tr>
<tr>
<td>Medical Care</td>
<td>Inadequate</td>
<td>Inadequate</td>
<td>Requires improvement</td>
<td>Requires improvement</td>
<td>Good</td>
<td>Requires improvement</td>
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<tr>
<td>Surgery</td>
<td>Requires improvement</td>
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<td>Requires improvement</td>
<td>Requires improvement</td>
<td>Good</td>
<td>Requires improvement</td>
</tr>
<tr>
<td>Maternity &amp; Gynaecology</td>
<td>Requires improvement</td>
<td>Requires improvement</td>
<td>Good</td>
<td>Not rated</td>
<td>Good</td>
<td>Not rated</td>
</tr>
<tr>
<td>Children &amp; Young People</td>
<td>Requires improvement</td>
<td>Good</td>
<td>Good</td>
<td>Not rated</td>
<td>Good</td>
<td>Not rated</td>
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<td>End of Life Care</td>
<td>Inadequate</td>
<td>Inadequate</td>
<td>Requires improvement</td>
<td>Requires improvement</td>
<td>Good</td>
<td>Not rated</td>
</tr>
<tr>
<td>Outpatients &amp; Diagnostic Imaging</td>
<td>Inadequate</td>
<td>Good</td>
<td>Requires improvement</td>
<td>Not rated</td>
<td>Good</td>
<td>Not rated</td>
</tr>
<tr>
<td>Overall rating</td>
<td>Inadequate</td>
<td>Inadequate</td>
<td>Requires improvement</td>
<td>Good</td>
<td>Good</td>
<td>Requires improvement</td>
</tr>
</tbody>
</table>

Notes: The CQC state they are currently not confident that they are collecting sufficient evidence to rate effectiveness for Outpatients & Diagnostic Imaging.

Community inpatient services (intermediate tier - Monument House & Queen Elizabeth House)

<table>
<thead>
<tr>
<th>Community</th>
<th>Safe</th>
<th>Effective</th>
<th>Caring</th>
<th>Responsive</th>
<th>Well-led</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community health</td>
<td>Requires improvement</td>
<td>Inadequate</td>
<td>Requires improvement</td>
<td>Requires improvement</td>
<td>Good</td>
<td>Requires improvement</td>
</tr>
</tbody>
</table>
Outstanding practice identified by the CQC

The reports praised the caring nature of Trust staff across all of its services and all of its hospital sites. It outlined several areas of outstanding practice, which included:

- MYHT had made clear progress in the outpatient service which included standardised processes, and reduction in outpatient backlog.
- Trust ‘Listening into Action’ programme to support staff transform services.
- Most staff felt that the culture within the organisation had changed. Management was stronger and communication had improved.

Areas where the Trust must make improvements:

- Ensure at all times there are sufficient numbers of suitably skilled, qualified and experienced staff in line with best practice and national guidance taking into account patients’ dependency levels.
- Demonstrate they follow and adhere to the ten expectations from the national quality board.
- Ensure policies and procedures to monitor safe staffing levels are understood and followed.
- Strengthen the systems in place to regularly assess and monitor the quality of care provided to patients.
- Ensure where actions are implemented to reduce risks these are monitored and sustained.
- Ensure all patients identified at risk of falls have appropriate assessment of their needs and appropriate levels of care are implemented and documented.
- Ensure there are improvements in the monitoring and assessment of patient’s nutrition and hydration needs to ensure patients’ needs are adequately met.
- Ensure all staff have completed mandatory training, role specific training and had an annual appraisal.
- Continue to strengthen staff knowledge and training in relation to the mental capacity act and deprivation of liberty safeguards.
- Ensure that systems and processes are in place and followed for the safe storage, security, recording and administration of medicines, and that oxygen is prescribed in line with national guidance.
- Ensure that infection control procedures are followed in relation to hand hygiene, the use of personal protective equipment and cleaning of equipment.
- Ensure staff follow the trust’s policy and best practice guidance on DNACPR decisions when the patient’s condition changes or on the transfer of medical responsibility.
- Ensure there are improvements in referral to treatment times and accident and emergency performance indicators to meet national standards to protect patients from the risks of delayed treatment and care. The trust must also ensure ambulance handover target times are achieved to lessen the detrimental impact on patients.
- The trust must ensure there are improvements in the number of fractured neck of femur patients being admitted to orthopaedic care within 4 hours and surgery within 48 hours.
- The trust must improve the discharge process for patients who may be entering a terminal phase of illness with only a short prognosis.
- The trust must ensure robust major incident and business continuity plans are in place and understood by staff. This must include fire safety at Queen Elizabeth House.

In addition the trust should:

- The trust should continue to review the prevalence of pressure ulcers and ensure appropriate actions are implemented to address the issue.
- The trust should continue to improve interdepartmental learning and strengthen governance arrangements within the accident and emergency departments.
- Review the use of emergency theatres and improve the processes to prioritise patients in need of emergency surgery.
- Take action to reduce the number of last minute planned operations cancelled for non-clinical reasons.
- Ensure staff are involved and informed of service changes and re-design.
- Take action to address the historical management–clinician divides that had not been resolved amongst certain surgical specialities.
- Ensure in community inpatient services there is a referral criteria for the service and in-reach processes are carried out consistently to improve the admission and referral process.
- Ensure toilet facilities in community inpatient services are designated same sex, in order to comply with the government’s requirement of Dignity in Care.
- Ensure care and treatment of service users is only provided with the consent of the relevant person.
- Ensure patients receive person-centred care and are treated with dignity and respect.
- Ensure the equipment and premises are suitable for the purpose for which they are being used and are appropriately maintained.

Next Steps

The CQC presented its findings to a local Quality Summit on 15 December 2015 involving commissioners, providers, regulators and NHS England. The Summit considered the Trust’s proposed actions in response to issues identified and external support offered. The Trust has developed an action plan in response to the findings, which was discussed at MYHT Executive Quality Board in December 2015. The CQC will return to check that the improvements identified have been made.

Additional Patient Safety Walkabouts have taken place on Gates 20, 41, 42 and 43 during September and October 2015 following the CQC identifying concerns on these wards. The findings of these walkabouts have been summarised in previous reports.
## System Wide Quality Measures - organising ourselves

### CQC Inspection Report

<table>
<thead>
<tr>
<th>Provider</th>
<th>Flanshaw Lodge</th>
<th>Outcomes</th>
<th>Current Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Inspection</td>
<td>16 and 18 September 2015</td>
<td>Safe</td>
<td>Good</td>
</tr>
<tr>
<td>Review Type</td>
<td>Unannounced</td>
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</tr>
<tr>
<td>Link to Report</td>
<td>Flanshaw</td>
<td>Caring</td>
<td>Good</td>
</tr>
</tbody>
</table>

**CQC history:** October 2013 – provider met the regulations the CQC looked at

**Type of home:** Accommodation for up to 26 people, all of whom have dementia.

<table>
<thead>
<tr>
<th>Provider</th>
<th>Attlee Court, Normanton</th>
<th>Outcomes</th>
<th>Current Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Inspection</td>
<td>25 June 2015</td>
<td>Safe</td>
<td>Inadequate</td>
</tr>
<tr>
<td>Review Type</td>
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<tr>
<td>Link to Report</td>
<td>Attlee</td>
<td>Caring</td>
<td>Requires improvement</td>
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</table>

**CQC history:** 12,13 August 2014 – provider met the regulations the CQC looked at

**Type of home:** Accommodation and nursing care.

**Action:** The home will be re-inspected by the CQC within 6 months. If the CQC deems that any aspect of the service is still inadequate, then they will take action in line with their enforcement procedures.

Attlee Court closed the Dementia nursing unit, which resulted in some patients being moved. The CCG undertook a joint monitoring visit with the Local Authority on 8th December 2015. The CCG piloted the Care Home Quality Assurance tool on the visit. Further work with Attlee Court and the tool is ongoing.

<table>
<thead>
<tr>
<th>Provider</th>
<th>Stockingate Residential Home, South Kirkby</th>
<th>Outcomes</th>
<th>Previous inspection</th>
<th>Current Status</th>
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</thead>
<tbody>
<tr>
<td>Date of Inspection</td>
<td>29 July 2015</td>
<td>Safe</td>
<td>Inadequate</td>
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<tr>
<td>Review Type</td>
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<td>Effective</td>
<td>Inadequate</td>
<td>Requires improvement</td>
</tr>
<tr>
<td>Link to Report</td>
<td>Stockingate</td>
<td>Caring</td>
<td>Requires improvement</td>
<td>Good</td>
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</tbody>
</table>

**CQC history:** Several breaches of the legal requirements that the CQC checked at the last inspection in January 2015.

**Type of home:** Residential

**Overall rating**

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**Note:** The table layout and content are based on a screenshot of a document, which includes additional text not included in the initial description. The table and the provided text summarize the inspection outcomes and actions for three different providers: Flanshaw Lodge, Attlee Court, and Stockingate Residential Home, South Kirkby.
**Provider**: System Wide Quality Measures - organising ourselves
**CQC Inspection Report**

<table>
<thead>
<tr>
<th>Provider</th>
<th>Carr Gate, Wakefield</th>
<th>Outcomes</th>
<th>Current Status</th>
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</thead>
<tbody>
<tr>
<td>Date of Inspection</td>
<td>23 and 27 July 2015</td>
<td>Safe</td>
<td>Inadequate</td>
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<tr>
<td>Review Type</td>
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<td>Effective</td>
<td>Inadequate</td>
</tr>
<tr>
<td>Link to Report</td>
<td>Carr Gate</td>
<td>Caring</td>
<td>Requires improvement</td>
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</table>

**CQC history**: January 2014 – Compliant with regulations
**Type of home**: Accommodation and nursing care.

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Current Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responsive</td>
<td>Requires improvement</td>
</tr>
<tr>
<td>Well-led</td>
<td>Inadequate</td>
</tr>
<tr>
<td><strong>Overall rating</strong></td>
<td>Inadequate</td>
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</table>

**Action**: The CQC has asked the provider to send them a report stating what action they will take. The CQC will assess whether these actions have been implemented. The CQC did not take formal enforcement action. The Continuing Healthcare Team regularly visit the provider and will directly raise any potential concerns with the CCG.
Recommendations:

Members of the Governing Body are asked to:

i. Note the update on the Vanguard Programmes and how this impacts the delivery of the Forward View;
ii. To agree to receive further reports about all the vanguard programmes outlined in this report.
iii. To agree to support that the Urgent Care/Emergency Care Vanguard is hosted in Wakefield and that Wakefield Clinical Commissioning Group Chief Officer takes forward a significant leadership role as SRO for this vanguard programme.

Executive Summary:

As reported to the Governing Body on 15 September 2015 Wakefield have been successful in securing the opportunity to lead two national vanguards to develop new Models of Care for both a Multi-Speciality Community Provider and Enhanced Care Homes. In addition West Yorkshire have also been successful in securing two further national vanguards, the Urgent/Emergency Care and future models of acute collaboration (submitted by West Yorkshire Association of Acute Trusts (WYAATs). This is a real accolade not only for Wakefield but also for our wider partnership leadership role across West Yorkshire.

The guidance for this year’s planning round indicates the need for Wakefield Clinical Commissioning Group to move towards a whole system approach to planning as illustrated in the NHS Mandate and a message to move faster on areas of transformation. Wakefield and West Yorkshire are in a strong position as many of the areas that are ‘must do’s outlined in the guidance we are already making significant progress both through our existing commissioning programmes, Meeting the Challenge Strategy, Connecting Care and Vanguard programmes.

The Sustainability and Transformation Plan will also become the single application and approval process for being accepted onto programmes with transformational funding for 2017/18 onwards. In order to access the funding, the plans need to be ‘compelling and credible’. This protected transformation funding is for initiatives such as the spread of new care models through and beyond the vanguards, primary care access and infrastructure, technology roll-out, and to drive clinical priorities such as diabetes prevention, learning disability, cancer and mental health.

It has been made clear in the planning round guidance that to enable timely allocation, the limited available additional transformation funding for 2016/2017 will continue through separate processes which is why the national NHS England Investment Committee will make decisions about all of our vanguards business cases in March 2016 as outlined earlier in the paper. However it is clear that future funding for 2017/18 will only be...
successful if we have a quality Sustainability and Transformation Plan that has a clear and powerful vision and create coherence across workforce, self-care, digital, patient empowerment and new care models which can only be embedded with the key enablers outlined.

<table>
<thead>
<tr>
<th>Link to overarching principles from the strategic plan:</th>
<th>Citizen Participation and Engagement</th>
<th>Wider Primary Care at Scale including Network development</th>
<th>✓</th>
<th>A Modern Model of Integrated Care</th>
<th>✓</th>
<th>Access to the Highest Quality Urgent and Emergency Care</th>
<th>✓</th>
<th>A Step Change in the Productivity of Elective Care</th>
<th>✓</th>
<th>Specialised Commissioning</th>
<th>Mental Health Service Transformation</th>
<th>Maternity, Children and Young People Transformation</th>
<th>Organising ourselves to deliver for our patients</th>
<th>✓</th>
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<tr>
<td>Outcome of Impact Assessments completed (e.g. Quality IA or Equality IA)</td>
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<td>Outline public engagement – clinical, stakeholder and public/patient:</td>
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</tr>
<tr>
<td>Management of Conflicts of Interest:</td>
<td>Dr Adam Sheppard GP practice is a member of the MSCP Vanguard. Through their GP practice Dr Sheppard, Dr Harries, Dr Earnshaw, Dr Biswas and Alison Sugarman are involved with the Care Homes Vanguard.</td>
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<td>Assurance departments/organisations who will be affected have been consulted:</td>
<td>CCG Executive Team</td>
<td>West Wakefield Health and Wellbeing</td>
<td>Provider Alliance</td>
<td></td>
<td></td>
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<td>Previously presented at committee / governing body:</td>
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<tr>
<td>Risk Assessment:</td>
<td>None identified – NHS Wakefield Clinical Commissioning Group has robust conflict of interest procedures.</td>
<td></td>
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</tr>
<tr>
<td>Finance/ resource implications:</td>
<td>The new sub-committee of the Connecting Care Executive will require administrative support from the CCG and managerial support from the CCG plus all partner organisations involved in the new models of care programmes.</td>
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</table>
Vanguard Programmes: 
Update and delivering the Forward View for 2016/17 to 2020/21

1. Introduction

1.1. As reported at the Governing Body on the 15th September 2015 Wakefield has been successful in securing the opportunity to lead two national vanguards to develop new Models of Care for both a Multi-Speciality Community Provider and Enhanced Care Homes. In addition West Yorkshire have also been successful in securing two further national vanguards, the Urgent/Emergency Care and future models of acute collaboration (submitted by West Yorkshire Association of Acute Trusts (WYAATs). This is a real accolade not only for Wakefield but also for our wider partnership leadership role across West Yorkshire.

1.2. At this stage NHS England transformation funding for all the vanguards is only confirmed for 2015/2016, however all the vanguard projects are being asked to submit their business cases for 2016/2017 for the 8th February 2016 with a decision from NHS England to be confirmed for all vanguard programmes through the NHS England national investment committee on the 14th March 2015.

1.3. The guidance for this year’s planning round indicates the need for Wakefield Clinical Commissioning Group to move towards a whole system approach to planning as illustrated in the NHS Mandate and a message to move faster on areas of transformation. Wakefield and West Yorkshire are in a strong position as many of the areas that are ‘must do’s outlined in the guidance we are already making significant progress both through our existing commissioning programmes, Meeting the Challenge Strategy, the Connecting Care and Vanguard programmes.

1.4. An area to highlight which will be a key piece of work is the requirement by end June 2016 for Wakefield to develop a five year Sustainability and Transformation Plan (STP) which must be place-based and needs to be clearly driving forward the Five Year Forward View. Our vanguards across Wakefield and West Yorkshire places our District in a very strong position as we are not only developing and designing models of care which will be replicable across the country but we are also accessing direct national support to help us on this journey as being part of the Models of Care programme.

1.5. Health and social care systems are being asked to come together to develop their plans for delivering the five year forward view, covering a period of 2016/17 – 20/21. This indicates a move towards a place based approach to complement organisational plans. In order to do this there will be a need to have strong system leadership through which all aspects of the system are engaged and for all involved to have a shared vision for the future. The plans must cover all commissioned activity including specialised services, Primary care and integration reflecting Health and Wellbeing strategies.

1.6. The Sustainability and Transformation Plan will also become the single application and approval process for being accepted onto programmes with transformational funding for 2017/18 onwards. In order to access the funding, the plans need to be ‘compelling and credible’. This protected transformation funding is for initiatives such as the spread of new care models through and beyond the vanguards, primary care access and infrastructure, technology roll-out, and to drive clinical priorities such as diabetes prevention, learning disability, cancer and mental health. Local health systems now also are required to develop
their own system wide local financial sustainability plan as part of their Sustainability and Transformation Plan (STP). Further guidance around the development of STPs will be published in January 2016.

1.7. It has been made clear in the planning round guidance that to enable timely allocation, the limited available additional transformation funding for 2016/2017 will continue through separate processes which is why the national NHS England Investment Committee will make decisions about all of our vanguards business cases in March 2016 as outlined earlier in the paper. However it is clear that future funding for 2017/18 will only be successful if we have a quality Sustainability and Transformation Plan that has a clear and powerful vision and create coherence across workforce, self-care, digital, patient empowerment and new care models which can only be embedded with the key enablers outlined.

1.8. Below is a diagram that captures the different layers of transformation work that Wakefield Clinical Commissioning Group leads either at a place, system or West or South Yorkshire level. This diagram highlights why our current work in Connecting Care is significant at a place layer, the Meeting the Challenge strategy is critical at a system layer and the West and South Yorkshire transformation and commissioning programmes are key. These different layers of how Wakefield Clinical Commissioning Group leads and transacts our commissioning approaches are mirrored in the expectations of the planning round guidance. As a clinical commissioning group it is important to understand that these layers of transformation are not nice ‘pilots’ these are core to our central business, which is why the Governing Body can be assured that we are in strong position to deliver the asks outlined in the Five Year Forward View and in this year’s planning guidance for both the Sustainability and Transformation Plan and Wakefield Clinical Commissioning Group one year operational plan for 2016/2017.

**Layers of Sustainable Transformation**
2. Vanguard Programmes Update

2.1. Care Homes Vanguard

2.1.1. Since the Governing Body update in September the business case for the Care Home Vanguard has been supported by NHS England and work is underway now in mobilising the first phase of the delivery of this work.

2.1.2. The Care Home Vanguard aims to enhance integration between health and social care and is made up of, and supported by, a wide range of organisations from across the local health economy:

- Age UK;
- Wakefield District Housing;
- General practitioners;
- Nova Wakefield District (a support agency for voluntary and community groups);
- Wakefield Council;
- Yorkshire Ambulance Service NHS Trust;
- South West Yorkshire Partnership NHS Foundation Trust;
- Mid Yorkshire Hospitals NHS Trust.

2.1.3. Significant support has been provided from clinical leads Dr Ann Carroll, Dr Greg Connor and Dr Phil Earnshaw and with advice and support from the Local Medical Committee (LMC) a Local Enhanced Service was developed for the 19 GP practices who will be involved in the first phase of the care home vanguard.

2.1.4. An expression of interest was sent out in November to all 19 practices that have residents within the initial 11 care homes across the district. Eighteen out of the nineteen practices have expressed an interest to be part of the enhanced service. A service specification is in place and all 18 contracts have been issued for sign up from the practices. The contract start date for the enhanced service commenced on the 1 December 2015, to allow for a smooth transition with previous pilots that were due to finish at the end of November 2015.

2.1.5. Features of the enhanced service include:

- A one GP practice: one care home care model, in line with the recommendations of ‘The Future of Primary Care Creating teams for tomorrow’ report by the Primary Care Workforce Commission, July 2015. Larger homes of more than 40 beds may be covered by providing one practice: one floor or wing;
- Existing and new residents in the care homes will be offered the opportunity to register with the GP practice providing the enhanced service. Patients can choose to stay registered with another practice if they and their existing practice prefer but will be encouraged to benefit from the enhanced service instead;
- The practice responsible for delivering the enhanced service will ensure that a suitably qualified and experienced clinician (a GP or appropriately skilled senior nurse) provides a flexible “ward round”. This will encompass advanced care planning, chronic disease management, medication review, participation in multidisciplinary care, end of life care, avoidance of unnecessary admissions and A&E attendances and clinical audit as well as care for acute and subacute conditions and support to care home staff;

2.1.6. The interim Care Home Taskforce is in place whilst recruitment is underway at MYHT. To reduce the risk of delaying the start of this aspect of the vanguard Wakefield Clinical Commissioning Group has brought together an interim team to commence laying the
foundations and planning the initial care home taskforce approach to ensure a speedy and co-ordinated start to the project. This team now includes the following:

- Community Geriatrician (1 day per week);
- Mental Health Nurse (full time);
- General Nurse band 6 (full time);
- Pharmacists (Medicines Optimization Pharmacist 2 days per week & MH Pharmacist (1 day per week);
- Occupational Therapist (MYHT);
- Dietician (MYHT);
- Speech and Language Therapist (MYHT);
- Advanced Nurse Practitioner (MYHT) - to commence Feb 2015.

The team are based at Tieve Tara Medical Centre and the team members met for an induction day on 24th November 2015 and have been introducing the Vanguard and MDT team to Care Home Managers, visiting Care Homes (9 to date). Meeting wider staff, identifying issues for the Care Homes in relation to Healthcare access and developing working relationships.

Learning from previous pilots is being taken into consideration in developing the approach to the future way of working, starting with initial assessments. Links are also being made to develop ways of working with other professionals who already support Care Homes to ensure a co-ordinated approach, for example GP’s and APN’s, the Hospices and EOL training post, infection control team, Stay Steady Campaign as well as with the national Care Home Vanguard projects. The team are currently getting consent to be able to access care plans and will have access to the unscheduled care module on SystmOne by the end of January.

Portrait of a Life, LEAF 7, Dementia care Mapping and Pull up a Chair are a suite of assessment tools and training that we have commenced using to date with two of the care homes and the extra care living scheme. Pull up a Chair is a tool that has been developed to support tackling loneliness and isolation. The concept has been adapted to our local requirements and is based on a video diary, where the camera is brought to ‘you in your place of residence’. It will be tailored to suit the different audiences in care homes and assisted living depending on each person’s: personality; capacity and available support.

LEAF-7 is a method of measuring a person’s quality of life and any changes to that quality of life, which occur over time. It can provide an excellent basis for undertaking accurate person-centred support planning and reviews; and is designed to be used by support workers working with vulnerable people, typically in later life. It is also designed to be simple, systematic and to measure the things that people have reason to value. The tool is structured around seven outcome areas of quality of life. Age Uk are leading both of these holistic assessment tool.

Lots of other work is underway with VCS through interventions for Care Homes provided in part by Community Anchors and work is being developed on falls with Wakefield District Housing. The vanguard has received positive feedback to date from the national models of care team for progress within these tight timescales and the leadership of the vanguard illustrated by the Programme Lead Lesley Carver.
2.2. MSCP Vanguard

2.2.1. The business case for the Multi-speciality Community Provider was signed off by NHS England Models of Care Team at the end of September 2015. The progress to date from the MsCP vanguard is captured from their regular highlight report which Governing Body members are welcome to receive directly from WWHWB ltd if they would like to do so.

- Extended operating hours – strategic and operational. On-going strategic discussions with networks 3 and 5 leads – regarding elements of the Vanguard programme and how they wish to engage with the development of the Vanguard model;
- Teleconference with NECS to establish the requirements for evaluation of the programme – engaging project leads, SystmOne and data experts;
- Redesign the pathway for dealing with patient referrals from EOH service. Not all surgeries are happy with existing protocols and these need to be refined. Listening Exercise feedback – feedback regarding EOH has been mixed. Some practices make full use of the service, others feel they do not use it but actually have a reasonable uptake (500 appointments in one year), whilst one practice doesn’t use EOH at all for routine appointments;
- Liaison with 111 planned to support their referrals to EOH (on one morning shift on a Saturday it was noted that 19 patients from network 6 attended other services). Work Shadowing of 111 by ECP – Lisa Pammen. Further analysis of the trends working with NECS regarding the routine pulling of information on 111 referrals;
- Listening exercise with a particular focus on EOH at the request of West Wakefield Board members to ensure future options for the service consider a range of options which are developed and coproduced with GPs and Nursing staff. Initial meetings arranged with the majority of network 6 practices. Listening exercises completed with Network 6 Practices (with an EOH focus), ready to be circulated to each practice for checking and adding any additional information;
- First Listening Exercise held with Homestead Practice (network 3). The meeting was very constructive in terms of identifying the scope to provide proactive interventions to deliver alternatives to GP slots. It also gave an opportunity to myth bust some of the ongoing concerns regarding how some elements of the Vanguard are delivered;
- Pharmacy First- Lead Pharmacist role sought from Community Pharmacy West Yorkshire and via the CCG. However, no individuals identified at this stage. Job description developed and this will be progressed in New Year;
- Communicate to network 3 via listening event the potential of the Pharmacy First Scheme. First listening exercise complete with Homestead Network 3 practice. On-going dialogue with Network 3 chair and individual practices regarding how they can work with the MCP Vanguard programme. The principle of rolling out pharmacy first in Network 3 has been established, subject to practice buy in and establishing a method to refer directly to Pharmacy First;
- Agreed with Network 3 and Network 5 to not progress rolling out Pharmacy First but instead to invest MsCP resources in appointing Pharmacists in General Practice. The value based proposition will be revised to reflect this request for 2016/2017;
- The MsCP is making good progress to deliver pharmacists in general practice. This service will be delivering across 6 practices in January 2016 and will be developing a plan to roll out to Network 3 and 5. The service will provide the following core support to practices and patients:
  o Annual reviews of all medicines;
  o Letters and discharge note reconciliation;
  o Prescription reauthorisations;
• Responding to acute medication requests;
• Medication queries;
• Liaising with Community Pharmacists.

• Physio First - Explored new model of care provision with current provider, scoping possibility of telephone appointments and hub working arrangements;
• Scoped amendments to times and availability of Physio First at a practice level for network 6 – 15 hours a week, 60 hours a month;
• Scoped capacity for roll out to network 3 with current provider – with potential to roll out to Homestead, New Southgate and Stanley immediately and Outwood in January 2016;
• Secured agreement to work together with network 5 consolidating the Network 5 Physio First provision via the Vanguard programme – 8 hours of Physio First in four locations;
• Established link to Mid Yorkshire – regarding potential for extra capacity for the service.

**Schools App Challenge**

• The key for November has been the on-going support with the 6 schools as their Year 6 students research the health promotion topics and begin to identify the approach they want to take with their app concept and prepare for the shortlisting sessions, where they would need to prepare visuals and a short presentation. This has needed to run parallel with finalising the confirmed clinical (GP) and tech (Microsoft) resources to support the work taking place in school. It has also been essential to continue to drive focus on the release of the phase 2 App (DITA) in conjunction with Bullying Awareness Week;
• Shortlisting sessions completed in all 6 schools – over 50 health app concepts were presented by the students – demonstrating fantastic energy and creativity to making good health choices fun. GP engagement support across all 6 schools including GPs from Network 6;
• The confirmations to all 6 Schools regarding their Finalist teams was done in conjunction with promoting the self-care messaging which was subsequently pushed out via their website, newsletters & twitter;
• Marketing and communications activity in the buildup and during Bulling Awareness Week (wc Nov 16th) to drive awareness of the mental health aspects of DITA version 1.0 and the soon to be released additions to the App (cyber-bullying and staying safe online). A shortlisting blog story was also posted on the Wakefield West website to outline shortlisting outcomes and next phase of the competition. This was supported via Twitter activity;
• Finalised collaboration with MakeWaves on the App milestones for being awarded the Stress Buster digital badge (Public Health badge). Infrastructure and digital architecture now agreed - users will need to complete all 3 mental health quizzes to unlock a redemption code for the StressBuster badge. This will be part of the December App release. Framework will then be in place to add further PH and NHS digital badges (e.g. Health Eating, Active Lifestyle, Me and My Teeth, Health Champion, Knowing My Schools Nurse);
• Completed all DragonApp Phase 2 release planning with YooMee for planned Nov 19th launch. Finalisation of all content for the e-safety quiz (25 scenario based questions/answers) and the 'CyberAttack' mini game including user-testing refinement. The DITA version 1.0 App was also finally approved for the App Store. There is also now a HTML5 version that can be accessed via web browser. A Windows version of the App will be released in December. All versions can be accessed / downloaded via dragonapp.me;
• Progress made to align the operability of the Dragon App with the elephant kiosks in the surgeries and the West Wakefield website. Target being to have these ready by end of December;
• As the Schools App Challenge moves into Phase 2 – the Microsoft tech support planning and finalisation through to Christmas has been completed. Lee Stott, one of Microsoft’s Tech Evangelists will be delivering 6 x 1 hour skype sessions to the schools. The 6 Finalist teams will be working through Touch Develop coding tutorials and will be armed with lots of questions for Microsoft about how best to develop and build their health app concept;
• Mentors session support via Skype with Rare Studios have also now been confirmed for all 6 schools in January 2016 – where they will have the chance to test out their pitch presentation / app concept with a team of top game developers;
• Planning preparations underway for the Dragon’s Den Final Judging event in January 2016 (27 or 28 TBC) at Unity Works. We are hoping to have a senior member of the NHSE MCP Vanguard team involved in the judging.

MsCP vanguard is also progressing working with the Connecting Care team at Waterton Hub, Care Navigation approaches and extending the Healthpod initiative.

2.3. **Urgent Care Vanguard**

2.3.1 The Urgent Care/Emergency Care vanguard programme received a visit from national colleagues working across the Models of Care programme in November 2015. This involved challenge, scrutiny and recommendations from the national team to help support the vanguard move forward with robust business case for their delivery model which was required to be submitted for the Urgent Care/Emergency Care vanguard in November 2015.

2.3.2 The Governing Body will recall that the bid was made on behalf of the West Yorkshire Urgent and Emergency Care Network (WYUECN) – a system wide network of commissioning and provider organisations supported by a regional Academic Health Science Network (AHSN). The individual organisations that have pledged their support for this Vanguard bid include (not exhaustively):

• The 10 West Yorkshire CCG and Harrogate and Rural Districts CCG;
• The 5 West Yorkshire plus Harrogate System Resilience Groups (SRGs);
• Yorkshire Ambulance Service as both 999 and NHS111 provider;
• Local Care Direct as West Yorkshire urgent care (out of hours) provider;
• Locala Community Health Care;
• Leeds Teaching Hospitals NHS Trust;
• Bradford Teaching Hospitals NHS Trust;
• Airedale and Wharfedale NHS Foundation Trust;
• Mid Yorkshire Hospitals NHS Trust;
• Calderdale and Huddersfield NHS Foundation Trust;
• Harrogate and District NHS Foundation Trust;
• South West Yorkshire Partnership NHS Foundation Trust;
• Bradford District Care NHS Foundation Trust;
• Leeds and York Partnership NHS Foundation Trust;
• Yorkshire and Humber Academic Science Network (AHSN);
• West Yorkshire HealthWatch organisations;
• West Yorkshire Police.
2.3.3 The bid outlines a shared vision for Urgent and Emergency Care and agreed that by April 2017 the following will be delivered as part of the new model of care:

- practical examples and evidence of our workforce working differently in the UEC system;
- front line clinicians actively using a shared clinical record based on the learning from the Leeds Care Record;
- shared learning from testing new payment models and funding flows that will inform further roll out;
- reconfigured clinical pathways for people with specialist emergency care needs;
- reconfigured the HASU provision across West Yorkshire;
- gained further insight into the behaviour and choices of people using the UEC system and evidence of how we have used this to redesign services or develop new offers;
- evidence of reducing numbers of people being unable to get the immediate mental health support they need at a time of crisis;
- developed a multi-agency frequent attenders action plan;
- commissioned an alternative transport service for conveying section 2 and section 3 patients to place of safety;
- evaluated the benefits of using a whole system ‘real-time’ dashboard.

2.3.4 Significant work is underway with the Urgent/Emergency Care West Yorkshire vanguard which has now established key workstreams to drive forward the work outlined above. This has input from Wakefield Clinical Commissioning Group representatives including Dr Adam Sheppard, Richard Main (who supports Dr Clive Harries with IT transformation), and other members of Wakefield Clinical Commissioning Group Executive Team.

2.3.5 NHS England regional team have seconded Colin McIlwain to lead the Urgent/Emergency Care West Yorkshire vanguard and he is also supported at this time by Eric Davies. Due to the impending retirement of the current SRO to the programme (Chris Dowse) it has been agreed that Jo Webster will take a SRO lead on this vanguard programme moving forward. Wakefield Clinical Commissioning Group have also offered to host the Urgent/Emergency Care West Yorkshire vanguard programme at White Rose House on the fourth floor. Therefore moving forward Wakefield will play a significant leadership role for this vanguard programme alongside our colleagues across West Yorkshire.

2.4 Future models of acute care collaboration

2.4.1 On the 31st July 2015 a vanguard application on the future models of acute collaboration was submitted by a number of organisations that refer to themselves as West Yorkshire Association of Acute Trusts (WYAATs) to create a system of high quality, resilient, and sustainable acute services which consistently deliver the best patient outcomes compared to any system in the country. The new models of care programme for acute care collaboration provides an immediate catalyst for our journey. At this stage this vanguard application is still under consideration by the new models of care team and a further update will come to a future Governing Body meeting if it is approved by NHS England. This bid is outlined in Appendix A.

2.4.2 West Yorkshire Association of Acute Trusts (WYAATs) includes the following organisations:

- Leeds Teaching Hospitals NHS Trust;
- Calderdale and Huddersfield NHSFT;
- Bradford Teaching Hospitals NHSFT, Airedale NHSFT;
- Harrogate and District NHSFT;
- Mid Yorkshire Hospitals NHS Trust;
• Leeds Teaching Hospitals NHS Trust.

2.4.3 West Yorkshire Association of Acute Trusts (WYAATs) focus is to drive forward a ‘model clinical network’ that will not only deliver improved and consistent outcomes for patients (building on the success of existing networks) but will use technology as a key enabler to change 30% of consultations to a virtual platform over the next 5 years. Developing this approach across networks at scale rather than in individual institutions will improve clinical productivity and work flows, the delivery of seven day working across a large population driving up quality and experience for patients and their families. The association is clear that they can go further and faster together to deliver clinically and financially sustainable services than they can on their own. It is centred on what patients want and preserving local access to services wherever feasible.

2.4.4 In the first year the bid has committed that West Yorkshire Association of Acute Trusts will:
• Finalise the system governance and accountability for the association and Vanguard including clinical engagement programme;
• Develop a system wide strategy for building the ‘model clinical network’. The first stages are described above;
• Map the existing technology against the ‘model clinical network’ requirements and develop a phased implementation/ adoption programme;
• Develop the benefits framework and evaluation process for the model clinical network with established baseline measurement;
• Full year efficiencies will be maximised further in years 2 and 3 including;
• Trajectory for achieving 30% of face to face consultations replaced with technology over 5 years;
• Sustained delivery of access targets across the West Yorkshire footprint;
• More flexible use of clinical capacity and agile response to variations in demand;
• Increased clinical productive time;
• Reduced use/demand and cost of Locum/ Agency spend;
• Develop the system strategy: Work to develop the WYAAT partnership strategy is already underway with expected completion December 2015. The strategy will take the Carter review as the baseline and identify value add through wide scale technology enabled change;
• Develop the Model Clinical Network: agree strategic and operational plans to improve access to specialist clinicians, share workforce and develop rotational posts across acute providers. This will include reconfigured clinical pathways for people with general and specialist needs including technology solutions to provide care closer to home once the immediate specialist care episode is complete. A tiered/stratified model will be developed for local vertical integration, horizontal networks and specialist services. We want to lead these changes in the UK and given our experience to date we are confident we can deliver.

3 Recommendations

The Governing Body are being asked to:

i. Note the update on the Vanguard Programmes and how this impacts of the delivery of the Forward View;
ii. To agree to receive further reports about all the vanguard programmes outlined in this report;
iii. To agree to support that the Urgent Care/Emergency Care Vanguard is hosted in
Wakefield and that Wakefield Clinical Commissioning Group Chief Officer takes forward a significant leadership role as SRO for this vanguard programme.

4 Enclosures:

Appendix A – Future models of acute care collaboration application
REGISTRATION OF INTEREST FOR FUTURE MODELS OF ACUTE CARE COLLABORATION

Please keep your applications to no more than 4 pages

Q1. Who is making the application?
(What is the entity or partnership that is applying? Interested areas may want to list wider partnerships in place, e.g. with the voluntary sector. Please include the name and contact details of a single CEO best able to field queries about the application and whether you are applying to lead a partnership or are applying to be part of a partnership.)

This application is made by the West Yorkshire Association of Acute Trusts (WYAAT), with the named contact being Julian Hartley, CEO- Leeds Teaching Hospitals NHS Trust. Julian is the chair of WYAAT which is an alliance of 6 Acute Providers - Calderdale and Huddersfield NHSFT, Bradford Teaching Hospitals NHSFT, Airedale NHSFT, Harrogate and District NHSFT, Mid Yorkshire Hospitals NHS Trust, and Leeds Teaching Hospitals NHS Trust.

West Yorkshire Population – The Scale of the Opportunity

- The population of West Yorkshire is circa 2.35m people.
- Projected population growth is to 2.47m out to 2025, 6% over the next 10 years, with continued growth beyond this.
- The 65 and older population is expected to grow rapidly, in some age bands by more than 30% over the next 10 years.
- £2.55bn expenditure on acute care

WYAAT members are also actively engaged in the 5 existing Vanguards located in West Yorkshire and key stakeholders in the West Yorkshire Urgent and Emergency Care Vanguard. Developing a strong provider association into a Vanguard will also support the wider development of the commissioner collaboration across West Yorkshire (10CC) strategic programme – Healthy Futures

Contact points for this bid is Stacey.Hunter@anhst.nhs.uk

Q2. What are you trying to do?
(Please outline your vision and what you want to achieve by being part of the new care models programme)

Our shared vision is to create a system of high quality, resilient, and sustainable acute services which consistently deliver the best patient outcomes compared to any system in the country. The new models of care programme for acute care collaboration provides an immediate catalyst for our journey.

Our ambition with the support of the Vanguard is to draw on West Yorkshire’s track record on technology innovation and use this as a platform to deliver a radical change in the way clinical resource and expertise is delivered to patients in acute services across our population. In the US and Canada 1 in 6 acute consultations are virtual rather than face to face, and for those who are leading innovation the evidence demonstrates this could be as high as 50%. Kaiser predicts that by 2016 they will have reached a tipping point of more non face to face consultations than traditional face to face.

WYAATs focus is to drive forward a ‘model clinical network’ that will not only deliver improved and consistent outcomes for patients (building on the success of existing networks) but will use technology as a key enabler to change 30% of consultations to a virtual platform over the next 5 years. Developing this approach across networks at scale rather than in individual institutions will improve clinical productivity and workflows, the delivery of 7/7 working across a large population driving up quality and experience for patients and their families. The association is clear that they can go further and faster together to deliver clinically and financially sustainable services than they can on their own. It is centered on what patients want and preserving local access to services wherever feasible.

We want to lead these changes in the UK and given our experience to date we are confident we can deliver. Therefore through this Vanguard we will:
1) Prioritise the services that would benefit most from establishing **horizontal clinical networks** supported by proven innovative implementation of technology. The initial focus will be on diagnostics e.g. Radiology Network due to increased demand over the last 5 years, scope of services and specialisation, potential impact across multiple acute pathways and known workforce pressures. The proposal is to collaborate and form a radiology network of expertise across WYAATs population. Larger groupings of clinicians working in this way (enabled by technology to share data and virtual platform) has the potential to give greater capacity to provide 24/7 cover across a range of specialties than individual organisations working in isolation.

This approach will improve patient access to specialist radiologist expertise and skills when they need it. The ambition is to translate the learning and evidence from Airedale’s use of Telemedicine as well as Leeds’ experience of a shared care record and apply it at scale across acute pathways and services. The association recognises the opportunities of spreading this approach across a range of specialties and are working together to identify those that can benefit most. The group do not underestimate the scale of this challenge hence are keen to have access to the Vanguard programme. The evidence from international health systems and local experience to date coupled with the system leadership WYAAT brings offers an excellent foundation to develop at pace.

2) Developing the workforce – Design and implement a new approach to workforce development and managing the West Yorkshire labour market. Having developed the Calderdale Framework locally, HR Directors will work across our association to develop strategies for improving capacity through recruitment, developing new alternative roles, reducing excessive costs and improving productivity We will use our existing workforce in a more creative and agile way across organisations and reduce the perverse incentives in the market. **New workforce models will be developed** across the region to support the Model Network approach which includes joint appointments, shared rotas and staff working flexibly across the network. The vision over time will require clinicians and clinical teams to deploy their expertise across networks of care as opposed to in individual hospitals.

3) Bring together **patient information/clinical and social care systems** so we have a full picture of the patient journey, their record and services across West Yorkshire. We will also accelerate change by learning from our Prime Minister’s Challenge Fund and Vanguard sites, particularly in primary care and care homes, as well as scaling up local innovation. Having developed an exemplar approach to technology and telehealth our vanguard will focus on extending the scope, reach, impact and lead times for developing this model on a West Yorkshire footprint covering over 2.3m people and 39,000 staff.

Q3. Please articulate how your vision will deliver clinically and financially sustainable high quality acute services to maintain local access for patients and their families and/or how you will help codify and replicate effective clinical and managerial operating models in order to reduce avoidable variations in the cost and quality of care?

WYAAT is aiming to extend the concept of a 'model hospital' which delivers efficient high quality services across the footprint of 6 organisations to develop a 'model clinical network' operating at scale across a population of over 2.3m people. The 'model clinical network' will enable large scale improvement in:

- Patient access (remote, virtual and multi-channel provided 7 days a week)
- Patient experience and confidence (accuracy of information and single input)
- Geographical reach to specialist skills independent of service or patient location
- Capacity optimisation – utilising clinical expertise in a collaborative network approach will allow the capacity to be spread more evenly and smooth access to services for patients
- Quality and safety (safety systems, access to information and specialist skills)
- Efficiency and productivity through system wide delivery. A network approach will enable better demand optimisation through streamlining of clinical pathways, reduce unnecessary and duplicate testing. Sustainability of services where there are challenges to achieving the standard of care relating to access or workforce/skills
- Clinical productive time and capacity for patient care through shared information and system wide pathways
- Cost effectiveness of services across the network
The association is already aiming to share knowledge, practice and skills to deliver the Carter
principles and ‘model hospital’ however this Vanguard will take the approach to the next level, looking
to implement additional benefits which can be delivered across a much wider footprint – all providers
thinking and planning as a system not individual organisations.

The total expenditure on acute care across the West Yorkshire region is £2.55bn. In terms of financial
efficiency we need to improve our overall combined financial position by 4.7% in the current year. On
that basis we are planning to develop the approaches described in section 2 to enhance utilisation of
clinical resources and capacity whilst minimising the variation in practice. This will deliver sustainable
high quality clinical services whilst reducing costs. The patient benefits will be significant as well as
establishing a national model for developing and delivering the ‘model clinical network’ across multiple
providers.

The opportunity is for the association to exploit economies of scale using technology as the key
enabler to support horizontal networks. The technology platform will improve access to services, and
give a better return on workforce investment. This has the potential to deliver approximately 15-20%
additional value for every pound we spend.

A detailed breakdown of the attributable benefits is being developed by the CFO group to identify and
quantify these by autumn. We have also established the potential to stress test these assumptions
through our emerging partnerships and to offset our expenditure from the public purse to cover our
costs through new commercial and investment opportunities.

Q4. Please describe where you are currently and what steps you have already taken in
thinking through and delivery towards your proposed care model.

Below is a brief summary of steps already taken in realising our vision for a ‘model clinical network’.
Whilst this is not exhaustive WYAAT believes this demonstrates our commitment and ambition in
delivering a new care model for the population of West Yorkshire.

**Leadership:** WYAAT has a well-established, stable and credible CEO team. Each Trust Board has
approved and supported the association and Terms of Reference. WYAAT is an ambitious enterprise,
built on a shared desire to create sustainable care and a sound financial base in the knowledge that
individual institutions have only limited ability to deliver this. The system has a high degree of
collaborative behaviors which differentiates it from many other areas. Significant time has been spent
on building and maintaining relationships across the WYAAT CEOs which has led to successful
smaller scale integration.

**Governance:** A governance framework and infrastructure is being developed with the aim of providing
a flexible, agile approach whilst supporting the speed of adoption and implementation. This means
substantial progress can be made quickly an ambition which is shared across medical and clinical
leaders. The association recognises as the work and commissioning alliances develops the
accountability and governance models for the new services will need to be developed. There is
experience locally in developing Joint Ventures and an appetite to explore other models e.g. prime
provider, alliance model. WYATT would welcome the support and experience other Vanguards will
offer to this

**Logistics:** The work programme is already established with lead CEOs and Directors for each strand
and dates agreed for the outputs. These will inform the strategic development of acute services in
West Yorkshire and add weight to the existing vanguard sites within the region. If successful we will be
in a strong position to implement changes at pace joining up with our vanguard MCPs.

**Resources:** We have agreed a small budget contribution to enable to work to progress where external
support is needed and have identified people and resource from our trusts that all adds up to a
commitment approaching £200k in cash and resource. We are also hopeful of inward investment in a
number of our work strands through agreement of new partnerships.

**Model Clinical Network:** the initial focus of our work programme after Radiology targets urgent care
and hyper acute stroke, Children’s services, Cancer services, and subsequently acute surgical
services. The model network will look to develop a sustainable platform for providing a wide range of
acute 7 day services and maximizing the potential of productive clinical time. Commitment to a series
of collaborative changes that will transform acute services and reduce variation for a conurbation of
2.3m population that employs 39k staff. An existing example is LTHT and HDFT working in partnership
to increase access to Endoscopy services utilising HDFT workforce and LTHT estates.

**Technology resource, innovation and skills:** The WYAAT health and social care economy already
has the greatest density of Vanguards, has established networks linked by technology, delivers video consultations across England, is ambitious to become a test bed site and has extensive academic support including the Digital Health Enterprise Zone hosted by the University of Bradford. There is a regional Digital Health and Wellbeing Board hosted by the Y and H Academic Health Science Network that is chaired by one of the WYATT CEOs. This provides further opportunity to co-ordinate activities and identifies synergies in relation to technology innovations across the group.

Q5. Where do you think you could get to over the next year? (Please describe the changes, realistically, that could be achieved by then.)

In the first year WYATT will:

- Finalise the system governance and accountability for the association and Vanguard including clinical engagement programme
- Develop a system wide strategy for building the ‘model clinical network’. The first stages are described above.
- Map the existing technology against the ‘model clinical network’ requirements and develop a phased implementation/adoption programme
- Develop the benefits framework and evaluation process for the model clinical network with established baseline measurement

Full year efficiencies will be maximised further in years 2 and 3 including:

- Trajectory for achieving 30% of face to face consultations replaced with technology over 5 years
- Sustained delivery of access targets across the West Yorkshire footprint
- More flexible use of clinical capacity and agile response to variations in demand
- Increased clinical productive time
- Reduced use/demand and cost of Locum /Agency spend

Develop the system strategy: Work to develop the WYAAT partnership strategy is already underway with expected completion December 2015. The strategy will take the Carter review as the baseline and identify value add through wide scale technology enabled change.

Develop the Model Clinical Network: agree strategic and operational plans to improve access to specialist clinicians, share workforce and develop rotational posts across acute providers. This will include reconfigured clinical pathways for people with general and specialist needs including technology solutions to provide care closer to home once the immediate specialist care episode is complete. A tiered/stratified model will be developed for local vertical integration, horizontal networks and specialist services.

Q6. What do you want from a structured national programme? (Aside from potential investment and recognition: i.e. what other specific support is sought?)

- Access to information on the latest NHS technology innovations and thought leadership (national and international)
- Expertise in developing new forms of public private partnerships (accepting that normal procurement rules would need to be followed), including potential investment partners
- Access to national intelligence on reconfiguration greater efficiency and better outcomes can be achieved
- Opportunities to pilot new approaches to labour market management and workforce models
- Opportunities to pilot radical changes in our vanguard, where people have approached NHS England to identify capable demonstration sites
- The flexibility to develop local reinvestment where our programmes deliver a return on investment
- Opportunities to work closely with key national programmes, e.g. 7 day services
- Peer review and challenge from other Vanguards. Replicating models where there is a significant opportunity
- Guidance and support for best practice governance, accountability models and legal and contractual frameworks

We are confident that this approach can transform care for the patients of West Yorkshire and we hope that you can give us a chance to describe this further at a second stage of questioning.

Signed - All the CEOs in the member Trusts.
Please send the completed form to the New Care Models Team (england.newcaremodels@nhs.net) by 31 July.
Title of meeting: Governing Body

Date of Meeting: 12 January 2016

Paper Title: Annual Public Health Report 2015
Creating health for a generation: the 1,000 day challenge

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

Report Author and Job Title: Dr Andrew Furber, Director of Public Health

Responsible Clinical Lead: Dr Andrew Furber, Director of Public Health

Responsible Governing Board Executive Lead: Dr Andrew Furber, Director of Public Health

Recommendation:
It is recommended that the Governing Body note the recommendations of the Director of Public Health’s Annual Report 2016 and discuss how they will respond to the 1,000 day challenge.

Executive Summary:
Many of our biggest killers, including heart disease, lung disease and cancer, have their beginnings in our early life experiences. Similarly our mental health, how we do at school, the sort of job we get and where we end up living are all profoundly affected by our experiences in our early years. Unhealthy children are likely to become unhealthy parents which perpetuates the cycle of disadvantage.

There is compelling and increasing evidence that our experiences during the 270 days of pregnancy and the first two years of life (270 + 365 + 365 = 1,000 days) determine much of our future health and wellbeing.

The Director of Public Health is challenging all those in Wakefield district – individuals, families, communities and organisations – to take action over the next 1,000 days so that the 10,000 babies born during that period will have the best possible start in life.

Link to overarching principles from the strategic plan:
- Citizen Participation and Engagement ✓
- Wider Primary Care at Scale including Network development ✓
- A Modern Model of Integrated Care ✓
- Access to the Highest Quality Urgent and Emergency Care ✓
- A Step Change in the Productivity of Elective Care ✓
- Specialised Commissioning ✓
- Mental Health Service Transformation ✓
- Maternity, Children and Young People Transformation ✓
- Organising ourselves to deliver for our patients ✓

Outcome of Impact Assessments completed (e.g. Quality IA or Equality IA) Not applicable

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

Management of Conflicts of Interest: None identified.
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Wakefield District Annual
Public Health Report

Creating health for a generation: the 1,000 day challenge

www.wakefield.gov.uk
Creating health for a generation: the 1,000 day challenge

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<td>Map of locations of Children’s Centres, Early Help Hubs and Neighbourhood Policing Teams</td>
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Welcome to my Annual Report for 2015. This is my independent assessment on the state of health of residents within Wakefield district. This year I am focussing on the first 1,000 days of a child’s life.

In previous reports I have noted that many of the health and wellbeing challenges facing the district have their origins in early childhood. For example, we have high rates of lung cancer in the district much of which is related to smoking. Smoking is an addiction which starts in adolescence, and those who take up smoking are much more likely to have grown up in a home where adults smoked.

Many of our biggest killers, including heart disease, lung disease and cancer, have their beginnings in our early life experiences. Similarly our mental health, how we do at school, the sort of job we get and where we end up living are all profoundly affected by our experiences in our early years. Unhealthy children are likely to become unhealthy parents which perpetuates the cycle of disadvantage.

There is compelling and increasing evidence that our experiences during the 270 days of pregnancy and the first two years of life (270 + 365 + 365 = 1,000 days) determine much of our future health and wellbeing.

This is not a counsel of despair; changes later in life can make a real difference. Nor is it a reason to blame parents and carers – their job is not at all an easy one. However it is a reason to look at children’s experiences in these first 1,000 days and see if there is anything we can do to make them better.

I am challenging all those in Wakefield district – individuals, families, communities and organisations – to take action over the next 1,000 days so that the 10,000 babies born during that period will have the best possible start in life.

I hope you find the report useful. I would welcome any feedback and can be contacted on afurber@wakefield.gov.uk or 01924 305501 or write to me at:

Wakefield Council
Wakefield One
PO Box 700
Wakefield
WF1 2EB

Dr Andrew Furber
Director of Public Health
Wakefield Council
From birth to age 18 months, connections in the brain are created at a rate of one million per second.

Babies are disproportionately vulnerable to abuse and neglect. Around 26% of babies are estimated to be living within complex family situations where there are problems such as substance misuse, mental illness or domestic violence.

During the first 1000 days of life a child’s brain develops rapidly, increasing in size from 25% of its adult size at birth to about 75% of its adult size by the end of second year.
When to have a baby

Whilst it is possible to have a healthy successful pregnancy at whatever age a woman conceives, the chances are much better between the ages of 18 and 35 years of age. In Wakefield district we still have too many under 18 year olds conceiving, despite teenage conception rates falling by nearly half over the last 15 years.

Babies born to mothers who are under 18 years old are more likely to be premature, small and suffer from a range of long term health problems. They are more likely to go on and become a teenage parent themselves which perpetuate the cycle of disadvantage.

There is a lot of support in Wakefield district to empower young people to say no to sex before they feel ready. For the minority who are sexually active there is also help available in terms of advice and access to contraception and other sexual health services. Further support is available if a young woman becomes pregnant. Information can be found at http://www.wfact.co.uk/

**Annual conceptions to women aged under 18**

(Rate of conceptions per 1,000 women ages 15 - 17. Source ONS, 2015)
The Family Nurse Partnership (FNP) is a voluntary home visiting programme for first-time young mums, aged 19 years or under. A specially trained family nurse visits the young mum regularly; from the early stages of pregnancy until their child is two.

Alison1 was a 17-year-old college student when she discovered she was 10 weeks pregnant with her first child. This was an unplanned pregnancy but a wanted baby. Alison had been with her partner for 8 months. She had not told her family about her pregnancy and described feeling low in mood, anxious and alone. Alison was living with her mum, but their relationship was strained.

Through visits from a Family Nurse it became clear that the primary issue for Alison was her limited support network, and the negative impact this was having on her emotional health. Her relationship with her mum broke down when she informed her of her pregnancy. Alison became homeless and moved into a hostel.

However, despite her low mood, Alison consistently spoke positively about her unborn child, there was evidence of emerging maternal instincts and attachment and she engaged well with FNP.

The Family Nurse supported Alison to resolve her housing problem and she is now in her own accommodation. The FNP programme strengthened and widened Alison’s support network. Listening visits were used to support Alison’s emotional health, and FNP materials explored attachment and supported the development of parenting skills.

Alison now has an improved support network, including her paternal grandmother who provides childcare one day a week to allow Alison time to herself. Alison’s mood is improved and she speaks positively about her maternal role and has bonded well with her baby. Alison has now enrolled back at college.

Alison’s baby is a happy, sociable boy who is achieving all developmental milestones. He socialises well with other children at groups and has consistent contact with his great-grandmother.

1. This is a true story but names have been changed.
Pregnancy

Becoming pregnant can be the most wonderful and the most stressful time of life. Having healthy parents both before conception and during pregnancy is an extremely important for the development of a healthy child. This is the time when the foundations for the child’s future are laid.

Health and care services within the district will do much to keep mums-to-be fit and well. But there are some really important things that parents and families can do for themselves. These include:

- **Giving the mum-to-be the necessary social and emotional support**
- **Eating healthily**
- **Avoiding alcohol**
- **Stopping smoking**

Stopping smoking is the single most important thing anyone can do to become healthier. More women from poorer backgrounds will smoke during pregnancy. This contributes to the inequities in health and life expectancy experienced by those already disadvantaged groups.

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In 2013 smoking at time of delivery nationally was **12.7%**

In Yorkshire and the Humber it was **16.5%**

In Wakefield it was **22.8%**

This relatively high level varied considerably across Wakefield from **6.8%** in Sandal and Agbrigg to **38.2%** in Lupset.

In 2013/14 the Wakefield rate had reduced to **21.9%** and in 2014/15 it was down to **19.7%**

The target for Wakefield for 2015/16 has already been set at **18%** or below
We should be ambitious about supporting this generation of children and young people to grow up in a smokefree district. Families and communities have a big role here as well as supporting women to stay smokefree during pregnancy. Schools, workplaces and public sector agencies all have a role to play. Healthcare providers have a particular responsibility, but their advice and help won’t help if that support is not extended to the environment where the person lives.

**So far we have implemented a number of initiatives aimed at reducing the level of smoking in pregnancy these include:**

- Our midwifery service has targets to ensure women who smoke are identified and offered support
- An incentive scheme for pregnant smokers provided through our specialist stop smoking service
- Smoking in pregnancy identified as a priority by NHS Wakefield Clinical Commissioning Group and GP Network development plans
- Funding our midwifery service to access carbon monoxide meters in order to demonstrate to women the effect of cigarette smoking
- Working with local women to develop resources for use to support to stop smoking while pregnant

**More work is still needed to:**

- Identify and provide appropriate education and training to help staff support women effectively
- Ensure the strategies we are currently implementing are successful through evaluation

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**Case study: Shape Your Pregnancy**

Eating well and feeling good about your self are especially important during pregnancy. Shape Your Pregnancy is a local programme which supports pregnant women to do just this.

Michelle, mum-of-two, started coming to Shape Your Pregnancy sessions after she began feeling down and unmotivated during her second pregnancy. The programme helped her to turn her life around and she is now enjoying being active with her daughter and new born baby.

**Before I started doing the Shape Your Pregnancy programme, I felt like my mood was going down.** I was feeling really lazy, suffering from headaches and dizziness and eating way too much. I ate a lot of junk food as I wasn’t preparing or cooking food very much. I didn’t exercise at all - I rarely left the house. I found this hard at first as my legs felt tired, but I found the more walking I did, the easier it became. I felt happier day by day and felt much more confident about being out in public, and my self-confidence went up. I also noticed my energy levels increase hugely from doing more exercise and drinking more water, my headaches also disappeared and I felt that I could cope better looking after my young daughter throughout my pregnancy. I also started sleeping much better, and I woke up feeling refreshed and wanting to eat breakfast. I feel so good about myself now, as I know I look good, I feel good and people are commenting on how well I look and how good my skin is! I can even now fit into clothes that I couldn’t fit into before I was pregnant! I would advise any woman to just go for it!

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2. This is a true story but the lady’s name has been changed to protect her anonymity.
The birth of a child and the immediate period after birth is both a brilliant and a vulnerable time. Being a good parent is terrifically rewarding as well as being tremendously challenging.

Developing a good attachment bond with your baby is fundamental to a child's development and to enjoying parenthood. The attachment bond is the unique emotional relationship between your baby and you as his or her primary carer. During pregnancy and in the year after birth women can be affected by a range of mental health problems which can impact on attachment. Mental health during this (perinatal) period is one of Public Health England's Early Years priorities and our local action plan will ensure support is available.

For many developing a good attachment will come naturally, but the following actions\(^3\) will help:

1. Having main caregiver during the first six months – whilst it’s fine for others to help out, attachment develops best where one person provides most of the care.
2. Developing a consistent schedule of eating, sleeping and play during the first few months
3. Regularly smile, touch and show affection to your baby
4. Act consistently in response to your baby’s distress – provide comfort but don’t overdo it, babies need to learn to calm themselves
5. Make sure the relationship with your baby is two way – interact and play in ways the baby initiates rather than just how you feel
6. Take care of yourself – caring for a baby is a tough job!

Breastfeeding your baby can go a long way to developing good attachment with your baby. It requires a main caregiver, provides touch and an opportunity to interact and helps mum stay healthy too.

Wakefield district has one of the lowest breastfeeding rates in our region. This suggests there is a major opportunity to improve attachment through promoting breastfeeding. 60% of Wakefield babies are breastfed at birth but this drops to 45% after 10 days and only 33% at 6-8 weeks after birth.

• It is recommended that all infants are exclusively breastfed for six months and thereafter alongside other foods
• Breastfeeding is great for both the mother and child – breast milk is free, it boosts a child’s immune system protecting them from developing many allergies and infections, it helps mums lose weight and reduces their risk of developing breast and ovarian cancer in the future.

What works to support breastfeeding and relationship building?
Mid Yorkshire Hospitals NHS Trust has achieved recognition from UNICEF’s (United Nations Children’s Fund) Baby Friendly Initiative. This standard needs to be maintained across all services to ensure consistent levels of evidence based support for all parents.

What could we do better?
• Ensure services provide targeted support for mothers who are least likely to breastfeed and who are at risk of poor health outcomes
• All relevant organisations sign up to a Wakefield district infant feeding action plan. This will help develop a culture where breastfeeding is accepted, with more women empowered to breastfeed and to continue to breastfeed for longer
• Services to adopt revised Baby Friendly Initiative standards. Our re-assessment for the Baby Friendly Initiative is due in February 2016. These are recognised standards for maternity, neonatal, health visiting and children’s centre services

Case study: Breastfeeding Support Groups
Weekly or monthly breastfeeding support groups offer breastfeeding parents the chance to socialise with other breastfeeding families and share experiences. This helps to normalise the reality of breastfeeding. It allows the opportunity for families to support each other whilst still being able to access the support of a trained peer supporter.

"Breastfeeding support groups really help! There is one in my local children centre on Tuesday morning. You can always discuss your problems with other mums or breastfeeding supporter"

"Don't give up because no matter how hard it is now it will get better very soon and it makes life so much easier in long run. See if there is a local breast feeding group, having a cup of tea once a week with people going through exactly the same as you is so beneficial"
During the first two years of life the child is developing rapidly. The challenges of being a good parent begin to change. Providing for a child’s physical needs, such as nutritious food, health care including immunisation, and a healthy environment (for example dry, warm, free from exposure to tobacco smoke and free from poverty) are important but only part of what is needed.

The child’s emotional and mental development is interlinked with their physical development. The early social experiences of a child will influence their future behaviour and their future emotional and physical health into adulthood.

For very young children much of their environment revolves around their relationship with their parents or carers. Strong, secure relationships will provide a solid basis for their development; this includes development of language, social skills, resilience, emotional wellbeing and confidence. The way the parent speaks to the child, the language they use, the care and security of emotional support they provide even at this very young age will help shape the child’s future in either a positive or negative way. The emotional and mental health of parents and carers is therefore also of utmost importance. For example high levels of maternal depression have been found to be associated with language and developmental delay and behavioural problems for the child.

In Wakefield we believe that creating health and not just treating illness is the key to ensuring the future wellbeing of our population. Children’s Centres offer a menu of activities and services aimed at supporting the child and family to ensure healthy emotional and physical development. The transfer of commissioning responsibilities for the Health Visitor Service and Family Nurse Partnership to Wakefield Council in October 2015 will provide greater opportunities for health and social care professionals to work together. This will help develop integrated and effective ways to support our young children and their families and carers.
Oral health is an important part of health both before and after birth. At birth a baby has twenty primary (milk) teeth that have begun to form during pregnancy.

Older children in Wakefield have higher levels of decayed teeth than regional and national figures. For example, 19.8% of Wakefield 3 year olds have some decayed teeth. This is the highest percentage across Yorkshire and Humber and higher than the England average of 11.7%.

**Steps for achieving good oral health in young children include:**
- Tooth brushing with fluoride tooth paste from when the teeth start to appear
- Reducing the amount sugary food and drinks that a child consumes
- Visiting the dentist for regular dental check-ups

Improving children’s oral health is a priority for Wakefield underpinned by the delivery of Oral Health Action Plan as one of Public Health England’s Early Years priorities.
Children living in poverty

In Wakefield we experience higher levels of child poverty and national. In 2012 the national rate was 19.2% regional 20.8% and Wakefield 20.6%

Case study: Emma and Jack

Emma, a first time mother who suffered with low mood, disclosed how her family were rather negative about her ability to be a good parent to her son, Jack. She lacked confidence in herself. At Jack’s 8 week check-up he showed signs of delayed physical and social development.

Emma and Jack were introduced to Wakefield’s Stay, Play & Learn programme. Emma’s confidence grew and she began to take on board the advice and support of other parents, taking comfort from their shared experiences.

Jack’s communication skills improved, his posture and ability to mobilise increased dramatically. He became more socially aware and his responsiveness to others improved.

Jack has now been discharged from the care of paediatricians. Emma is actively involved with promoting Stay, Play & Learn. She helps set up sessions and welcome new attendees. Emma and other local parents have created a parent’s forum which allows them to provide further advice and help to local mums and dads. Emma has been transformed from someone who thought she was a bad parent to someone who now offers support to other parents. Jack is developing as a healthy and happy child.

4. This is a true account but names have been changed.
The role of Adverse Childhood Experiences

The first 1,000 days is a crucial period for the development of a child’s brain. If the child is subject to adversity during this period the impact on thinking skills, social skills and emotional resilience can be profound. The more of these Adverse Childhood Experiences (ACEs) a child suffers, the greater the risk of harm to their physical and mental health.

Adverse Childhood Experiences can include any of the following:

- physical, sexual or emotional abuse
- emotional or physical neglect as a child, including being undernourished or dirty
- growing up in a household with domestic violence
- parental separation
- having a family member with a substance misuse problem
- having a family member having been in prison
- serious mental illness within the family

The more of these Adverse Childhood Experiences (ACEs) a child suffers, the greater the risk of harm to their physical and mental health.
Parents are the most important reading role models for children and young people, not only showing children what it’s like to be ‘a reader’, but how and where to access books. ‘When Professor Kathy Sylva, the principal investigator for the Effective Provision of Pre-School Education (EPPE) research team was asked “What is it that parents should do in those early years?” she replied “Take them to the library”\(^2\).

There is overwhelming evidence that literacy has a significant relationship to people’s life chances. Sharing stories, books and rhymes with young children promotes strong and loving relationships and secure attachment bonds. These are crucial to developing positive emotional health and wellbeing in later life. Parents can discover that their child enjoys being read to and so they read even more – a ‘virtuous circle’ of deepening attachment and the pleasure of reading. Studies have shown that differences in reading and cognitive skills are not related to the child’s family background or home environment, but are the direct result of how frequently they have been read to prior to starting school. Parents have an incredible opportunity to have a positive impact on children’s ability to read. As the ‘Read On, Get On’ campaign\(^1\) reminds us,

It’s never too early to start sharing stories and rhymes with babies. Those ten minutes a day can begin when baby is still a ‘bump’. Babies in the womb might not be following every word, but they are listening to their mother’s voice and can recognise familiar songs and rhythms after birth.


‘Parents, carers and anyone with a child in their life can make a huge difference by reading for just ten minutes a day’.
Wakefield Council Libraries offer a friendly and welcoming environment, allowing very young children and their parents and carers the freedom to explore books/rhymes and have fun in a non-threatening and non-judgemental setting. Libraries have worked hard to become more welcoming and accessible to families with very young children. All the newly refurbished libraries in Wakefield, Castleford, Stanley, Horbury, South Elmsall, Normanton, Featherstone and Sandal have specially designed and dedicated areas. Children are welcome at any time and each library has at least one story time session per week with more frontline staff than ever trained to deliver these sessions. Working in partnership with Mid Yorkshire Hospitals NHS Trust and Early Years’ services, libraries deliver the Bookstart book gifting programme to babies and 3 year olds across the district. This gives every parent access to free books to support their literacy journey.

Try these top tips for reading with your child:

• Encourage your child to hold the book themselves and/or turn the pages
• Don’t be afraid to use funny voices – it’s a great way to make your child giggle
• Talk to your child about what’s going on in a book and give them plenty of time to respond.
• Sharing books isn’t just about the words - point to the pictures and relate them to something your child knows
• Using a puppet to act out a story can help your child to understand what’s going on and learn how to pretend play
• And lastly – make it fun! It doesn’t matter how you read with a child, as long as you both enjoy the time together!
A general practitioner and others providing primary healthcare do so largely for individuals but must take account of all the fore-mentioned factors recognising that the greater the immaturity of child the greater the potential impact. Our service and practices aims to promote for families the concepts and application of healthy living which affect their children before and after birth.

Our services aim not only to provide health services but to measure their impact. Our focus is on healthcare for which we have primary responsibility and expertise. While these aim at health promotion and prevention they encompass the detection and management of illness and anomalies which may impair optimal health. Consequently we approach this in the framework of:

- Prevention and health promotion
- Mitigating the severity of emerging disease
- Reducing the impact of existing or detected long-term disorders.

The first 1,000 days are especially important because these include the sensitive periods amenable to permanent change.
Wakefield district’s integrated locality working provides high quality support to children, their families and communities. Support is offered at the right time, by the right worker in the right place and includes early help as well as help for children in need of protection. This model underpins the successful delivery of universal, prevention and early intervention and statutory support services.

In 2015, Children’s Services began a transformation programme in recognition of the need to improve outcomes for children, young people and families in the future. Research, data and local knowledge tells us Wakefield district has high levels of deprivation and demand for services. We need to ensure our resources are targeted in the right place and develop a way to improve outcomes, aspirations and life chances for all, especially our most vulnerable children, young people and families.

Children’s Services is committed to working with all partners to deliver the following jointly agreed District Outcomes to support children in their first 1,000 days:

- Make sure partners work more closely together in communities
- Support children who need help earlier in their lives
- Protect children who are at risk
- Support people to live smokefree lives and be more physically active
- Help children in care to find adoptive families sooner and do better in school
- Help our disadvantaged children do better in school
- Tackle domestic abuse and improve support for victims
Stillbirths
Stillbirths are babies born after 24 weeks of pregnancy with no sign of life. The stillbirth rate in Wakefield remains higher than the England and regional averages, although not statistically significantly higher. On average, around 25 pregnancies in Wakefield result in a stillbirth each year.

Infant mortality
Infant mortality is part of the Government’s strategy for public health; it remains a public health priority and is included as an indicator in the Public Health Outcomes Framework. In Wakefield, around 20 babies die each year before their first birthday. The infant mortality rate in Wakefield (4.9 per 1,000 live births, 2011-2013) although higher than both the national and regional averages (4.0, 4.3), is not significantly different (Public health Outcomes Framework, May 2015).

Stillbirth rate 2009 -11 to 2011-13 (per 1,000 births)

<table>
<thead>
<tr>
<th></th>
<th>Wakefield</th>
<th>England</th>
<th>Region</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011-2013</td>
<td>5.7 (4.5-7.2)</td>
<td>4.9 (4.8-5.0)</td>
<td>5.3 (5.0-5.6)</td>
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<tr>
<td>2010-2012</td>
<td>6.6 (5.3-8.2)</td>
<td>5.0 (4.9-5.1)</td>
<td>5.4 (5.1-5.7)</td>
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<tr>
<td>2009-2011</td>
<td>5.7 (4.5-7.1)</td>
<td>5.2 (5.1-5.2)</td>
<td>5.6 (5.3-5.9)</td>
</tr>
</tbody>
</table>

Source: HSCIC Compendium of Population Health Indicators
Supporting Data

**Low birth weight**

Since 2009 the proportion of babies born with a low birth weight has decreased in Wakefield. Latest data shows that Wakefield had a lower proportion of low birth weight births than both the England and regional averages, 2.5% (98) of babies had a low birth weight in 2012.
School readiness – child development

School readiness measures the proportion of children achieving a good level of development at the end of reception (Early Years Foundation Stage). It is a key measure of early years development, across a range of developmental areas and is included as an indicator in the Public Health Outcomes Framework. In Wakefield 60.3% of pupils achieved a good level of development at the end of reception, similar the national average of 60.4%, and significantly higher than the regional average of 58.7% (2013/14).

There are a number of risk factors associated with poor outcomes, both in the early part of a child’s life and in later years; including smoking in pregnancy, maternal obesity, low socioeconomic status of the mother, ethnicity, and older and younger mothers 7, 8

Maternal obesity

Maternal obesity increases the risk of stillbirth and perinatal mortality 8,9 (deaths occurring in the first 7 days of life). Data on maternal obesity is not routinely available; this will change in the future as a result of the national maternity and children’s dataset, scheduled to commence in June 2015. Prior to April 2013 and the changes to the Health and Social Care Act, public health had access to maternity data, unfortunately maternal BMI was not routinely recorded.


Supporting Data

**Breastfeeding**

Breastfeeding has health benefits for both the mother and baby. It is considered to be an important public health measure, illustrated by the inclusion of two breastfeeding measures in the Public Health Outcomes Framework and the national support to deliver the Breastfeeding Commissioning pack as one of Public Health England’s Early years priorities.

The graphs below show that breastfeeding rates in Wakefield, both at birth and 6-8 weeks, are lower than the national and regional averages.
Of those women who initiated breastfeeding at birth, 22% had stopped by the time their baby was 10 days old, almost 45% of had stopped by the time their baby was aged 6-8 weeks.

Local data for 2012/13 shows there are huge inequalities in breastfeeding rates in Wakefield, in the most deprived areas rates for breastfeeding initiation and breastfeeding at 6-8 weeks are significantly lower in the most deprived areas.
Smoking at time of delivery

The proportion of women smoking during pregnancy remains significantly high in Wakefield. In 2013/14 21.9% (846) of women who gave birth were recorded as smokers, significantly higher than the national and regional averages (12.0, 16.2), and is one of the highest rates in the region.

Within Wakefield a higher proportion of women living in the most deprived areas continue to smoke during pregnancy; 41.6% in the most deprived areas, compared to 6.9% in the least deprived (2012/13).
### Unequal Life Chances - The first 1000 days of a child's life

For every 100 children born in these areas, how many will meet the following characteristics?

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>10% most deprived areas of the District</th>
<th>10% least deprived areas of the District</th>
</tr>
</thead>
<tbody>
<tr>
<td>Their mother will smoke during pregnancy</td>
<td>41</td>
<td>7</td>
</tr>
<tr>
<td>They will be born with a low birth weight (&lt;2500 grams)</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>Their life expectancy at birth (males)</td>
<td>72.4 years</td>
<td>82.0 years</td>
</tr>
<tr>
<td>Their life expectancy at birth (females)</td>
<td>76.7 years</td>
<td>85.7 years</td>
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<tr>
<td>They will be breastfed from birth</td>
<td>38</td>
<td>75</td>
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<tr>
<td>They will still be breastfed at 6-8 weeks after birth</td>
<td>28</td>
<td>45</td>
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<tr>
<td>They will live in poverty</td>
<td>42</td>
<td>5</td>
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<tr>
<td>They will achieve a good level of school readiness</td>
<td>49</td>
<td>72</td>
</tr>
<tr>
<td>They will be overweight by the time they reach reception</td>
<td>26</td>
<td>22</td>
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</tbody>
</table>
## Unequal Life Chances - The first 1000 days of a child's life

For every 100 children born in these areas, how many will meet the following characteristics?

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Airedale and Ferry Fryston Ward</th>
<th>Stanley and Outwood East Ward</th>
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<td>Their mother will smoke during pregnancy</td>
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<td>12</td>
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<tr>
<td>They will be born with a low birth weight (&lt;2500 grams)</td>
<td>11</td>
<td>3</td>
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<tr>
<td>Their life expectancy at birth (males)</td>
<td>75 years</td>
<td>79.8 years</td>
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<tr>
<td>Their life expectancy at birth (females)</td>
<td>79.4 years</td>
<td>86.4 years</td>
</tr>
<tr>
<td>They will be breastfed from birth</td>
<td>37</td>
<td>66</td>
</tr>
<tr>
<td>They will still be breastfed at 6-8 weeks after birth</td>
<td>27</td>
<td>43</td>
</tr>
<tr>
<td>They will live in poverty</td>
<td>35</td>
<td>9</td>
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<tr>
<td>They will achieve a good level of school readiness</td>
<td>51</td>
<td>67</td>
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<td>They will be overweight by the time they reach reception</td>
<td>29</td>
<td>16</td>
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<tr>
<td>Recommendation</td>
<td>Who should take action?</td>
<td>How will we know if it has worked?</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------</td>
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<tr>
<td><strong>Main recommendation</strong></td>
<td>All individuals, families, communities and organisations.</td>
<td>Improved outcomes for children and young people.</td>
</tr>
<tr>
<td>That all of us in Wakefield district to take action over the next 1,000 days so</td>
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<tr>
<td>that the 10,000 babies born during that period will have the best possible start</td>
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<tr>
<td>in life.</td>
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<tr>
<td><strong>Other recommendations</strong></td>
<td>Health and Wellbeing Board</td>
<td>Early years featuring within Health and Wellbeing Board work programme.</td>
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<td>Wakefield district’s Health and Wellbeing Board, in collaboration with the</td>
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<td>Improved outcomes for children and young people.</td>
</tr>
<tr>
<td>Children and Young People’s Partnership, should prioritise support in the</td>
<td></td>
<td></td>
</tr>
<tr>
<td>first 1,000 days and set an ambition for improved outcomes.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Further development of Wakefield district’s Children’s Services offer to families</td>
<td>Wakefield Council Children’s Services and relevant partners.</td>
<td>Community champions in place. Evidence that families are supported by the most appropriate service.</td>
</tr>
<tr>
<td>with or expecting young children by signposting to universal services and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>community groups, development of community champions, quality assurance and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>better marketing of these activities.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>There should be an evaluation of services provided within the first 1,000</td>
<td>Service commissioners.</td>
<td>Decommissioning of less effective services in order to secure investment in the most effective services.</td>
</tr>
<tr>
<td>days to ensure they are effective and offer value for money.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reading is a very effective and straightforward way of strengthening early</td>
<td>All public sector services and community groups who work with families including local</td>
<td>Bookstart gifting to all babies.</td>
</tr>
<tr>
<td>attachment and language development. Parents should be encouraged to read for</td>
<td>libraries, childminders, nurseries and childcare settings.</td>
<td>Increased numbers of families accessing Storytimes in Wakefield Council libraries.</td>
</tr>
<tr>
<td>at least 10 minutes a day with their child and to access library services</td>
<td></td>
<td>Increased issues of books to under 5s in Wakefield Council libraries.</td>
</tr>
<tr>
<td>regularly.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Progress on 2014 recommendations

<table>
<thead>
<tr>
<th>Recommendation from 2014 report</th>
<th>How we will measure progress?</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Everyone should try to move more – physical activity is a really important part of staying well and preventing ill health</td>
<td>National surveys of physical activity Participation in physical activity within the district</td>
<td>There is no significant change in the active people survey reports from last year. However we are showing a significant increase from our base line figures We continue to implement interventions aimed at Health by Stealth, and mass participation e.g. walking and cycling. We have developed a new strategy to increase participation We have carried out local research into our barriers and are working to enable these barriers within the new strategy We have produced a directory of opportunities for participation so that across the district people are more aware of what is available.</td>
</tr>
<tr>
<td>Wakefield should aspire to be a smokefree district. Although most people (and fewer young people than ever) are smoking, tobacco use remains the district’s leading cause of ill health</td>
<td>Increase in the number of smokefree environments Reduction in the proportion of adults who smoke Reduction in the proportion of women who smoke during pregnancy</td>
<td>Latest published (2013) adult prevalence is 25%, a slight increase (0.2%) on the previous year (2012). Smoking at the time of delivery is seeing a small but steady reduction South West Yorkshire Partnership NHS Foundation Trust will go smokefree on December Stop Before Your Op scheme implemented with Mid Yorkshire Hospitals NHS Trust and Public Health Midwife recruited to support activity to reduce smoking during pregnancy Wakefield district’s Smokefree Alliance aims to expand the smokefree play parks campaign and work with local businesses (routine and manual workers smoking prevalence is 33.4%) particularly in more disadvantaged areas Breathe 2025, a vision to inspire a smokefree generation will be launched on 12 November, and we are looking for as many people/organisations as possible to pledge support to the campaign by visiting <a href="http://www.breathe2025.org.uk">www.breathe2025.org.uk</a> Smoking in pregnancy identified as priority in 6 of the 7 GP clinical networks in the district and the Stop Smoking Service is delivering training to the networks.</td>
</tr>
<tr>
<td>Continue progress on dementia awareness</td>
<td>Number of individuals, communities and organisations working towards becoming dementia friendly Rate of diagnosis of dementia</td>
<td>The Dementia Action alliance was created last year to support dementia friendly environments. So far 35 individuals, communities and organisations have signed up to being dementia friendly Wakefield District has exceeded the national target for rate of dementia diagnosis.</td>
</tr>
<tr>
<td>Domain 1: Improving the wider determinants of health</td>
<td>Number</td>
<td>PHOF reference</td>
</tr>
<tr>
<td>---------------------------------------------------</td>
<td>--------</td>
<td>----------------</td>
</tr>
<tr>
<td>1</td>
<td>1.01</td>
<td>Percentage of children living in relative poverty</td>
</tr>
<tr>
<td>2</td>
<td>1.05</td>
<td>Percentage of 16-18 year olds not in education, employment or training</td>
</tr>
<tr>
<td>3</td>
<td>1.10</td>
<td>Number of people killed or seriously injured on the roads, all ages, per 100,000 resident population</td>
</tr>
<tr>
<td>4</td>
<td>1.17</td>
<td>% of households considered fuel poor</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Domain 2: Health Improvement</th>
<th>Number</th>
<th>PHOF reference</th>
<th>Indicator Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>2.02i</td>
<td>Breastfeeding Initiation</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>2.02ii</td>
<td>Breastfeeding prevalence at 6-8 weeks after birth</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>2.03</td>
<td>Rate of smoking at time of delivery</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>2.06i</td>
<td>Percentage of children aged 4-5 classified as overweight or obese</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>2.06ii</td>
<td>Percentage of children aged 10-11 classified as overweight or obese</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>2.07i</td>
<td>Crude rate of emergency admissions caused by unintentional and deliberate injuries in children aged 0-14 years, per 10,000 resident population</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>2.07ii</td>
<td>Crude rate of emergency admissions caused by unintentional and deliberate injuries in children aged 15-24 years, per 10,000 resident population</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>2.14</td>
<td>Smoking prevalence in all adults</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Domain 3: Health Protection</th>
<th>Number</th>
<th>PHOF reference</th>
<th>Indicator Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>13</td>
<td>3.02</td>
<td>Crude rate of chlamydia diagnoses per 100,000 young adults aged 15-24</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>3.03iv</td>
<td>MenC coverage (Aged 1)</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>3.03v</td>
<td>PCV coverage (Aged 1)</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>3.03viii</td>
<td>MMR 1 dose (Aged 2)</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>3.03x</td>
<td>MMR 2 doses (Aged 5)</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>3.03xiv</td>
<td>Flu coverage (aged 65+)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Domain 4: Healthcare public health and preventing premature mortality</th>
<th>Number</th>
<th>PHOF reference</th>
<th>Indicator Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>19</td>
<td>4.01</td>
<td>Crude rate of infant deaths (persons aged less than 1 year) per 1,000 live births</td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>4.03</td>
<td>Age-standardised rate of mortality from causes considered preventable per 100,000 population</td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>4.10</td>
<td>Age-standardised mortality rate from suicide and injury of undetermined intent per 100,000 population</td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>4.15</td>
<td>Excess winter deaths index</td>
<td></td>
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</table>

**Notes and Data Sources:**

<table>
<thead>
<tr>
<th>Domain 1: Improving the wider determinants of health</th>
<th>Domain 2: Health Improvement</th>
<th>Domain 3: Health Protection</th>
<th>Domain 4: Healthcare public health and preventing premature mortality</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Percentage of children living in relative poverty</td>
<td>2. Breastfeeding Initiation</td>
<td>3. Rate of smoking at time of delivery</td>
<td>4. Crude rate of infant deaths (persons aged less than 1 year) per 1,000 live births</td>
</tr>
</tbody>
</table>
| 2. Percentage of 16-18 year olds not in education, employment or training | 2. Breastfeeding prevalence at 6-8 weeks after birth | 2. Smoking prevalence in all adults | 2. Crude rate of infant deaths (persons aged less than 1 year) per 1,000 live births (
| 3. Number of people killed or seriously injured on the roads, all ages, per 100,000 resident population | 2. Rate of smoking at time of delivery | 3. Crude rate of chlamydia diagnoses per 100,000 young adults aged 15-24 | 2. Crude rate of infant deaths (persons aged less than 1 year) per 1,000 live births |
| 4. % of households considered fuel poor | 2. % of children aged 4-5 classified as overweight or obese | 3. Crude rate of chlamydia diagnoses per 100,000 young adults aged 15-24 | 2. Crude rate of infant deaths (persons aged less than 1 year) per 1,000 live births |

**Key:**
- Better than the national figure
- Similar to national figure
- Worse than the national figure
- Performance is improving
- Performance is level
- Performance is getting worse

Notes and Data Sources:
1. Children living in families in receipt of out of work benefits, or tax credits where their reported income is less than 60% median income. HMRC;
Map of locations of Children’s Centres, Early Help Hubs and Neighbourhood Policing Teams

**Integrated Early Help Hubs**
1. Chesneys Centre
2. City Limits
3. Five Towns Centre
4. Haucroft Children’s Centre
5. Ossett Library
6. Platform 1 Centre Hemsworth
7. Pontefract Library

**Main Children’s Centre Sites**
1. Airedale Children’s Centre
2. Castle Children’s Centre
3. Cedars Children’s Centre
4. Oakhill Children’s Centre
5. Pomfret Children’s Centre
6. Stanley Children’s Centre

**Link Children’s Centre Sites**
1. Acorn Children’s Centre
2. Butterflies Children’s Centre
3. Forrest Wood Children’s Centre
4. Pinmoor Children’s Centre
5. Sharlston Children’s Centre
6. Stanley Children’s Centre

**Neighbouring Policing Teams**
1. Castleford - Castleford Fire Station
2. Normanton & Featherstone - Divisional HQ Havertop Lane
3. Pontefract & Knottingley - Pontefract Police Station
4. South East - South Kirkby Police Station
5. Wakefield Central - Northgate
6. Wakefield North West & Rural - Ossett Police Station

**Neighbouring Coordinators (NCOs)**
West - Helen Walker
East - Alison Bird

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Acknowledgements

Lisa Chandler
Andrea Firth
Paul Jaques
Sarah Jones
Anna Middlemass
Jill Poole
Anna Ross
Helen Sweaton
Karen Wilkinson
Andy Wright
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<th>Title of meeting:</th>
<th>Governing Body</th>
<th>Agenda Item:</th>
<th>12</th>
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<tr>
<td>Date of Meeting:</td>
<td>12 January 2016</td>
<td>Public/Private Section:</td>
<td></td>
</tr>
<tr>
<td>Paper Title:</td>
<td>Mid Yorkshire Health System Resilience Update</td>
<td>Public</td>
<td>✓</td>
</tr>
<tr>
<td>Purpose (this paper is for):</td>
<td>Decision</td>
<td>Discussion</td>
<td>Assurance</td>
</tr>
<tr>
<td>Report Author and Job Title:</td>
<td>Michala James, System Resilience Manager</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Responsible Clinical Lead:</td>
<td>Dr Adam Sheppard, Assistant Clinical Chair</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Responsible Governing Board Executive Lead:</td>
<td>Jo Pollard, Chief of Service Delivery and Quality</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recommendation:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. New Mid Yorkshire SRG arrangements</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. High level SRG risks and mitigating actions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Mid Yorkshire SRG winter assurance position as being ‘partially assured’.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>4. Wakefield CCG 2015/16 allocation of system resilience finance</td>
<td></td>
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</tr>
<tr>
<td>5. Revised Surge and Escalation Policy</td>
<td></td>
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<tr>
<td>6. Resilience for Christmas and New Year</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Link to overarching principles from the strategic plan:</td>
<td>Citizen Participation and Engagement</td>
<td></td>
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<tr>
<td></td>
<td>Wider Primary Care at Scale including Network development</td>
<td></td>
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<tr>
<td></td>
<td>A Modern Model of Integrated Care</td>
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<td></td>
<td>Access to the Highest Quality Urgent and Emergency Care</td>
<td>x</td>
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<tr>
<td></td>
<td>A Step Change in the Productivity of Elective Care</td>
<td></td>
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<tr>
<td></td>
<td>Specialised Commissioning</td>
<td></td>
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<tr>
<td></td>
<td>Mental Health Service Transformation</td>
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<tr>
<td></td>
<td>Maternity, Children and Young People Transformation</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Organising ourselves to deliver for our patients</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Outcome of Impact Assessments completed (e.g. Quality IA or Equality IA):</td>
<td>Not applicable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outline public engagement – clinical, stakeholder and public/patient:</td>
<td>Not applicable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assurance departments/organisations who will be affected have been consulted:</td>
<td>Members of the Mid Yorkshire System Resilience Group Integrated Governance Committee</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Previously presented at committee/governing body:</td>
<td>Integrated Governance Committee in November 2015</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk Assessment:</td>
<td>Used to inform the risk assessment and forms as part of the CCG review of assurance for winter 2015/16</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Finance/ resource implications:</td>
<td>Finance implications in relations to the funding of schemes for 2015/16 as funding now for 2015/16 now in the CCG baseline.</td>
<td></td>
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</tbody>
</table>
MID YORKSHIRE SYSTEM RESILIENCE GROUP UPDATE

1. Purpose

The paper has been written to provide the Governing Body with an update on the current System Resilience Group (SRG) arrangements, including the winter preparedness assurance position.

2. Background

System Resilience is the sustainable year round delivery of high quality services and is founded on the principle of ensuring patient flows both unplanned and planned throughout the health and social care systems consistently during the year.

System Resilience Groups (SRG) were established to develop a co-ordinated approach across commissioner and providers to ensure one planning process across all areas of health and social care. Bringing together the systems planning processes underlines the importance of whole system resilience and that commissioner and provider processes need to be addressed simultaneously in order for local health and social care systems to operate as effectively as possible in delivering year-round services for patients. SRGs are established on acute hospital footprints.

Whilst winter is clearly a period of increased pressure, establishing sustainable year-round delivery requires careful co-ordination and for planning to be ongoing and robust. This work will put the health and social care economy in a position to move away from a reactive approach to managing operational problems to shifting towards a proactive system of year round operational resilience.

National guidance “The Preparation for Winter 2015/16” has been issued from the tripartite of NHS England, Monitor and the Trust Development Agency (TDA) outlining the following elements and key points for which SRGs are accountable:

SRG Assurance
- The expansion of the SRG remit to include cancer and planned care (18 weeks referral to treatment target)
- The nine high impact interventions for Ambulance Trusts.
- 24/7 Liaison Mental Health (LMH) services in A&E.
- Crisis Care Concordat
- The enhanced support team.
- Delayed transfers of care.
- Communications and marketing campaigns.
- Declaring a critical incident or emergency, and the role of the Emergency Preparedness, Resilience and Response (EPRR) framework
- National flu programme

The Wakefield CCG, in partnership with North Kirklees CCG, takes the lead in planning, managing and holding the ‘system’ to account during periods of increased demand and activity. However, this lead role can only be enacted with the consent and support of all the agencies involved, including but not limited to:
• Mid Yorkshire Hospitals Trust (MYHT)
• Locala
• Yorkshire Ambulance Service (999; 111 and Out Hours services) (YAS)
• South West Yorkshire Partnership Foundation Trust (SWYPFT)
• Local Care Direct
• Wakefield
• Kirklees Council

3. SRG Arrangements

In October 2015 the arrangements of the SRG were revised to ensure we are maximising the role and potential of the group. All SRG members are now senior decision makers for their organisation at either chief executive or director level, with delegated authority. Revising the membership of the group been crucial in developing the most effective strategy and in making timely decisions, at the right level.

A System Intelligence Group was established, as sub group of the SRG to provide support and to develop system wide intelligence on the provision of urgent and elective care services. It was agreed that members and nominated deputies will be senior manager level (tactical). The System Intelligence Group will;

• Provide a support function to the SRG in understanding the key blockages within the system and to identify, where possible, solutions and to escalate key decisions to the SRG.
• Provide monthly updates to the SRG to include exception reports for areas of underperformance, key operational challenges and potential solutions.
• Aim to develop a consensus about what the data is showing and to address assumptions made about the data.
• Reporting a range of whole system metrics to identify system effectiveness.
• Utilise operational intelligence to tell the story or the narrative behind the data.
• Undertake specific pieces of work as requested by the SRG

4. Risks and mitigation

The Mid-Yorkshire footprint health and social care economy is a complex system delivered by multiple agencies. All organisations are responsible for managing their own individual risks with the SRG responsible for identifying, agreeing mitigating actions and monitoring system risks through the system resilience plan.

The following table provides an example of the high level risks across the system in delivering system resilience and the SRG’s mitigating actions.

<table>
<thead>
<tr>
<th>Risk</th>
<th>Mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>There is a risk of not maintaining system resilience due to increased demand, acuity of patients, workforce capacity and capability over 7 days resulting in failure to meet constitutional standards, deliver improved outcomes for patients &amp; reputational impact for SRG partners.</td>
<td>The development and implementation of robust multiagency structures, processes and services to manage patients through the system to ensure they are in the most appropriate place to meet both their medical and social needs. Dedicated work streams to reduce the levels</td>
</tr>
<tr>
<td>Risk</td>
<td>Solution</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Delayed transfer of care across all providers with agreed priority areas and reduction trajectory.</td>
<td>Dedicated transformation work stream to address the main issues to drive a reconfiguration of workforce to align with both national and local priorities across the system in line with the West Yorkshire Urgent &amp; Emergency Care Network. Create a shared workforce culture built on common values and more staff able to work flexibly across the system.</td>
</tr>
<tr>
<td>Risk organisations across the SRG are unable to secure and align workforce capacity and skills to meet the local demand for their services resulting in adverse impacts on system resilience across the footprint.</td>
<td>Further work required to improve alignment and to gain shared understanding of additional capacity and intended impact/benefits of all funding sources that contribute to improving systems resilience e.g. routine contractual, transformational schemes, Vanguard, Better Care Fund and SRG winter funded schemes etc.</td>
</tr>
<tr>
<td>Risk that financial challenges across the health and social care system may have an adverse impact on systems resilience across the SRG footprint.</td>
<td>Dedicated workstreams to understand the challenges to care homes and to generate ideas for market development, care home support and sustainability.</td>
</tr>
<tr>
<td>Risk that the number of nursing and residential care homes and associated bed numbers may reduce further due to regulatory changes &amp; increased CQC scrutiny and nurse re-validation process, resulting in delays to assessments and discharges which may have an adverse impact on discharge flow and system resilience across the SRGs footprint.</td>
<td></td>
</tr>
</tbody>
</table>

5. Winter Preparedness

In the letter NHS England Publications Gateway reference: 03815, the tripartite wrote to System Resilience Group (SRG) chairs outlining their expectation that all systems will have robust plans in place for winter, and to set out the next steps and goals for the rest of the year. There is close liaison between the CCG system resilience team and the NHS England Yorkshire and the Humber team ensuring positive, two-way flow of information to ensure clarity and timely communication. The SRG was required to submit assurance to NHS England on;

- Winter readiness
- Governance and leadership
- Capacity, demand and data analysis
- Non-acute demand
- Progress against the eight high impact interventions for urgent and emergency care
As the Mid Yorkshire Hospitals Trust is not achieving the 4 hour A&E standard the SRG is required to complete an additional assurance to outline reasons for underperformance and actions taken to address these.

Following regional moderation from NHS England on 30 September 2015, the SRG was scored as being ‘partially assured’. This score is consistent with SRGs across Yorkshire and the Humber and, indeed, wider.

In order to develop our winter preparedness and strengthen our position, the timetable below outlines some of the key actions undertaken and completed by SRG partners.

<table>
<thead>
<tr>
<th>Action</th>
<th>Deadline</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Submit SRG winter assurance to NHS England</td>
<td>2 September 2015</td>
<td>Completed</td>
</tr>
<tr>
<td>Confirm the winter schemes funded from system resilience</td>
<td>18 September 2015</td>
<td>Completed</td>
</tr>
<tr>
<td>Provide further information to NHS England assurance</td>
<td>30 September 2015</td>
<td>Completed</td>
</tr>
<tr>
<td>following moderation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Finalise SRG winter communications plan</td>
<td>29 September 2015</td>
<td>Completed</td>
</tr>
<tr>
<td>Hold a Winter Preparedness: Confirm and Challenge event</td>
<td>29 September 2015</td>
<td>Completed</td>
</tr>
<tr>
<td>Revise the SRG Surge &amp; Escalation Policy</td>
<td>29 September 2015</td>
<td>Completed</td>
</tr>
<tr>
<td>Deliver Breaking the Cycle: Help Me Home exercise</td>
<td>11 – 18 November 2015</td>
<td>Completed</td>
</tr>
<tr>
<td>SRG winter plan to be finalised</td>
<td>16 November 2015</td>
<td>Completed</td>
</tr>
<tr>
<td>Christmas and New Year Plan to be finalised</td>
<td>18 December 2015</td>
<td>Completed</td>
</tr>
</tbody>
</table>

5.1 SRG Surge and Escalation Policy

The SRG Surge and Escalation Policy was revised and signed off by the SRG in November 2015. Following the formal 2014/15 de-brief it was agreed that the refresh of the plans needs to be substantial, particularly in relation to improving the prediction of surge, identification of system triggers, how we organise together and also the actions we take. The SRG Surge and Escalation Policy uses the 6 REAP levels as outlined below. System wide triggers and actions have been agreed for each level of escalation.

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Normal</td>
</tr>
<tr>
<td>2</td>
<td>Concern</td>
</tr>
<tr>
<td>3</td>
<td>Moderate Pressure</td>
</tr>
<tr>
<td>4</td>
<td>Severe Pressure</td>
</tr>
<tr>
<td>5</td>
<td>Critical (Major Incident Stand By)</td>
</tr>
<tr>
<td>6</td>
<td>Potential Service Failure (Major Incident)</td>
</tr>
</tbody>
</table>
5.2 SRG Winter Plan

The Mid Yorkshire SRG Winter Plan 2015/16 outlines SRG partner organisations arrangements in place over the winter period, using demand and capacity planning. Development of the winter strategy is built on a number of principles. These are that the health and social care community should:

- Maintain people who need care/support in their own home as far as possible
- Keep people out of hospital
- Provide hospital care only for the most acutely ill
- Provide safe services
- Maintain effective and mutual partnership across the health and social care economy

5.3 Breaking the Cycle: Help Me Home exercise 11 – 18 November 2015

From 11 – 18 November, the SRG ran a Breaking the Cycle: Help Me Home exercise. The aim of ‘Breaking the Cycle’ initiatives is to rapidly improve flow to produce a step-change in performance, safety and patient experience. The initiative is typically run over one week during which the whole organisation and its health and social care partners focus on improving the emergency care pathway. The exercise was undertaken;

To develop sustainable changes that will improve patient flow across the local system;

- As part of the SRG winter preparation to create capacity;
- To further embed Helping People Home recommendations;
- To further embed CQC Improvement Plan actions;
- To engage frontline staff with their ideas of how, by working in new/different ways the patient experience can be improved; and
- As part of the local Emergency Care Improvement Plan using the Safer Faster, Better guidance published on 2 September as the evidence base on which to build improvements that includes the Safer Bundle.

An evaluation is currently being carried out and recommendations from the event will be presented to the SRG in January 2016.

5.4 SRG Christmas and New Year Plan

Building on from the Winter Plan, a Christmas and New Year plan was written to provide details of the local health and social care arrangements in place over the Christmas and New Year Period (21 December 2015 – 15 January 2016).

At the beginning of December a series of letters were sent from Monitor, Trust Development Authority, Department of Health, Department for Communities and Local Government and the Emergency Care Improvement Programme asking system leaders asking to consider additional actions in to manage the Christmas and New Year period.
The Mid Yorkshire SRG was asked to achieve a 20% bed availability buffer on 24 December 2016 and to maintain this through to 4 January 2016. In order to achieve this key recommended actions for the system were to;

- Make sure appropriate levels of senior medical, nursing, diagnostic, social care and therapy cover are in place from 25 December through to the second week in January to ensure flow through the acute bed base
- Consider a reduction of elective activity immediately prior to Christmas to create non-elective capacity.
- Consider the cancellation of some outpatient activity to free senior decision makers to enhance ward presence and accelerate discharge where appropriate
- Put enhanced therapy and social worker resources in place to facilitate discharge
- Apply local ‘choice policies’ to ensure transfers to available care home capacity
- Have clear discharge plans written up prior to the holiday period to allow for discharge (including nurse-led) as appropriate during Christmas week.
- Frequently review of all patients in community beds to facilitate discharge and allow appropriate ‘pull’ from acute hospital beds.
- Run a Multi-disciplinary Accelerated Discharge Event (MADE) in early January with the express purpose of increasing safe and appropriate discharges from the acute site (see section 5 for details).
- This plan outlines the arrangements for MY SRG partners over the Christmas and New Year period, including the additional actions outlined above. All partners have committed to running a Breaking the Cycle: Help Me Home exercise (see section 4 for details).

In response to the target placed on health and social care systems to achieve a 20% bed ‘buffer’ availability by 24 December and though until 8 January, Mid Yorkshire SRG partners have committed to running Breaking the Cycle: Help Me Home events on the following days;

- 21 December – 24 December 2015
- 29 December – 31 December 2015
- 4 January – 8 January 2016

6 Emergency Care Improvement Programme

The Mid Yorkshire SRG has been selected to participate in the national Emergency Care Improvement Programme (ECIP) due to its performance against the 4 hour A&E standard. The Emergency Care Improvement Programme is a clinically led programme that will offer practical help and support to the 27 urgent and emergency care systems across England that are under the most pressure. It will support rapid and sustained improvements in quality, safety and patient flow. The programme will help improve care for patients, with a particular focus on improving system performance across the winter months, when emergency departments are working under additional pressure.

ECIP will focus on helping local systems implement evidence based tried and trusted improvements that are proven to work. The success of ECIP will be measured against better patient outcomes and experience as well as improvements to the emergency care four hour waiting time standard.
The ECIP team carried out a walkthrough of Pinderfields Hospital on 16 November 2015 and Dewsbury Hospital on 17 November 2015. The review was structured around a clinical walkthrough of the patient pathway across the hospital’s urgent and emergency care system. This included meeting with both clinical and managerial staff involved in running and working across the acute pathways. Reports have been presented to SRG on 22 December which builds on the initial verbal feedback provided at the end of the day and aims to provide practical recommendations.

7 SRG Finance

The Wakefield CCG allocation for system resilience funding for 2015/16 was £2,491,000. The table below provides a high level breakdown of the CCG’s allocation of system resilience funding, which is accurate at the time of writing.

The process for agreeing the allocation of system resilience funding for 2015/16 was;
1. SRG members recommend resilience schemes to Wakefield CCG
2. Wakefield CCG Executive Team approved the schemes
3. Chief Officer and Chief Finance Officer signed off financial allocation

The Wakefield CCG funding allocation can be categorised into the following types of initiatives;
- Admission avoidance – this includes a wide range of initiatives, i.e. extending primary care out of hours, community respiratory services, surge capacity for West Yorkshire GP out of hours, care home pilots, community pharmacy repeat prescription scheme.
- Hospital surge capacity – this includes schemes within the acute trust to help support surges in demand to provide additional capacity.
- Discharge support – this includes a wide range of initiatives, i.e. elderly discharge schemes, integrated discharge arrangements, voluntary sector transport scheme.
- Leadership and management – to provide support to system leadership including staffing, training and communications initiatives.

The pie chart below provides an outline of the split of the system resilience allocation in the categories mentioned above.
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<tr>
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<th>Governing Body</th>
<th>Agenda Item:</th>
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<td>Public/Private Section:</td>
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<tr>
<td>Paper Title:</td>
<td>Delivering the Forward View: NHS Planning Guidance 2016/17 –2020/21</td>
<td>Public</td>
<td>✓</td>
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<tr>
<td>Purpose (this paper is for):</td>
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<td>Discussion</td>
<td>Assurance</td>
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<tr>
<td>Report Author and Job Title:</td>
<td>Esther Ashman, Head of Strategic Planning Andrew Pepper, Director of Finance</td>
<td></td>
<td></td>
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<td>Responsible Clinical Lead:</td>
<td>Dr Phil Earnshaw, Chair of Governing Body</td>
<td></td>
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<td>Responsible Governing Board Executive Lead:</td>
<td>Pat Keane, Director of Strategy and Organisational Design</td>
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<tr>
<td>Recommendation:</td>
<td>That Governing Body delegate the approval of the 8th February draft submission of the 2016/17 Operational Plan to the appropriate Directors within NHS Wakefield CCG Executive Team.</td>
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<td>Executive Summary:</td>
<td>The planning guidance for 16/17 – 20/21 ‘Delivering the five year forward view: NHS Planning Guidance’ was published on the 23rd December 2015 and sets out how it intends the NHS to deliver the five year forward view. It provides specific guidance as to what it is expected to be contained within the 16/17 operational plans and gives an overview of what is expected of the five year System Transformation Plans (STP). Further guidance of what is expected within the STP’s along with details of CCG financial allocations and the Better Care Fund will be published later in January 2016.</td>
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<tr>
<td>Link to overarching principles from the strategic plan:</td>
<td>Citizen Participation and Engagement ✓</td>
<td>Wider Primary Care at Scale including Network development ✓</td>
<td>A Modern Model of Integrated Care ✓</td>
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<td>Outcome of Impact Assessments completed (e.g. Quality IA or Equality IA):</td>
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<td>Outline public engagement – clinical, stakeholder and public/patient:</td>
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<td>Management of Conflicts of Interest:</td>
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<td>Assurance departments/ organisations who will be affected have been consulted:</td>
<td>Departments and organisations affected will be consulted with as part of the planning process.</td>
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<tr>
<td>Previously presented at committee / governing body:</td>
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<td></td>
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</tbody>
</table>
• Delivering the Forward View: NHS Planning Guidance 16/17 – 20/21 summary briefing  
• Appendix 1 Financial Planning Assumptions and Business Rules |
| **Risk Assessment:** | Any risks associated with the detail of the planning guidance will be reviewed as part of the planning process. |
| **Finance/ resource implications:** | Detailed financial and resource implications have been highlighted within the summary paper and as part of appendix 1. Further detail around specific allocations however, have yet to be published. |
Delivering the Forward View: NHS Planning Guidance 16/17 – 20/21

Introduction

The guidance for this year’s planning round was published on the 23rd December and sets out how it intends for the NHS to implement the five year forward view, restore and maintain financial balance and to deliver core access and quality standards for patients. With an £8.4bn real term increase in funding by 20/21 the guidance indicates how together as commissioners and providers we will reduce the three gaps of finance and efficiency, care and quality and health and wellbeing. There is a clear move towards a whole system approach to planning as illustrated in the NHS Mandate and a message to move faster on areas of transformation. The requirement in this years planning round is to produce:

- a five year Sustainability and Transformation Plan (STP), place-based and driving the Five Year Forward View; and
- a one year Operational Plan for 2016/17, organisation-based but consistent with the emerging STP.

Sustainability and Transformation Plans

Health and social care systems are being asked to come together to develop their plans for delivering the five year forward view, covering a period of 16/17 – 20/21. This indicates a move towards a place based approach to complement organisational plans. In order to do this there will be a need to have strong system leadership through which all aspects of the system are engaged and for all involved to have a shared vision for the future. The plans must cover all commissioned activity including specialised services, Primary care and integration reflecting Health and Wellbeing strategies.

The STPs will also become the single application and approval process for being accepted onto programmes with transformational funding for 17/18 onwards. In order to access the funding, the plans need to be ‘compelling and credible’. This protected transformation funding is for initiatives such as the spread of new care models through and beyond the vanguards, primary care access and infrastructure, technology roll-out, and to drive clinical priorities such as diabetes prevention, learning disability, cancer and mental health. Local health systems now also are required to develop their own system wide local financial sustainability plan as part of their STP.

The STP is designed to be an overarching plan with several delivery plans underneath, likely to be covering different footprints. CCG’s are asked to define their ‘transformation footprints’ by the end of January. In Wakefield we have already developed our thinking around our transformation footprints and have had these approved at both Clinical Cabinet and Governing Body. Further guidance around the development of STPs will be published in January.

National ‘must dos’ for 2016/17

NHSE have developed a set of clear priorities for 16/17 which align to the NHS Mandate. They set out that by March 2017, 25 percent of the population will have access to acute hospital services that comply with four priority clinical standards on every day of the week, and 20 percent of the population will have enhanced access to primary care. There are three challenges they raise under the banner of seven day services:

- reducing excess deaths by increasing the level of consultant cover and diagnostic services available in hospitals at weekends. During 16/17, a quarter of the country must be offering four of the ten standards, rising to half of the country by 2018 and complete coverage by 2020;
• improving access to out of hours care by achieving better integration and redesign of 111, minor injuries units, urgent care centres and GP out of hours services to enhance the patient offer and flows into hospital; and
• improving access to primary care at weekends and evenings where patients need it by increasing the capacity and resilience of primary care over the next few years.

This is an area which will need to be addressed by both our STP and our 16/17 operational plan.

Other ‘must dos’ set out in the guidance for 16/17 are:

1. Produce a sustainability and transformation plan for the health economy.
2. Return to “aggregate financial balance” with secondary care providers delivering savings through the Lord Carter productivity programme and caps on agency spending. CCGs will be expected to save money through reducing variation and implementing the Right Care programme in every area.
3. Develop and implement a local plan to address the sustainability and quality of general practice, including workforce and workload issues.
4. Achieve waiting time targets for A&E patients and ambulance response times.
5. Improve and maintain performance against the 18 week RTT target.
6. Deliver the 62 day cancer waiting time target, including the two week referral and 31 day treatment targets. The guidance also calls for progress in one year survival rates by increasing the proportion of cancers diagnosed early.
7. Achieve and maintain new mental health waiting time targets which include more than 50 per cent of people experiencing a first episode of psychosis being treated within two weeks of referral and 75 per cent of people with common mental health conditions being referred to talking therapies within six weeks of referral, with 95 per cent treated within 18 weeks. Areas will also need to diagnose two thirds of their estimated population that has dementia.
8. Improve care for people with learning disabilities including improved community services and reducing inpatient facilities.
9. Providers will be required to publish avoidable mortality rate

There is a clear signal that the further development of new models of care should be in our STP’s, incorporating the work of the vanguards and what are the next steps for developing further.

**Operational Plans 16/17**

Local system leaders are required to have a shared and open-book operational planning process for 2016/17. This will cover activity, capacity, finance and 2016/17 deliverables from the emerging STP. The detailed requirements for the operational plan will be contained within the technical guidance which will be published in January 2016. However, we are advised that as part of our operational plan (which is to be classed as year one of our STP) CCG’s must set out:

• how they intend to reconcile finance with activity (and where a deficit exists, set out clear plans to return to balance);
• their planned contribution to the efficiency savings;
• their plans to deliver the key must-dos;
• how quality and safety will be maintained and improved for patients;
• how risks across the local health economy plans have been jointly identified and mitigated through an agreed contingency plan; and
• how they link with and support with local emerging STPs

**Allocations**

NHS England’s allocations to commissioners are intended to achieve:
• greater equity of access through pace of change, both for CCG allocations and on a place-based basis;
• closer alignment with population need through improved allocation formulae including a new inequalities adjustment for specialised care, more sensitive adjustments for CCGs and primary care, and a new sparsity adjustment for remote areas; and
• faster progress with our strategic goals through higher funding growth for GP services and mental health, and the introduction of the Sustainability and Transformation Fund.

Overall primary care spend will rise by 4-5% each year and specialised services funding will rise by 7 percent in 2016/17, with growth of at least 4.5 percent in each subsequent year. To support long-term planning, NHS England has set firm three year allocations for CCGs, followed by two indicative years. For 2016/17, CCG allocations will rise by an average of 3.4 percent and no CCG will be more than 5% below its target funding. Mirroring the conditionality of providers accessing the Sustainability and Transformation Fund, the real terms element of growth in CCG allocations for 2017/18 onwards will be contingent upon the development and sign off of a robust STP during 2016/17.

**Returning the NHS provider sector back to balance**

During 16/17 NHS Trusts will be required to return to financial balance. £1.8 billion of income from the 2016/17 Sustainability and Transformation Fund will replace direct Department of Health (DH) funding. The distribution of this funding will be calculated on a trust by trust basis by NHS Improvement and then agreed with NHS England. Providers who are eligible for sustainability and transformation funding in 2016/17 will not face a double jeopardy scenario whereby they incur penalties as well as losing access to funding; a single penalty will be imposed.

Quarterly release of these Sustainability Funds to trusts and foundation trusts will depend on achieving recovery milestones for (i) deficit reduction; (ii) access standards; and (iii) progress on transformation. The three conditions attached to the transitional NHS provider fund have to be hard-edged. Where trusts default on the conditions access to the fund will be denied and sanctions will be applied. There is a clear message that providers need to focus on cost reduction not on income growth. There will also be a focus on workforce productivity.

**Efficiency assumptions and business rules**

Consultation on tariff will propose a 2% efficiency deflator and a 3.1% inflation uplift for 16/17. To support system stability it is proposed to remain on HRG4 for a further year with no changes to specialist top-ups for 16/17. For planning purposes indicative price lists have been published and are available on the Monitor site. The consultation also includes a timetable for implementing a new payment approach to mental health.

NHS England is developing a single national purchasing and supply chain arrangement for specialised commissioning high cost tariff excluded devices with effect from April 2016. Transition plans will be put in place prior to this date with each provider to transition from local to national procurement arrangements. The 2 percent efficiency requirement is predicated upon the provider system meeting a forecast deficit of £1.8 billion at the end of 2015/16. Any further deterioration of this position will require the relevant providers to deliver higher efficiency levels to achieve the control totals to be set by NHS Improvement.
Commissioners will be required to deliver a surplus of 1% and are required to plan to spend 1% of allocation non-recurrently. There will also be a requirement to hold a contingency of 0.5% of allocation.

CCGs and councils will need to agree a joint plan to deliver the requirements of the Better Care Fund (BCF) in 2016/17. The plan should build on the 2015/16 BCF plan, taking account of what has worked well in meeting the objectives of the fund, and what has not. CCGs will be advised of the minimum amount that they are required to pool as part of the notification of their wider allocation. BCF funding should explicitly support reductions in unplanned admissions and hospital delayed transfers of care; further guidance on the BCF will be forthcoming in the New Year.

Commissioners must continue to increase investment in mental health services each year at a level which at least matches their overall expenditure increase. Where CCGs collaborate with specialised commissioning to improve service efficiency, they will be eligible for a share of the benefits. NHS England and NHS Improvement continue to be open to new approaches to contracting and business rules, as part of these agreements.

**Measuring progress of plans**

Plans will be measured via a new CCG Assessment Framework which will be consulted on in January. This will be through the new CCG Scorecard which will be the new assurance framework through which CCGs will be assessed.

**Timetable**

<table>
<thead>
<tr>
<th>Timetable</th>
<th>Date</th>
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<tbody>
<tr>
<td>Publish 2016/17 indicative prices</td>
<td>By 22 December 2015</td>
</tr>
<tr>
<td>Issue commissioner allocations, and technical annexes to planning guidance</td>
<td>Early January 2016</td>
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<tr>
<td>Launch consultation on standard contract, announce CQUIN and Quality Premium</td>
<td>January 2016</td>
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<tr>
<td>Issue further process guidance on STPs</td>
<td>January 2016</td>
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<tr>
<td>Localities to submit proposals for STP footprints and volunteers for mental health and small DGHs trials</td>
<td>By 29 January 2016</td>
</tr>
<tr>
<td>First submission of full draft 16/17 Operational Plans</td>
<td>8 February 2016</td>
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<tr>
<td>National Tariff S118 consultation</td>
<td>January/February 2016</td>
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<tr>
<td>Publish National Tariff</td>
<td>March 2016</td>
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<tr>
<td>Boards of providers and commissioners approve budgets and final plans</td>
<td>By 31 March 2016</td>
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<tr>
<td>National deadline for signing of contracts</td>
<td>31 March 2016</td>
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<tr>
<td>Submission of final 16/17 Operational Plans, aligned with contracts</td>
<td>11 April 2016</td>
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<tr>
<td>Submission of full STPs</td>
<td>End June 2016</td>
</tr>
<tr>
<td>Assessment and Review of STPs</td>
<td>End July 2016</td>
</tr>
</tbody>
</table>

**Recommendation**

That Governing Body delegate the approval of the 8th February draft submission of the 16/17 Operational Plan to the appropriate Directors within NHS Wakefield CCG Executive Team.

**Esther Ashman**

**Head of Strategic Planning**
APPENDIX 1

Financial Planning Assumptions and Business Rules

At the time of writing, the CCG level allocations have yet to be issued.

However, NHS England have advised that:

- There will be 3-year firm allocations and 2-year indicative allocations
- There will be changes to the allocation formula which revise the inequality adjustments, the Emergency Ambulance Cost Adjustment and introduce a new sparsity adjustment
- There will be increased investment in GP services, growth in mental health (in line with allocation growth) and growth in the Better Care Fund
- A new ‘Sustainability and Transformation Fund’ will be created to accelerate the introduction of 7 day services, GP access, Cancer and Mental Health initiatives and Prevention. In 2016/17, £1.8bn of the sustainability and transformation will be applied to delivering provider sustainability
- There will be an opportunity for systems to have shared financial control totals in the future
- Contributions to the national CHC restitution risk pool will be reduced in 2016/17 and reduced to nil beyond that.

The increases applied to CCG allocations will reflect pace-of-change adjustments (i.e. distance from target formula) and formula revision. However, on average, it is expected that allocations and activity growth will be:

- CCG budgets +3.4% growth (average)
  (nb all CCGs will receive growth uplift of +0.91%; being +1.66% inflation minus 0.75% average population growth. In addition, CCGs will receive real terms cash growth but this is reduced through pace-of-change adjustments)
- GP budgets +4% growth (average)
- Specialist Services budgets +7% growth (average)
- Acute care demand growth +2.9% (incl +0.7% demographic growth)

With regard to the CCG business rules; CCGs are required to:

- Deliver a minimum 1% surplus,
- Retain a minimum 0.5% contingency
  (nb the CCG retained a 1% contingency in 2015/16)
- Ensure that a minimum of 1% is invested non-recurrently
  (nb 1% non-recurrent reserve must be held uncommitted at the start of the year).
- Drawdown needs to be structured over 3 years
- Mental Health investment should be increased to match overall increase
- Systems can apply for a single control total
- Changes to the tariff system (HRG4+) will not be introduced this year
• There will be a net inflator of 1.1% representing 3.1% inflation and 2% efficiency factor.

With regard pace-of-change rules:

• The pace of change adjustment will ensure that no CCG should be under 5% away from target
• All CCGs will receive minimum cash growth equal to real terms growth and specific policy pressures (e.g. pension contributions and 7 day service). However, where a CCG is 10% above then cash growth is limited to specific policy pressures only OR where a CCG is between 5% and 10% then phasing applies
• With regard to Primary Care Medical allocations, there will be a minimum allocation to ensure that no locality is below 5% (although no CCG area will receive more than 10% per head growth) and real terms cash growth will be subject to phasing rules where a CCG area is above 5%

With regard system transformation planning:

• System wide local financial sustainability reconciling demand, efficiency, productivity and income generation which brings the system to aggregate financial balance.
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<th>Title of meeting:</th>
<th>Governing Body</th>
<th>Agenda Item:</th>
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<td>12 January 2016</td>
<td>Public/Private Section:</td>
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<tr>
<td>Paper Title:</td>
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<td>Discussion</td>
<td>Assurance</td>
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<td>Elizabeth Goodson, Commissioning Accountant</td>
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<td>Responsible Governing Board Executive Lead:</td>
<td>Andrew Pepper, Chief Finance Officer</td>
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<td>Recommendation:</td>
<td>It is recommended that the Governing Body receive and note the contents of the report.</td>
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<tr>
<td>Executive Summary:</td>
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<tr>
<td>The Month 8 Finance Report provides a year to date position as at 30th November 2015.</td>
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<td>The CCG is showing a breakeven position to date and at year end. This is including achievement of the required surplus of £5,935k</td>
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<td>All key performance targets are green, with the exception of QIPP year to date delivery.</td>
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<tr>
<td>Link to overarching principles from the strategic plan:</td>
<td>Citizen Participation and Engagement</td>
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<td>Wider Primary Care at Scale including Network development</td>
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<td>A Modern Model of Integrated Care</td>
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<td>Access to the Highest Quality Urgent and Emergency Care</td>
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<td>A Step Change in the Productivity of Elective Care</td>
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<td>Maternity, Children and Young People Transformation</td>
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<td>Organising ourselves to deliver for our patients</td>
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<td>Management of Conflicts of Interest:</td>
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<td>Assurance departments/organisations who will be affected have been consulted:</td>
<td>Elements of the Finance Report are also reported to NHS England via standard template returns. These are Headline Position, QIPP, Non-Recurrent Funds and Risks &amp; Opportunities.</td>
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<td>The report is a regular monthly report which is presented to IGC and also presented on a bi-monthly basis to governing body.</td>
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<td>Reference document(s)/enclosures:</td>
<td>Month 8 Finance Report.</td>
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<td><strong>Risk Assessment:</strong></td>
<td>The CCG risk register also includes the following risks which relate to our financial position:</td>
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<td>• Risk that the CCG fails to forecast its short term (1516) and long term financial plan accurately due to incorrect assumptions, changing funding landscape or lack of planning guidance, resulting in inappropriate commissioning decisions being made.</td>
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<td>• Risk that the CCG will be liable for the charge of void spaces in building which were the PCT responsibility which have now transferred to NHS Property Services.</td>
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<td>• Risk that the CCG will not meet its 15/16 10% reduction in running costs target due to increasing cost pressures resulting in a failure to meets its statutory duty.</td>
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<td>• Risk of the YHCS failing to deliver support service functions according to the contract levels due to the organisation's unsuccessful application to the national lead provider framework (LPF). There is also a risk that CCGs will have to share in any stranded costs putting greater pressure on the CCG running costs budget.</td>
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| **Finance/ resource implications:** | The CCG is forecast to deliver the NHS England required surplus of £5,935k. |
Finance Report
Month 8
2015/16
Financial Dashboard

### Assurance Indicators

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### Financial Position

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### Supporting Primary Indicators

- QIPP Risks and Mitigations

### Risks and Mitigations

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### Better Payment Practice Code

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<td>Total bills paid within target cumulative</td>
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<tr>
<td>Percentage of bills paid within target</td>
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Liz Goodson
Commissning Accountant
10th December 2015
## Key Issues

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<th>Issue No</th>
<th>More detail on page</th>
<th>Key Focus Area</th>
<th>Action</th>
<th>Recommendation</th>
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<td>1</td>
<td>4</td>
<td>Internal Turnaround</td>
<td>As a result of system pressures the CCG made the decision to start an ‘Internal Turnaround’ process. The aim is to identify efficiencies across all areas of expenditure. The projects will be risk assessed to ensure there is not a impact on service delivery.</td>
<td>To note current assumptions</td>
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<td>2</td>
<td>4</td>
<td>Mid Yorkshire Hospitals Trust</td>
<td>The trading position to date is an undertrade. The year to date position after taking account of risk share arrangements will be used to inform the agreed Forecast Out Turn with Mid Yorkshire Hospitals NHS Trust. ( MYHT )</td>
<td>To note current assumptions</td>
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<tr>
<td>3</td>
<td>4</td>
<td>Leeds Teaching Hospitals NHS Trust</td>
<td>The year to date position before adjustment is an overtrade. This has increased since last month. The CCG is working the host CCG to understand whether this trend will continue.</td>
<td>To note current assumptions and need to clarify work Leeds West CCG to understand the forecast position.</td>
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<tr>
<td>4</td>
<td>3</td>
<td>Managing Running Costs within the running cost allocation (RCA)</td>
<td>The CCG is reporting a small increase in the underspend. This is a result of staffing vacancies and non pay efficiencies.</td>
<td>Note management review of post CSU arrangements.</td>
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<tr>
<td>5</td>
<td>7</td>
<td>Managing QIPP delivery</td>
<td>A ‘QIPP ’Stop the Line’ event was carried out in October. Members of the CCG worked to identify how the 15/16 gap could be closed and also to identify schemes for 16/17. The process has identified c£600k of savings in 15/16. The CCG is now reporting £3.6m of unachieved QIPP based on the assumption that residual QIPP will be delivered and internal turnaround initiatives met.</td>
<td>Note the regular updates of QIPP achievements via Planning &amp; Delivery to Clinical Cabinet”.</td>
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<tr>
<td>6</td>
<td>4</td>
<td>Managing Children’s Complex Care growth</td>
<td>The budget is fully committed to date and had been forecasting an overspend. Following Budget Holder review the risk has not crystallised as originally anticipated.</td>
<td>Note that the CCG will need to urgently address this risk with WMDC.</td>
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<td>7</td>
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<td>Continuing Healthcare</td>
<td>Continuing Healthcare is overspending as a result of the increase in ‘Interim funding’ discharges and also the number of funding streams identified within the QA reporting system. This is being explored further.</td>
<td>To note current assumptions and need for detailed review of the QA system.</td>
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<td>8</td>
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<td>Risks and Opportunities</td>
<td>Prescribing and QIPP risks have been crystallised into the position, therefore reducing the overall risk to the CCG.</td>
<td>To note current assumptions.</td>
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## COMMISSIONED SERVICES 2015 / 16

### Month 8 - November 2015

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<th>Budget to Date</th>
<th>Expenditure to Date</th>
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<td><strong>Running Costs</strong></td>
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<td>15 / 16 Surplus</td>
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<tr>
<td><strong>Total Allocation</strong></td>
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The change of £4,555k is due to allocations:

- GPIT: 926
- Vanguard - MCP: 150
- Vanguard - CH: 150
- Waiting List Validation: 14
- Children's Eating disorders: 196
- Vanguard - MCP (part): 1,768
- Tier 3 Neurology Commissioning Responsibility: 17
- Liaison Psychiatry - Mental Health: 94
- UEC Vanguard sites - Liaison Psychiatry: 88
- Vanguard Care Homes: 663
- CAMHS Transformational Funding: 489
Internal Turnaround
As a result of pressures across the whole health economy, the CCG made the decision to start an Internal turnaround process. This has been communicated across the organisation, including at Staff Briefing, Integrated Governance Committee, Clinical Cabinet and the Membership meeting. All staff and budget holders were asked to revisit current commitment of expenditure against budget and assess the risk to services if commitment was either stopped or delayed. The process has already identified a range of savings that will not impact on service delivery. Internal turnaround is now a weekly agenda item at the executive team meeting. This will be a key area of focus for all staff and members and will require continued focus to the end of the year at this critical time.

Mid Yorkshire Hospitals NHS Trust (MYHT)
The headline position at month 7 flex position is showing an under trade. However the CCG is showing year end break even with the exception of Audiology AQP which is an assumed undertrade. Discussions with Mid Yorkshire are currently ongoing to agree whether any of the identified underspend can be crystallised in the CCG position, taking into account adjustments and overall health economy financial position and the need to deliver access targets at the same time as responding to the national winter resilience measure.

Leeds Teaching Hospitals NHS Trust (LTHT)
There has been an increase in the overtrade from the previous month. This is mainly down to a general increase in activity, largely in Non Elective (in particular Non Elective Non Emergency) and also the amount of challenges achieved was less than originally forecast.
There was a large change in Non Elective Non Emergency treatment, these are transfers from other hospitals to LTHT. This has happened for other CCGs (in particular Leeds South and East CCG (LSE) and so further analysis is being done by Leeds West CCG around this. LSE are meeting with YAS to discuss whether there has been any change to patient flows. Outpatient procedures have also increased at LTHT. These have also increased at MYHT. The host CCG is investigating all these issues.

Children’s Complex Care
At the end of October the whole £2.2m of budget had been committed for packages that had been approved and will continue until the end of March 2016. Following Budget Holder review of the current position, the forecast has been revised and is now lower than originally anticipated.

Continuing Healthcare
Adults continuing care overspend has increased. Part increase is due to additional interim packages of care being approved. Interim funding is a result of a pragmatic decision to enable patients to be discharged into their own homes without a full decision support tool (DST) being completed. The number of interim packages has increased and action has been taken to ensure appropriate policies are implemented and applied. The CCG is an outlier in allowing this type of funding decision as it is not a policy adopted in other CCG’s. The CCG is also reviewing current packages of care to see if these are still appropriate for individual patients. Data suggests that the number of funding streams has increased in year. It is possible for a patient to receive care from more than one provider depending on their need. packages of care should be reviewed at regular intervals based on patient need.

Mental Health
The year end position is a forecast overspend, however this has not increased for several months. This is due to highly complex, long term out of area packages where care provision is not available in Wakefield. In 15/16 the Mental Health Commissioning team have identified many efficiencies in the system that have improved care for patients and also contributed to the QIPP target. Work is still ongoing to identify areas where improvements can still be made. The CCG has been successful in securing additional external funding in 2015/16 to improve services in Childrens eating disorders, Liaison psychiatry and CAMHS and Future in Mind.

QIPP
Following the “stop the line” initiative, £600k was found to contribute towards the target. There remained a gap of which £3.6m was included in the financial position on the assumption that the Internal turnaround initiative will enable the CCG to achieve financial balance.

Risks and Opportunities
The CCG has crystallised the prescribing and un-achieved QIPP risks into the month 8 position, therefore reducing the outstanding risks and mitigations. There is still an outstanding risk relating to specialist commissioning. The CCG is working towards resolving this issue quickly.
Contingency
The CCG has now reduced to cover the risks crystallised into the month 8 position.

Allocations

<table>
<thead>
<tr>
<th>Month</th>
<th>Programme Allocation</th>
<th>£000's</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td>466,885</td>
</tr>
<tr>
<td></td>
<td>Running Costs</td>
<td>7,695</td>
</tr>
<tr>
<td></td>
<td>Bfwd Surplus</td>
<td>7,685</td>
</tr>
<tr>
<td></td>
<td>BCF</td>
<td>7,557</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td>1,520</td>
</tr>
<tr>
<td></td>
<td>YAS resilience</td>
<td></td>
</tr>
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<td></td>
<td>ETO/DTR Funding</td>
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<td></td>
<td>Co-commissioning</td>
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<tr>
<td></td>
<td>GPIT</td>
<td>926</td>
</tr>
<tr>
<td>3</td>
<td>Vanguard - MCP</td>
<td>150</td>
</tr>
<tr>
<td>4</td>
<td>Vanguard - CH</td>
<td>150</td>
</tr>
<tr>
<td></td>
<td>Waiting List Validation</td>
<td>14</td>
</tr>
<tr>
<td>5</td>
<td>Children's Eating disorders</td>
<td>196</td>
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<tr>
<td>6</td>
<td>Vanguard - MCP (part)</td>
<td>1,768</td>
</tr>
<tr>
<td>7</td>
<td>Tier 3 Neurology Commissioning Responsibility Transfer - NHS England</td>
<td>17</td>
</tr>
<tr>
<td></td>
<td>Liaison Psychiatry - Mental Health</td>
<td>94</td>
</tr>
<tr>
<td></td>
<td>UEC Vanguard sites - Liaison Psychiatry</td>
<td>88</td>
</tr>
<tr>
<td></td>
<td>Vanguard Care Homes</td>
<td>663</td>
</tr>
<tr>
<td></td>
<td>CAMHS Transformational Funding</td>
<td>489</td>
</tr>
<tr>
<td>Total Allocation</td>
<td>551,208</td>
<td></td>
</tr>
</tbody>
</table>

Additional Allocations

The CCG received additional allocations in Month 7 for Tier 3 Neurology commissioning responsibility transfer, Mental health Liaison psychiatry and Vanguard Liaison psychiatry.

Wakefield CCG and West Wakefield Health and Wellbeing Ltd are currently in discussions to agree the lead commissioning of the separate services of the MSCP vanguard. Quarterly funding requirements, expenditure forecasts and variances against budget are also reported to the Vanguard Group.

Further allocations are expected to be received in relation to:
Mental Health - Future in Mind
Offender Health
Vanguard
Transformation
IAPT childrens and young people
## Non Recurrent Expenditure

<table>
<thead>
<tr>
<th>Details of scheme</th>
<th>Gross Budget £'000</th>
<th>Reduction £'000</th>
<th>Net Budget £'000</th>
<th>YTD Budget £'000</th>
<th>YTD Actual £'000</th>
<th>FOT £'000</th>
<th>FOT Variance to net budget £'000</th>
<th>SRO</th>
<th>Clinical Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>Connecting Care (Care Closer to Home) Integration and Health &amp; Wellbeing with WMDC</td>
<td>- 1,600</td>
<td>1,600</td>
<td>4,300</td>
<td>1,685</td>
<td>4,100</td>
<td>- 200</td>
<td>Melanie Brown</td>
<td>Dr Avijit Biswas</td>
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</tr>
<tr>
<td>Mental Health Transformation</td>
<td>336</td>
<td>336</td>
<td>196</td>
<td>156</td>
<td>336</td>
<td>-</td>
<td>Michele Ezro</td>
<td>Dr Clive Harries</td>
<td></td>
</tr>
<tr>
<td>(b) Various other business cases</td>
<td>664</td>
<td>664</td>
<td>387</td>
<td>313</td>
<td>664</td>
<td>-</td>
<td>Michele Ezro</td>
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<td>MYHT Reserve</td>
<td>2,600</td>
<td>45</td>
<td>2,555</td>
<td>1,490</td>
<td>1,488</td>
<td>2,555</td>
<td>- Andrew Pepper</td>
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<tr>
<td>Podiatry MYHT Contract</td>
<td>26</td>
<td>26</td>
<td>15</td>
<td>15</td>
<td>26</td>
<td>-</td>
<td>Gill Day</td>
<td>Dr Patrick Wynn</td>
<td></td>
</tr>
<tr>
<td>Primary Care Investment</td>
<td>1,992</td>
<td>1,992</td>
<td>1,162</td>
<td>1,144</td>
<td>1,962</td>
<td>- 30</td>
<td>Dr Greg Connor</td>
<td>Dr Greg Connor</td>
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<td>CHC legacy provision risk share</td>
<td>3,079</td>
<td>3,079</td>
<td>3,079</td>
<td>3,078</td>
<td>3,079</td>
<td>-</td>
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<tr>
<td>Reconfiguration Transitional Costs</td>
<td>1,500</td>
<td>1,500</td>
<td>875</td>
<td>875</td>
<td>1,500</td>
<td>-</td>
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<tr>
<td>PMO Support</td>
<td>600</td>
<td>600</td>
<td>350</td>
<td>327</td>
<td>564</td>
<td>36</td>
<td>Melanie Brown</td>
<td>Dr Avijit Biswas</td>
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<tr>
<td>10CC Programme Work</td>
<td>65</td>
<td>65</td>
<td>38</td>
<td>65</td>
<td>-</td>
<td></td>
<td>Jo Webster</td>
<td>Dr Phil Earnshaw</td>
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</tr>
<tr>
<td>Supporting the Third Sector - Nova Wakefield</td>
<td>70</td>
<td>70</td>
<td>41</td>
<td>70</td>
<td>70</td>
<td>-</td>
<td>Anthony Sadler</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communications and Engagement (Integration)</td>
<td>205</td>
<td>205</td>
<td>120</td>
<td>120</td>
<td>150</td>
<td>- 55</td>
<td>Melanie Brown</td>
<td>Dr Avijit Biswas</td>
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<tr>
<td>Urgent Care Practitioners</td>
<td>400</td>
<td>325</td>
<td>75</td>
<td>44</td>
<td>-</td>
<td>- 75</td>
<td>Jenny Feeley</td>
<td>Dr Adam Sheppard</td>
<td></td>
</tr>
<tr>
<td>Multi Agency Safeguarding Hub</td>
<td>29</td>
<td>29</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
<td>Mandy Sheffield</td>
<td>Dr Ann Carroll</td>
<td></td>
</tr>
<tr>
<td>Wakefield &amp; Pontefract Rapid</td>
<td>400</td>
<td>400</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
<td>Michelle Ashbridge</td>
<td>Dr Patrick Wynn</td>
<td></td>
</tr>
<tr>
<td>Intervention Service (Hospices)</td>
<td>500</td>
<td>300</td>
<td>-</td>
<td>-</td>
<td>75</td>
<td>75</td>
<td>Jenny Feeley</td>
<td>Dr Adam Sheppard</td>
<td></td>
</tr>
<tr>
<td>Working Together</td>
<td>-</td>
<td>-</td>
<td>90</td>
<td>107</td>
<td>107</td>
<td></td>
<td>Pat Keane</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Healthy Futures</td>
<td>-</td>
<td>-</td>
<td>57</td>
<td>71</td>
<td>71</td>
<td></td>
<td>Pat Keane</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Healthy Futures (Urgent care)</td>
<td>-</td>
<td>-</td>
<td>9</td>
<td>9</td>
<td>9</td>
<td></td>
<td>Pat Keane</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Healthy Futures (Comms, Stroke, )</td>
<td>-</td>
<td>-</td>
<td>22</td>
<td>22</td>
<td>22</td>
<td></td>
<td>Pat Keane</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Healthy Futures - Collaborative</td>
<td>-</td>
<td>-</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td></td>
<td>Pat Keane</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NRJ Solutions</td>
<td>-</td>
<td>-</td>
<td>34</td>
<td>47</td>
<td>47</td>
<td></td>
<td>Pat Keane</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>15,966</strong></td>
<td><strong>2,099</strong></td>
<td><strong>13,867</strong></td>
<td><strong>9,372</strong></td>
<td><strong>8,685</strong></td>
<td><strong>13,804</strong></td>
<td><strong>63</strong></td>
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</table>
2015/16 Co-Commissioning Budgets

Position as at 30th November 2015

<table>
<thead>
<tr>
<th></th>
<th>Total Budget £000</th>
<th>YTD Budget £000</th>
<th>YTD Actual £000</th>
<th>YTD Variance £000</th>
<th>Forecast outturn £000</th>
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<tbody>
<tr>
<td>GMS</td>
<td>8,519</td>
<td>5,679</td>
<td>5,679</td>
<td>-</td>
<td>8,519</td>
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<tr>
<td>PMS</td>
<td>43,853</td>
<td>29,235</td>
<td>29,235</td>
<td>-</td>
<td>43,853</td>
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<tr>
<td>APMS</td>
<td>642</td>
<td>428</td>
<td>428</td>
<td>-</td>
<td>642</td>
</tr>
<tr>
<td>Other NHS England Costs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>460</td>
<td>307</td>
<td>307</td>
<td>-</td>
<td>460</td>
</tr>
<tr>
<td>Sub Total</td>
<td>53,014</td>
<td>35,343</td>
<td>35,343</td>
<td>-</td>
<td>53,014</td>
</tr>
<tr>
<td>QIPP Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>-</td>
<td>297</td>
<td>297</td>
<td>-</td>
<td>446</td>
</tr>
<tr>
<td>Other Costs (Note 1)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1,160</td>
<td>773</td>
<td>773</td>
<td>-</td>
<td>660</td>
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<tr>
<td></td>
<td>54,188</td>
<td>36,125</td>
<td>36,125</td>
<td>-</td>
<td>53,688</td>
</tr>
</tbody>
</table>

Note 1. Other Includes

- Premises
- QOF delivery
- DES delivery
- Generic pricing risk associated with the 14/15 approach
- Childhood Immunisations
- Pro-rata invoice approach from NHS England e.g. (Premises voids, Interpretation etc.)
- NHS Health checks
- GP Choice

PMS Review

The national PMS Review process requires a redistribution of funds between PMS and GMS practices to achieve approximately the same £ per weighted patient for all practices for core services. In Wakefield the PMS Review funds will be returned to practices by way of a new Wakefield Premium Practice Contract (WPPC) which will be available equally to PMS and GMS practices from 1 April 2016 subject to the approval of the CCG’s Probity Committee and NHS England.
## Risks and Opportunities

<table>
<thead>
<tr>
<th>Net Risk last month</th>
<th>Gross Risk</th>
<th>Likelihood</th>
<th>Net Risk Estimate</th>
<th>Mitigations</th>
<th>Owner</th>
</tr>
</thead>
<tbody>
<tr>
<td>£m</td>
<td>£m</td>
<td>%</td>
<td>£m</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialist Commissioning Changes</td>
<td>0.25</td>
<td>1.00</td>
<td>25</td>
<td>0.25</td>
<td>Close contact with NHSE. Advice awaited</td>
</tr>
<tr>
<td>CHC Demand and Price - (Adults and Childrens)</td>
<td>0.13</td>
<td>0.40</td>
<td>32.5</td>
<td>0.13</td>
<td>Review of costs on QA. Review of &amp; implementation of policies</td>
</tr>
<tr>
<td>QIPP Unachieved</td>
<td>6.33</td>
<td>2.75</td>
<td>100</td>
<td>2.75</td>
<td>Accelerate new schemes and generate recurrent measures</td>
</tr>
<tr>
<td>Care Act &amp; ICES</td>
<td>0.00</td>
<td>0.00</td>
<td>0</td>
<td>0.00</td>
<td>Mitigated through BCF</td>
</tr>
<tr>
<td>Impact of CSU transition including stranded costs</td>
<td>0.13</td>
<td>0.40</td>
<td>32</td>
<td>0.13</td>
<td>Stranded costs from CSU confirmed. Maintain tight control of SLA</td>
</tr>
<tr>
<td>Prescribing</td>
<td>2.7</td>
<td>0.00</td>
<td>-</td>
<td>0.00</td>
<td>Risk is now included in the FOT financial position</td>
</tr>
<tr>
<td>Review of LHT and other provider challenges</td>
<td>0.00</td>
<td>0.40</td>
<td>50</td>
<td>0.20</td>
<td>Dialogue with provider</td>
</tr>
<tr>
<td>Total Risk</td>
<td>9.54</td>
<td>5.95</td>
<td>3.46</td>
<td></td>
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</tr>
</tbody>
</table>

### Contingency

<table>
<thead>
<tr>
<th>£m</th>
<th>£m</th>
<th>%</th>
<th>£m</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2.81</td>
<td>0.23</td>
<td>100</td>
<td>0.23</td>
<td></td>
</tr>
</tbody>
</table>

The original contingency was £4.8m. This has now been released: £0.3m YAS contract; £1.69m in month 7 to manage risks against LHHT and CHC and a further £2.58m in month 8 to manage risks against prescribing and unachieved QIPP.

### Internal Turnaround

<table>
<thead>
<tr>
<th>£m</th>
<th>£m</th>
<th>%</th>
<th>£m</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>0.00</td>
<td>0.39</td>
<td>-</td>
<td>0.00</td>
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</tr>
</tbody>
</table>

Mitigation is now included in the FOT financial position.

### Stop the Line

<table>
<thead>
<tr>
<th>£m</th>
<th>£m</th>
<th>%</th>
<th>£m</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>0.60</td>
<td>0.00</td>
<td>-</td>
<td>0.00</td>
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</table>

Detailed schemes now identified and shown below.

<table>
<thead>
<tr>
<th>£m</th>
<th>£m</th>
<th>%</th>
<th>£m</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>0.00</td>
<td>0.04</td>
<td>100</td>
<td>0.04</td>
<td>Usage and risk share with MHHT</td>
</tr>
<tr>
<td>0.00</td>
<td>0.03</td>
<td>100</td>
<td>0.03</td>
<td>Additional rebate scheme</td>
</tr>
<tr>
<td>0.00</td>
<td>0.11</td>
<td>100</td>
<td>0.11</td>
<td>Review of MH investments</td>
</tr>
<tr>
<td>0.00</td>
<td>0.10</td>
<td>100</td>
<td>0.10</td>
<td>Reduce demand</td>
</tr>
<tr>
<td>0.00</td>
<td>0.05</td>
<td>100</td>
<td>0.05</td>
<td>Manage schemes</td>
</tr>
<tr>
<td>0.00</td>
<td>0.07</td>
<td>100</td>
<td>0.07</td>
<td>Manage schemes</td>
</tr>
<tr>
<td>0.00</td>
<td>0.09</td>
<td>100</td>
<td>0.09</td>
<td>Various transactions agreed with CSU</td>
</tr>
<tr>
<td>0.00</td>
<td>0.13</td>
<td>100</td>
<td>0.13</td>
<td>Review existing arrangements</td>
</tr>
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<td>0.00</td>
<td>0.85</td>
<td>100</td>
<td>0.85</td>
<td>Additional areas to work through</td>
</tr>
<tr>
<td>9.54</td>
<td>4.35</td>
<td>3.46</td>
<td></td>
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</table>

### Net Risk

<table>
<thead>
<tr>
<th>£m</th>
<th>£m</th>
<th>%</th>
<th>£m</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>0.00</td>
<td>1.60</td>
<td>-</td>
<td>0.00</td>
<td></td>
</tr>
</tbody>
</table>
Co-Commissioning

There is currently an outstanding issue with NHS England regarding Vaccinations and Immunisations, the CCG are working with NHSE to understand the granularity of details before any agreements are made.

Two submissions have been made to NHSE:
> A bid for £194k against the Primary Care Transformation Fund submitted on 3rd Dec 2015. This includes baseline assessments, utilisation studies, feasibility studies and expert advice and support
> A bid against the Primary Care Infrastructure Slippage Fund. Part of the criteria was to ensure bids fulfilled the definition of capital and that any funds could be spent by 31st March 2016. The NHSE moderation process is currently underway and the CCG awaits formal feedback.

Financial Planning 2016 / 2017

Meetings are scheduled with budget holders to communicate the methodology and gather local intelligence required to set accurate budgets. The guidance is due to be published in late December 2015. The first submission will be 8th February 2016. The first draft of the financial plan will be presented to Integrated Governance Committee in January 2016. The final plan will presented In February 2016 with final Governing body sign off in March 2016.

Hospice Grants

The CCG has submitted two applications for 2015/16 Hospice Grants. They are:
Wakefield Hospice Treatment Room £35k
Prince of Wales Hospice Heating and hot water systems upgrade £33k
Confirmation has been received from NHSE that these have been submitted to their regional team and will be reviewed at the meeting on 21st December.

£3.2m Capital Resource to support LD resettlement

When the North 2015/16 capital plan was agreed, a sum of £3.2m for LD grants to support resettlement of patients re Winterbourne was included. It has now been agreed that this sum can be transferred out of the regional reserve to the relevant organisations as bids are received and approved.

The £3.2m capital is available this year for LD grants in the North capital plan, so the work on any proposed scheme would have to be completed this financial year. If the bids received are more than £3.2m, then the LD group would be requested to prioritise the bids. However this is good news in that these funds are available this year to support resettlement of patients.

It is the intention that the CCG will bid for this funding.

Better Care Fund

The need for ongoing support has been picked up nationally in the light of the Q1 returns and the national BCF team have set aside an initial national pot of £500,000 for local areas to bid against.

In the bidding process we are encouraging local areas to think about how they might use the funding in the context of their quarterly return submission, and also the wider integration/transformation agenda. Bids that demonstrate cross-area working will also be looked upon favourably.

Cash Position

The Cash position at the end of November was £408k or 1.06% of the monthly drawdown. This is within the NHSE target of 1.75%.

Following the October submission to NHSE of an annual cash flow forecast, which was accepted by NHSE, the CCG is still on target to meet its Maximum Cash Draw Down figure (cash limits) at the year end, with no flexibility. A revised cash flow forecast is to be submitted in January 2016.

Better Payment Practice Code (BPPC)

The BPPC remains over the 95% NHSE target for both invoice numbers and value.
## QIPP Achievement 2015/16

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<th>Ref</th>
<th>Target QIPP Schemes</th>
<th>Budget Holder</th>
<th>Clinical Lead</th>
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<th>RAG £ 000’s</th>
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**Title of meeting:** Governing Body

**Date of Meeting:** 12 January 2016

**Paper Title:** Review of health services for Children Looked After and Safeguarding in Wakefield (the CLAS Inspection)

**Purpose (this paper is for):** Decision

**Report Author and Job Title:** Mandy Sheffield, Head of Safeguarding

**Responsible Clinical Lead:** Dr Hallott, Governing Body Lead for Children

**Responsible Governing Board Executive Lead:** Jo Pollard, Chief of Service Delivery and Quality

**Recommendation(s):**

It is recommended that the Governing Body note the content and recommendations of the CQC Inspection report, next steps and governance arrangements.

**Executive Summary:**

The Care Quality Commission (CQC) make regular inspections of NHS services to ensure that the safeguarding of children within the NHS is well managed and led, and to ensure that services are provided to meet the specific needs of the most vulnerable children, including those looked after by the Local Authority.

The CCG has a statutory responsibility for safeguarding across the health economy.

The CQC inspected CLAS in Wakefield during the week of the 2nd November 2015, and the report from the inspection was published on 31st December 2015. The report is attached, and is also available at: [http://www.cqc.org.uk/sites/default/files/20151231_CLAS_Wakefield_Final_Report.pdf](http://www.cqc.org.uk/sites/default/files/20151231_CLAS_Wakefield_Final_Report.pdf)

During the 4 days of inspection, there were a total of 6 inspectors working across all the services in all NHS providers. These included:

- Emergency Departments (ED) in Pinderfields and Pontefract hospitals;
- Maternity Services;
- 0-19 services;
- General Practice;
- CAMHS;
- Adult Mental Health Services;
- Adult Substance Misuse Services;
- Contraception and Sexual Health services including the Genito-Urinary service;
- The Looked after Children’s health services;
- The CCG.

The report following the inspection is structured around “The Child’s Journey”, and draws heavily from the experience of service delivery across all the services reviewed seen by the inspectors. The report is structured to analyse the effectiveness of the NHS at key stages for children and families, these being:

- Early Help;
- Child in Need;
- Child Protection;
- Children Looked After.
The report also covers analysis of:
- Leadership and Management;
- Governance, and
- Training and Supervision;

There are 26 recommendations to the services in Wakefield following the inspection, the majority sit with Mid Yorkshire Hospitals Trust (19), there are 4 for the CCG, and 3 for South West Yorkshire Partnership Foundation Trust.

Wakefield CCG is leading the development of the system wide action plan(s) in response to the inspection report. Performance monitoring of these will be through Wakefield CCG IGC and for the respective organisations” Executive Contract and Quality Boards.

The Wakefield and District Safeguarding Children Board will receive the report at the February 2016 meeting, and a further report will be provided to Wakefield CCG in February 2016

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<th>Citizen Participation and Engagement</th>
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<td>Wider Primary Care at Scale including Network development</td>
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<td>A Modern Model of Integrated Care</td>
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<td>Access to the Highest Quality Urgent and Emergency Care</td>
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<td>A Step Change in the Productivity of Elective Care</td>
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<td>Assurance departments/organisations who will be affected have been consulted:</td>
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Review of health services for Children Looked After and Safeguarding in Wakefield
Children Looked After and Safeguarding
The role of health services in Wakefield

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<td>Jeffrey Boxer, Lea Pickerill, Deepa Kholia-Mehta, Suzanne McDonnell, Elaine Croll</td>
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<td>Provider services included:</td>
<td>The Mid Yorkshire Hospitals NHS Trust South West Yorkshire Partnership NHS Foundation Trust Spectrum Community Health C.I.C. Inspiring Recovery (Turning Point / Spectrum Community Health C.I.C.)</td>
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<td>CQC region:</td>
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<td>CQC Deputy Chief Inspector, Primary Medical Services and Integrated Care:</td>
<td>Sue McMillan</td>
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Training and supervision 38

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Summary of the review

This report records the findings of the review of health services in safeguarding and looked after children services in Wakefield. It focuses on the experiences and outcomes for children within the geographical boundaries of the local authority area and reports on the performance of health providers serving the area including Clinical Commissioning Groups (CCGs) and NHS England Local Area Teams (LATs).

Where the findings relate to children and families in local authority areas other than Wakefield, cross-boundary arrangements have been considered and commented on. Arrangements for the health-related needs and risks for children placed out of area are also included.

About the review

The review was conducted under Section 48 of the Health and Social Care Act 2008 which permits CQC to review the provision of healthcare and the exercise of functions of NHS England and Clinical Commissioning Groups.

• The review explored the effectiveness of health services for looked after children and the effectiveness of safeguarding arrangements within health for all children.

• The focus was on the experiences of looked after children and children and their families who receive safeguarding services.

• We looked at:
  o the role of healthcare providers and commissioners.
  o the role of healthcare organisations in understanding risk factors, identifying needs, communicating effectively with children and families, liaising with other agencies, assessing needs and responding to those needs and contributing to multi-agency assessments and reviews.
  o the contribution of health services in promoting and improving the health and wellbeing of looked after children including carrying out health assessments and providing appropriate services.

• We also checked whether healthcare organisations were working in accordance with their responsibilities under Section 11 of the Children Act 2004. This includes the statutory guidance, Working Together to Safeguard Children 2015.

• Where we found areas for improvement in services provided by NHS but commissioned by the local authority then we will bring these issues to the attention of the local public health team in a separate letter.
How we carried out the review

We used a range of methods to gather information both during and before the visit. This included document reviews, interviews, focus groups and visits. Where possible we met and spoke with children and young people. This approach provided us with evidence that could be checked and confirmed in several ways.

We tracked a number of individual cases where there had been safeguarding concerns about children. This included some cases where children were referred to social care. It also included some cases where children and families were not referred, but where they were assessed as needing early help that they received from health services. We also sampled a number of other such cases.

Our tracking and sampling also followed the experiences of looked after children to explore the effectiveness of health services in promoting their well-being.

In total, we took into account the experiences of 108 children and young people.

Context of the review

Published information from the Child and Mental Health Observatory (ChiMat) shows that children and young people under the age of 20 make up 23.2% of the population of Wakefield. There are 11.1% of school age children from a minority ethnic group. The proportion of children under 16 in poverty is 20.6%, worse than the England average.

The data from ChiMat shows that, on the whole, the health and wellbeing of children in Wakefield is generally poorer than the England average. For example, whereas the proportion of children categorised as obese is similar to the England average, the proportion of children with poor dental health is significantly worse. Infant and child mortality rates are similar to the England average.

The data also shows that Wakefield is significantly worse than the England average for a number of other indicators of children’s health. These include the rate of hospital admissions caused by injuries to children and young people and hospital admissions due to self-harm, alcohol or substance misuse. Hospital admissions for asthma and for mental health conditions is similar to the England average.
The data reflecting the proportion of teenaged mothers and of under 18 conceptions is also significantly worse than the England average. However, the data for childhood immunisations for Wakefield is significantly better than the England average and these include the MMR vaccinations and the five-in-one vaccine at two years. Immunisations of children in care are significantly worse. The rate of family homelessness and the number of young people who enter the criminal justice system for the first time is also better than the England average.

The Department for Education (DfE) provide annual statistics derived from outcomes for children continuously looked after. As at March 2014, Wakefield had 335 children who had been continuously looked after for more than 12 months (excluding those children in respite care), 95 of whom were aged five or younger.

The DfE data indicated that a greater proportion of Wakefield’s looked after children had received an annual health assessment and a dental check-up than the average for England. There were 89% of the children aged five and under who had been looked after for more than 12 months had an up-to-date development assessment, greater than the England average of 86%. However, only 82% of looked after children were up-to-date with their immunisations, fewer than the England average of 87%.

Commissioning and planning of most health services for children, including those for children who are looked after are carried out by NHS Wakefield Clinical Commissioning Group (CCG).

Acute hospital services, including emergency care and maternity, are provided by the Mid Yorkshire Hospitals NHS Trust (MYHT). Community based services such as health visiting and school nursing are commissioned by Wakefield Metropolitan District Council. These services and the services for looked after children are also provided by the MYHT.

Child and Adolescent Mental Health services (CAMHS) and adult mental health services are provided by South West Yorkshire Partnership NHS Foundation Trust (SWYPFT).

Sexual health services are provided by Spectrum Community Health C.I.C. Adult substance misuse services are provided by Inspiring Recovery, a collaboration between Turning Point and Spectrum Community Health C.I.C. Both of these services are commissioned by Wakefield Metropolitan District Council.

The last inspection of safeguarding and looked after children’s services for Wakefield took place in December 2010. This was a joint inspection with Ofsted. At that time, the effectiveness of the arrangements for safeguarding children were judged to be ‘adequate’ whilst the services for looked after children were judged to be ‘good’. Actions for the providers arising from our recommendations from that review were said by the CCG to have been completed by July 2011.
Of the NHS trusts identified above, only the MYHT have been subject to a recent regulatory inspection under the CQC’s new inspection approach. At the time of this children looked after and safeguarding review the findings of that regulatory inspection have yet to be published and so they are not mentioned in this report.

The report

This report follows the child’s journey reflecting the experiences of children and young people or parents / carers to whom we spoke, or whose experiences we tracked or checked. A number of recommendations for improvement are made at the end of the report.

What people told us

We spoke to a parent who had attended the children’s emergency department with an infant and was receiving treatment.

She told us: “The staff have been really good here. We have become regulars here and we are normally always seen quickly”.

She continued: “We came here last Sunday and were seen in the adult emergency department because the children’s emergency department was closed. They took my daughter straight to the resus area because it was really busy in the waiting room”.

A parent told us: “The children’s waiting area is much better here than at the (another) hospital and the nurses have been good. The only thing that I would say is the doctors were talking amongst themselves and the communication wasn’t great, I would prefer them to talk more openly, but they have been very good with my daughter and have had plenty of patience with her.”

We spoke with a number of foster carers about their experience of the looked after children service. All of their comments were positive. Some of the comments we received were:

“All the looked after children nurses we have come across have been brilliant, our current allocated looked after children nurse needs a gold medal.”
“The looked after children nurses provide such a good service, I can’t praise them highly enough, they will go the extra mile every time to help sort out any problems.”

“The health and care of looked after children’ course opened my eyes, it is one of the best courses I have been on and should be essential training for all foster carers.”

“There are plenty of opportunities for foster carers to attend training, and the events are a great way of meeting and supporting other foster carers.”

“We feel fully involved with the health assessments and always get a written copy.”

“I have never had a problem getting hold of a looked after children nurse, I can always speak to someone when I need to, and always received support for a child or myself when I have needed it.”

“I can’t think of anyway the looked after children team could improve their service, it is second to none.”

“The looked after children service in Wakefield is an excellent example of teamwork, everyone pulling together for the benefit of the child, it’s all about the needs of the child.”

“If you are thinking of becoming a foster carer you need to move to Wakefield!”

We reviewed information provided to us by Healthwatch, who had carried out a young people’s GP access survey earlier in 2015. 84% of their respondents were aged between 11 and 16 years whilst 16% were aged between 17 and 24 years.

46% of young people told them that said that they usually got through to their doctor on the ‘phone while only 33% said it was easy to get a same-day appointment.

60% of young people said they had a good experience of their doctors.

30% of young people said they did not know they could be seen without a parent or carer present. 85% said they were involved or sometimes involved in decisions about their care.

Young people acting for Healthwatch carried out an ‘Enter and view’ visit to the children’s ward at Pinderfields hospital in September 2015. Some of their key findings were:

Signage to the children’s ward is not clear; the food is not particularly children friendly and there is no children’s menu; the majority of comments about staff were positive although communication was not always good; there were problems in nurses hearing buzzers in the high dependency unit.
The child’s journey

This section records children’s experiences of health services in relation to safeguarding, child protection and being looked after.

1. Early help

1.1. Before examining the child’s journey from the perspective of the health services, it is important to understand the pathway for referral to other services at each of the levels of intervention in this local authority area. This is important as it affects the liaison arrangements between the health disciplines and with other agencies for each level. The agencies in Wakefield use the Wakefield and District Safeguarding Children Board’s (LSCB) guidance known as the ‘Multi-agency Continuum of Need’ to determine the level and nature of support offered to children, young people and their families. This guidance sets five levels of intervention with the purpose of ensuring that children and their families have early access to services that meet their needs. The five levels are categorised according to the nature of the service provision.

1.2. The five levels are:

- Universal – where children and families’ needs are met by universal services;
- Universal plus – where additional needs are met by a single agency providing extra support;
- Coordinated support – where more than one agency’s contribution is coordinated using the common assessment framework (CAF);
- Integrated early help – where intensive, targeted and coordinated support is required;
- Specialist or protective services – for children with more acute needs or who are at risk of significant harm.

1.3. Health services in Wakefield feature strongly at levels one and two where single agency support is required. The health visiting and school nursing services (the child health team), are pivotal to ensuring good outcomes for young children who require additional support. They will identify the need for early help following assessment of needs, either as part of their mandated contacts with children or following emergency department (ED) attendances, referrals or other contacts. Practitioners participate in and can be the lead professional in the common assessment framework (CAF) process described at level three.
1.4. The provision of support at level four is led by seven ‘integrated early help hubs’ (IEHH), which have been operational since April 2015. For those instances where there are concerns about a child who might require intervention by specialist or protective services at level five, the usual referral route is through the Wakefield Council’s single point of access known as ‘Social Care Direct’ (SCD). Once a referral has been assessed by SCD, the Multi-agency Safeguarding Hub (MASH) is passed the referral for information sharing to take place and a decision as to the most appropriate intervention. It is in the context of this framework that health services’ contribution to early help, children in need and child protection is assessed.

1.5. Children and young people up to the age of 18 are currently only able to access a dedicated children’s ED at Pinderfields hospital during the hours of 9am to 10pm. Outside of these hours, children and young people are seen in the adult’s emergency department. This is recognised by the MYHT as not being an appropriate environment for children and young people to wait in for their assessment or treatment. Following analysis of peak pressure times that showed that the number of young patients under 17 had increased over the previous year, the MYHT plan to extend the opening hours of the paediatric ED. The area will be open until midnight by June 2016 and then for 24 hours by 2017. When children and young people wait for assessment and treatment in the adult emergency care environment, they are identified on the electronic patient list as a child and this ensures that all staff are aware of their presence in the waiting area.

1.6. At Pontefract hospital there is a small paediatric waiting area for children up to 11 years and an examination cubicle area with a trolley and a cot separate from the area used by adults. The waiting area is behind the nurses’ station and leads into the separate paediatric examination area. There is limited concession in the waiting area to suggest that this is a child friendly treatment area; although there are toys and a television to provide distraction there is no child friendly decoration. 

1.7. Between 9am to 10pm children in the ED at Pinderfields Hospital have access to a paediatric consultant on site. Out-of-hours coverage is through an on-call paediatric consultant. The current pathway is working well, which means that children who are most vulnerable are seen in a timely manner to be assessed by a medical professional. Our review of records showed that children and young people are triaged quickly using the Manchester triage system. This enables children’s emergency practitioners to see children within the recommended 15 minutes following the booking in process.

1.8. During triage at Pinderfields hospital, all parents, carers or young people are asked for their consent to allow GP records to be viewed if required during admission. This is currently a mandatory question on the electronic patient records template used in ED. There are, however, no signs to let parents, carers or young people know that their attendance will be shared with their GP, health visiting team or the school nursing service at Pinderfields hospital. This means that some patients may be unaware that their information will be shared in this way.
1.9. All children and young people attending the ED at both hospitals have their details collected by the reception staff. This includes next of kin information, the name and relationship of the adult accompanying the child or young person, the name of the school, their GP details and any other demographic information. Although we were given reassurances that ED practitioners ask enough questions to establish the relationship between the adult and child patient, in records we looked at we saw that the full name of the accompanying adult was not always recorded in the patient’s ED electronic records. A culture of curiosity is important at this point as it creates the opportunity to check that the child is with the person they should be with as they move between different staff members during their stay and any risks they might present would not be known. Staff would benefit from a better understanding of why this is important. (Recommendation 1.3).

1.10. We saw that the ED at Pinderfields and Pontefract hospitals are notified by children’s social care of any children or young people who are looked after or subject of a child protection plan. This information is entered onto the patient electronic records by the clerical team, and flags are created to alert practitioners of any additional vulnerability that needs to be taken into consideration during assessment and treatment. This is important as ED practitioners need to consider any additional vulnerability when safeguarding children and young people.

1.11. There is a clear policy in place to guide practitioners when children and young people leave the children’s ED at Pinderfields hospital without being seen for assessment or receiving treatment. We heard that ED practitioners contact parents and encourage them to return with their child for assessment and treatment. If ED practitioners have significant concerns then a referral to children’s social care is completed. Having such a clear policy ensures that appropriate action is taken to safeguard children and young people who have not accessed care.

1.12. There is currently no paediatric liaison function in the children’s ED at either hospital. However, we learned that children’s ED practitioners have recently completed a two-month pilot with the health visitors and school nurses (referred to as the child health team) in order to meet the challenges of resourcing a follow up of every child coming to notice and ensure a more targeted approach instead. This pilot is intended to ensure that information about certain types of presentation is telephoned through to the child health team’s message manager by an identified ED staff member according to certain referral criteria. These criteria include all children under one year old with an injury; children under five with ingestion or animal bite; all children and young people with a human bite; attendance following substance misuse or self-harm; any young person assessed as being at risk of child sexual exploitation (CSE) and any children and young people who have attended ED more than three times, although in the latter criterion this is subject to a judgment by the ED staff member about whether the three attendances merit a telephone notification prior to such a notification being made.
1.13. In a second phase of the pilot that began just prior to our review the responsibility for telephoning the child health team’s message manager was passed to any ED staff member who deals with a child’s attendance as opposed to an identified individual although the same referral criteria are used. The effect of this is that, whilst all children’s attendances are still notified routinely to the child health team, practitioners are no longer tasked with following up attendances at hospital unless it relates to a child who meets the above criteria. In one of the cases we were tracking across services and in one other case we sampled, we found that this arrangement has been ineffective in ensuring vulnerable children are followed-up appropriately. (Recommendation 1.4).

1.14. In the first case a young person who had attended ED on five occasions in the last year, two of which were in the last month, was not subject of a telephone notification. Since the school nursing team were not ‘tasked’ with this follow-up through a telephone notification there was no alert or analysis of the five ED attendances. Even though the child had been subject of routine written notifications with limited detail, the absence of a formal ‘task’ meant that the follow up of the child’s attendances had not been triggered.

1.15. In the second case, a child who had attended ED following a head injury and who did not meet the above referral criteria, was also not subject of a telephone notification to alert the child health team. There were two separate entries about domestic abuse logged on the child’s record by the school nurse within the previous 18 months but because the latest attendance had not been notified in the overt manner set out in the pilot, there was no opportunity to consider or exclude any possible link between the domestic abuse concerns and the head injury. Furthermore, neither information about the domestic abuse nor the information about the child’s attendance at hospital were logged on the safeguarding node of the patient record system and so the opportunity to alert staff of these important risk factors was missed. (Recommendation 1.4, recommendation 1.5).

1.16. All GPs, health visitors and school nurses receive a discharge summary for all children and young people who attend the EDs at both hospitals. However, this does not always provide sufficient information about the reason for attendance or any subsequent treatment or action that may be required by other professionals. For example, in one case we looked at, the ED records indicated that a follow-up was required by the health visitor; however this was not identified in the discharge summary. This means that community practitioners would not be well informed and able to consider the full details of the ED attendance in the context of the child or young person’s overall health needs. (Recommendation 1.6).

1.17. Children and young people who attend the children’s ED at Pinderfields hospital following alcohol or substance misuse are discharged to the care of their parents or admitted onto the paediatric ward for treatment if required. A referral form to the local young people’s substance misuse service is only completed if consent has been given by the young person or parents, as the referral will not be accepted without this. In the absence of any other pathway for children who do not provide consent, those particular, vulnerable children do not have access to help and support at an early opportunity although we acknowledge that the absence of consent is problematic.
1.18. Pregnant women access maternity services via their GP surgery. We saw evidence that midwives have a flexible approach to conducting antenatal appointments in a variety of settings including the woman’s home address, although most contact is at midwifery antenatal clinics held within GP practices. Home visits are generally only conducted if concerns are identified.

1.19. Community midwives enter pregnancy information onto the electronic patient record system used by most primary care providers. This is so that GPs are aware of a patient’s pregnancy and can discuss cases with the community midwife if necessary. GPs hold essential information about patients’ current and historical health and social issues which may impact on parenting capacity so sharing this information is an essential part of risk-assessing potential harm to an unborn child.

1.20. Maternity unit specialist midwives support midwifery colleagues with complex cases and we saw good evidence of their role in intra and multi-agency liaison. This ensures that vulnerable women are well supported and receive co-ordinated services throughout their period of care.

1.21. Pregnant women are not routinely offered the chance to be seen alone at any stage in their pregnancy to discuss possible domestic abuse or any other personal issues. In some of the notes we sampled we saw evidence of enquiry about domestic abuse but this was opportunistic. This area could be strengthened by informing all women during their booking in process that at certain scheduled appointments they will be seen on their own. This will reduce the reliance on professional confidence in asking an accompanying adult to leave a consultation and will standardise practice. This will assist in the identification of vulnerable women who are experiencing domestic abuse and their referral to appropriate support services. (Recommendation 1.7).

1.22. We learned anecdotally that, following local authority reorganisation, there is no central oversight of the impact of CAF. Data is said to be gathered centrally with the local authority CAF team dispersed across the seven IEHH. There is some perceived lack of consistency in applying thresholds in Wakefield and the five levels in the continuum of need. Staff were reported to be clearer around child protection and child in need thresholds (at level five) and would refer to SCD. However, they are still uncertain about decisions made around the other thresholds, particularly around levels three and four and the expectations of the level of complexity of cases managed by the child health teams. For example, we learned of a case where there had been some disagreement about the levels of intervention in circumstances that had suggested intervention at a higher threshold such as child in need, but which had been assessed as suitable for work at the lower threshold four. This uncertainty is troubling and our view is that such dissonance should be dealt with through supervision and the use of the escalation process.

1.23. We saw evidence of good liaison between the community midwives and the health visiting service. Although there is no stipulated frequency for meetings, the community midwives we spoke to all held monthly meetings with their health visitor colleagues to discuss vulnerable women and families. The records we looked at also showed good liaison between the midwives and other health professionals such as ED, health visiting and the adult mental health service.
1.24. Furthermore, we saw that the designation of specialist areas of interest for some health visiting staff, such as travelling families, asylum seeking families and infant mental health, has led to effective working across different health disciplines. For example, in response to a public health priority, the infant mental health visitors are leading on the integration of an infant mental health care pathway intended to be used in conjunction with the healthy child programme. The overall aim of this initiative is to promote the health, social and emotional development of infants from conception to three years of age, thus promoting attachment and an awareness of parents to the needs of the infant.

1.25. In addition, health visiting staff can access the support of child and adult mental health services (CAMHS) at a dedicated, monthly, half-day session to discuss cases of concern and agree a plan. The long-term aim of this approach is to reduce the risk of disruptive issues later in the child’s life thus improving their outcomes. This is good practice.

1.26. GPs use a contraception and sexual health template on the electronic records system, which prompts clinicians to assess young people for their competence to consent to treatment. However, we saw no evidence of GPs asking young people if they would like be seen on their own when they are attending with their parents and this is a missed opportunity to consider risks of CSE. Further, the template in use could be strengthened to include more questioning about particular factors, such as the number of sexual partners, the use of coercion, concerns around domestic abuse, mental health and other vulnerabilities. These factors would help in the assessment of risk of CSE. (**Recommendation 2.1**).

1.27. GPs we spoke to told us that they have good liaison with CAMHS although they highlight that there are difficulties with getting children seen quickly. Whilst the waiting times from referral to assessment are relatively short, the waiting time from assessment to treatment are significantly longer with are insufficient services to support children while awaiting CAMHS treatment. As we have reported below, under ‘Children in Need’, however, CAMHS are addressing this with additional training to staff in universal services around support and anxiety management.

1.28. In the records we reviewed we saw that GPs do not routinely record the full details of the adult accompanying the child or young person to the clinic appointment, with the terms ‘mum’ or ‘dad’ frequently used. This is important, not only to ascertain who has parental responsibility for a child or young person, and therefore able to consent to treatment, but in a fractured family with complex dynamics, the recording of a name is as relevant as the reported relationship.

1.29. We saw that GPs receive discharge summaries from hospital. However, these are brief and do not include enough information to help GPs consider risk to a child in the context of their wider health needs and their home and family. For example, in one record we looked at, a primary school age boy had attended the ED following a needle-stick injury but there was no information on the discharge summary about the mechanism of the injury which the GP could have considered at the child’s next visit. (**Recommendation 1.6**).
1.30. There is a clear and robust transition policy and pathway for young people from the CAMHS service to the secondary adult mental health teams. The transition process starts when the young person is 17 years and six months old, with all cases being assessed by the CAMHS and adult teams on an individual basis. The care programme approach is embedded within adult mental health services and this supports a co-ordinated approach between the two services being taken. During the transition period, there is joint working between the services with the young person in order to ensure the transition process runs smoothly for them. This is important as it helps ensure that young people have stability and are not lost in the system during this critical time, thereby helping to improve their mental health outcomes.

1.31. The transition process is further supported in part by an early intervention psychosis team, provided by the adult service and based in the community, who work with young people from the age of 14 and with adults up to the age of 35. This means that outcomes are improved for young people at risk of developing long-term mental health conditions because they are identified and treated at an early stage.

1.32. In the records we reviewed we saw evidence of good communication and joint working between adult mental health services, health visitors and social care. The benefit of this is that good information about adult mental health enables practitioners who deal with families to better assess risk to children and young people.

In the adult substance misuse service clients with families and their children are supported by the provider’s innovative Family Support Team comprised of attached staff from other areas; a senior social worker, a substance misuse health visitor and a substance misuse midwife. This ensures that children whose health, wellbeing and safety are affected by the behaviour of their parents who are adult clients of the service benefit from the intervention and service co-ordinating role of staff with particular expertise. This was demonstrated in one of the cases we tracked across services where we saw extensive involvement by the substance misuse midwife. In this case, a child protection plan in respect of an unborn child of a mother-to-be who misused substances alongside other risky lifestyle factors was de-escalated to a child in need plan. The proactive and effective inter-service work co-ordinated by the adult substance misuse midwife led to an eventual normal delivery with the child remaining with mother.
2. Children in need

2.1 Our review of records showed that, at the point of triage, ED practitioners at Pinderfields and Pontefract hospitals ask about who has parental responsibility for children and young people under the age of 18 years and ascertain if the family has any social care involvement. Where there is a social worker involved with the family, their name and contact details are recorded on the admission paperwork. Other than this, children and young people do not currently benefit from a comprehensive safeguarding assessment when they are first seen by a clinician. Safeguarding questions that explore potential risks, such as those outlined below, should be asked and recorded, in order to enable the opportunity to share information and intervene early.

2.2 The patient records system in use in the ED does not support effective, consistent recording. The current safeguarding risk assessment tool used at Pinderfields hospital does not encourage practitioners to focus on young people. There is no exploration regarding any risk-taking behaviours or vulnerabilities that they might exhibit or undertake, for example drugs and alcohol misuse. We saw no evidence, for example, of a CSE screening tool being used, so there is an over-reliance on practitioners to identify such additional vulnerabilities. This means that ED practitioners at Pinderfields hospital will not be able to assess for any additional vulnerabilities for young people who may be at risk of CSE. It is important that ED practitioners working closely with children and young people have the support and tools they require to help them identify and assess additional vulnerabilities in order to safeguard them and provide early help and support. This has consequences for the effectiveness of the pilot programme of notifications to the child health team of children who meet certain criteria as reported above in ‘Early Help’ since CSE is one of those criteria. (Recommendation 1.8).

2.3 Practitioners in the adult ED at both Pinderfields and Pontefract hospitals are expected to identify and record details of children or young people being cared for by an adult, who attend with risk-taking or concerning behaviours. However, such adults are not asked for details of any children that they have contact with; for example if they are living away from their children or if they are in a relationship with a partner who has children. This is a significant gap in information gathering for safeguarding purposes as it should feature in paediatric liaison with community health practitioners and children’s social care. (Recommendation 1.9).

2.4 The adult admission paperwork does, however, prompt individual practitioners to explore and ask patients whether they have any dependent children at home. This question is a mandatory field on the admission paperwork and must be asked before moving on to the next stage. There is variation in practice, and in one record we reviewed we saw that the mandatory question had been asked, but the practitioners had not recorded the full details of the child such as their name age. This limits the opportunities of adult ED practitioners to identify the need for early intervention.
2.5 The support provided by CAMHS for children and young people who attend the children’s ED at Pinderfields and Pontefract hospitals following an incident of self-harm, overdose or during a mental health crisis is reported to be good. ED practitioners told us that the CAMHS crisis team are very accessible and are always available by telephone for advice and support throughout the day and during out-of-hours. This support has promoted a more rapid assessment of these vulnerable children and young people and the current arrangements mean that children and young people are not facing unnecessary long waits in the emergency department.

2.6 Young people experiencing a mental health crisis in Wakefield receive a service from the dedicated CAMHS crisis team who operate between 9am and 5pm Monday to Friday and on an on-call basis outside of these hours. We were advised that CAMHS provide an assessment in person within 24 hours, whether this is in the ED, the children’s admission unit or the children’s ward. However, those children and young people who need to be admitted as medical patients are not seen by CAMHS until they are medically fit for an assessment. These children do not currently benefit from a formal risk assessment of their physical environment, emotional health or risk to others on the department. This has been identified as an area for development by the MYHT. We learned of work currently in progress involving CAMHS, the children’s ED, the children’s admissions unit and the children’s ward to launch a new risk assessment tool by February 2016.

2.7 We learned that each of the IEHH has a dedicated CAMHS ‘primary practitioner’ who acts as the first, early point of contact for any young person experiencing, or at risk of experiencing mental ill-health. Every new referral into the service is initially assessed by the primary practitioner to determine the nature and timeliness of the response. In this way the CAMHS service is configured to respond to all young people with mental health needs whatever their level of complexity or seriousness.

2.8 Whilst young people are seen very quickly and those with high needs or at greater risk are given priority, the service understands that it has work to do to continue to bring its waiting times down. Currently these stand at four weeks until formal assessment and then as much as seven months from assessment to treatment for those young people who are not otherwise prioritised. The SWYPFT acknowledges that this is their biggest challenge.

2.9 In an effort to ensure that support is provided children and young people whose needs do not meet the threshold for intervention through the IEHH, the CAMHS primary practitioners are engaged in training the staff in universal services. The purpose of this is help those services to support young people with anxiety management. Additionally, the primary practitioners review each young person who is still on the waiting list to check whether their priority for treatment has changed. In this way, the CAMHS service has taken steps to ensure that children are not left unsupported whilst they are awaiting treatment, although as we reflected above under ‘Early Help’, the impact of this has not yet been seen by all GPs.
2.10 Children who require admission for urgent treatment due to the complexity of their illness or acute mental health need are usually placed out of area. Commonly this is in a nearby part of Yorkshire but young people can sometimes be placed in other areas further afield in England. We learned that the SWYPFT has allocated one of the beds in one of the adult units situated in the neighbouring Calderdale area where 16 and 17 year old young people could be placed in an emergency and for a period not exceeding 48 hours. Whilst this is not an ideal situation, we were nonetheless given reassurances that staff in this unit had undergone appropriate checks and additional training to ensure they were safe to work with young people.

2.11 There is a risk that there are hidden children in Wakefield with unmet health needs as a consequence of poor systems to identify them, such as the lack of paediatric liaison outlined above in ‘Early Help’. Furthermore, it was reported to us that there is no robust system in place that informs the school nursing team of children being home schooled, moving schools or those missing from education. Additionally, we heard that there is no direct communication between the education admissions department and the school nursing service. This is exacerbated by the school nursing team only updating electronic records from class lists for years one and six; there are no agreed updates made for the other year groups. This is a significant gap as home educated children feature strongly in serious case reviews (SCR) nationally. (Recommendation 1.10).

2.12 The process for overseeing the primary care needs of vulnerable children is variable. GPs we spoke with in one practice told us that they hold regular, scheduled primary care meetings once every eight weeks when with the link health visitors are invited to attend. We saw notes of these meetings which showed that the needs of individual vulnerable children are discussed. However, as these are anonymised there is no means of checking whether the discussions or any plans are recorded as part of the child’s electronic record. The lead GP for safeguarding children meets regularly with the health visitor safeguarding lead where particular children might be discussed but once again, there are no notes kept from these meetings. Further, we learned that midwives and school nurses do not attend these meetings. Therefore, there is a risk that key information from these services might be overlooked, although the community midwives hold regular clinics at the GP practice and so there is often face-to-face dialogue between them about individual families. (Recommendation 2.2).

2.13 In two other practices, monthly vulnerable families and children meetings are held with health visitors. Each child in need or at risk is routinely and regularly considered and a record made on the patients’ electronic records. This is an important way of monitoring progress and improving outcomes for children, young people and their families.

2.14 The majority of GPs in the area use one particular type of electronic patient records system whilst a smaller number using another type of system. The school nursing and health visiting services use the same system as the majority of the GPs and share records with GPs through this medium. However, GPs are reported not to consistently share information in return with the health visiting team and this hinders access to a complete record. As a result, decision making about risk is compromised. (Recommendation 2.2).
2.15 The ‘Think Family’ approach is well embedded in the practices of the substance misuse service. We found that the adult substance misuse service’s Family Support Team were key to this approach, both in terms of providing advice and guidance to the team in particular cases and in supporting the team with joint work. For example, in one of the cases we sampled we saw that concerns had been raised about the children of a client over the weekend prior to our visit. These concerns had been discussed with the Family Support Team’s social worker and a record of the discussion made in the client’s notes. We saw that the specialist social worker and the client’s substance misuse worker planned a joint home visit during the week of our review in order to carry out an assessment of the client when their child was present. In this way the impact of the parenting behaviour and the environment upon the child would be critical in determining the nature of any referral onwards to other services.

In other cases we sampled, we saw that the approach to considering the impact on children of parental substance misuse is well embedded in the practice of staff. This is supported by clear and effective templates on the service’s bespoke case management database, and by accessible guidance on each practitioner’s computer desktop. For example, each client is asked a mandatory question about their parental status or about children they have access to during their initial discussion with the service. This triggers the completion of a safeguarding screening template followed by discussion with the Family Support Team or the client’s social worker if identified.

The first page of the client’s record on the database displays a family genogram, identifying children with a red spot, thus directing every staff member to further information in the record that relates to the child. The child that the client has contact with is then actively considered at each meeting with the client. This is directed by a children’s care plan which runs alongside the client’s treatment plan. This children’s care plan is reviewed every three months. This is good practice as it ensures the needs of the child are foremost in both the procedures used in the service and the approach by practitioners.
3. Child protection

3.1 ED practitioners use a standardised referral form to refer concerns to Wakefield’s Social Care Direct. Initial concerns are raised by telephone and followed-up in writing within 24 hours. A copy of the referral form is then forwarded to the MYHT safeguarding team and scanned onto the patient’s electronic records. The trust’s safeguarding team quality-assures the referrals, feeds back to individual practitioners and requests additional information if required. However, despite management oversight the referrals we looked at were variable in terms of the quality of information and the practitioner’s ability to fully articulate risk and concerns. This is an area which we are assured is about to be strengthened by the incorporation of the ‘Signs of Safety’ risk identification model into the referral form to coincide with the training of the model across the area.

3.2 There is a good protocol to review all under one year old non-ambulant babies who attend with burns, head injuries, bruises or fractures at both hospitals by a paediatric middle-grade doctor or a senior paediatric consultant. However, in records we reviewed we saw that not all under one year old children were being reviewed in accordance with the protocol. This means that infants are not being assessed by appropriately trained medical professionals and the significance of the presenting injury may be overlooked. (Recommendation 1.11).

3.3 A comprehensive Pregnancy Vulnerabilities Risk Assessment form is in use in maternity. This is updated at pre-defined points throughout pregnancy and into the postnatal period. We saw evidence of this being completed and appropriate action taken when risks are identified. We understand that reference to this checklist will be incorporated into the next version of the maternal hand-held notes to alert practitioners of its existence. This will ensure the notes are a more robust record as there is currently no ongoing safeguarding risk assessment within them.

3.4 We saw good evidence in the maternity cases we reviewed of relevant safeguarding information being held within maternal notes on the maternity services bespoke patient records system. Use of the alert system and case notes ensures that all staff accessing the system have up to date information. This could be strengthened, however, by having a dedicated safeguarding node or icon within the records. Currently a generic section of the system is used and this could potentially get merged with other general medical information and therefore overlooked.

3.5 We saw that the use of the integrated care pathway document is an effective way for community midwives to record all relevant safeguarding information in a single document. This ensures a complete paper record of significant events, referrals, safeguarding discussions or supervision throughout pregnancy to discharge from care. The document is then scanned onto the baby’s electronic health record so that any ongoing safeguarding issues are shared with hospital practitioners involved with the baby after discharge from midwifery care. This supports the flow of relevant information between services and is good practice.
3.6 The postnatal ward has a swipe card entry system but only a push button release exit. Whilst it is good practice to restrict access to the ward in this way, it does not mitigate the risk of some women who already on the ward from absconding with their babies where, for instance, there may be pending care proceedings. (Recommendation 1.12).

3.7 The majority of the referrals we saw from midwifery services to Social Care Direct are good. The referrals show that practitioners share information, analyse risk, the potential impact of parenting behaviour on a new-born and specify the required outcome of the referral. We were advised, though, that there was a perception among midwifery staff that there was some inconsistency between the different Integrated Early Help Hubs in the way that the appropriate levels of intervention are interpreted.

3.8 Community midwives are encouraged to attend safeguarding meetings and provide conference reports; however, attendance is not monitored within the maternity service or the MYHT safeguarding team. If midwives are not able to attend safeguarding meetings, either due to capacity issues, short notice or professional development needs then this should be escalated to and addressed by relevant managers in order to strengthen information sharing and multi-agency working.

3.9 Cases we looked at highlight that health visitors complete new referrals to Social Care Direct that are underpinned by detailed information of the concerns and an analysis of risk. However, there is some variability in the standard of articulating and analysing such risk in reports submitted by the health visiting service to child protection conferences. An initial child protection conference report we reviewed showed a holistic assessment of need with analysis of risk in the body of the initial referral but the summary report for conference did not reflect this detail and lacked impact. Whilst the health visitor made a recommendation that the child should be subject of child protection plan there was no linked underpinning rationale. This potentially could lead to ineffective decision making by the conference. As we have advised above, however, it is anticipated that the roll-out of Signs of Safety training across the area and the imminent incorporation of the model into the reporting documents will strengthen the quality of information provided to conferences.

3.10 Although the GPs we spoke with are confident about making referrals to social care whenever they identify concerns, the approach is variable across the three practices we visited. In two practices the use of coding on the electronic records system is used to identify and track children at risk so that progress can be monitored and discussed at vulnerable families meetings. In those practices information is placed on to the safeguarding section of the electronic records system so that it can be shared. However, it is usually the case that other health services in Wakefield do not have access to some information due to restrictions in sharing rights. We have commented on this in more detail in ‘Leadership and Management’ below. (Recommendation 2.2).
3.11 In both of these practices referrals are made by telephone and followed up in writing. However, in one practice the written follow-up is by way of a brief, free text letter as opposed to the standardised referral form. The referral letters we looked at had adequate detail about the risk but there is a potential for incomplete information to be passed over if the correct templated forms are not utilised fully.

3.12 In another practice the use of coding on the system is not used to identify particular children. In the absence of any formal notes of meetings where children are discussed, there is no other means of auditing the number of referrals made or of monitoring their progress other than to rely on the personal knowledge of the GPs. In this practice, although we saw that the correct templated form had been used in one case we reviewed the form did not fully articulate the concerns or identify risk to the child.

3.13 Commonly, all GPs are routinely invited to attend child protection meetings or conferences. However, due to short notice and clinic commitments they are often unable to attend. As GPs do not currently prioritise attendance at initial or review conferences, they send their apologies and submit any health related information they hold by way of a report. In two of the practices such reports are scanned on to the records system whilst in the third they were not. The reports we looked at were variable in the extent of detail and the articulation of any risk and this does not help good decision making at conference. (Recommendation 2.3).

3.14 GPs are not routinely sent minutes from child protection core groups meetings or the resulting updated child protection plans, nor are they sent child in need plans for children they have primary care responsibility for. This creates a risk of leaving GPs poorly informed about the current issues or concerns surrounding particular vulnerable children or families and any progress they have made whilst being subject of child protection or child in need plans. We were advised that minutes of child protection conferences are, however, routinely sent to GPs. These are generally scanned onto the electronic records system, although one practice relied on this being done by the child health team. Where sharing rights on the system existed, we saw that minutes and other documents that had been scanned into the system by the child health team were visible to the GPs. In those cases the risks arising out of being uninformed about particular children are reduced, provided the practice holds regular, focused multi-disciplinary safeguarding discussion with the child health team and has an effective monitoring process in place. However, the risks are heightened where these discussions are not held, or where there is no formal monitoring of cases. (Recommendation 2.2, Recommendation 2.4).
3.15 The CAMHS service is currently using a hybrid system for patient information, the well-established electronic case management database and detailed paper records about clients. This hybrid system has been in operation for some time because the particular, earlier version of the software in use does not have newer facilities for scanning in documentation or for using electronic templates for clinical or risk assessments. This means that copies of key documents such as child protection conference minutes or child protection plans are not readily available electronically. However, in the cases we tracked across services and in those we sampled, we consistently found that all database entries are completed in exceptional detail, are focused on the needs of the child and clearly articulated risks. This is also the case for all paper based templates used in assessing clinical need and risk.

3.16 The CAMHS practitioners are proficient at identifying risk to children and young people and are supported in doing so by effective internal safeguarding processes. For example, in two of the sampled cases we looked at we saw that risks had been assessed by the crisis team at the point of referral in relation to self-harm and suicide, violence, serious self-neglect and exploitation or abuse by others. In some instances further information had been sought from parents or carers and through other records. The resulting risk management plans are comprehensive, are outcome based and are subject of a planned review date depending on the significance of the risk.

In both crisis team cases we looked at and in one other sampled case, we saw that the assessment of risk was ongoing throughout each interaction with the young person. In each case new risk factors had been identified and guidance had been sought appropriately from the safeguarding team. In one of the cases, a separate risk assessment in relation to CSE had been completed and new concerns identified as a result. The analysis of the risks and agreed actions were documented in the young person’s notes including an action to refer the matter as a child protection issue.

These cases show that the CAMHS service uses robust, safe and effective systems, including skilled staff, to identify and respond appropriately to potential abuse.

3.17 Adult mental health practitioners informed us that they are aware of the process to follow when referring cases to Social Care Direct. All referrals are made by telephone, followed up in writing within 24 hours, and reported as an incident through the ‘Datix’ reporting system. Copies of all referrals are also expected to be sent to the trust named nurse for safeguarding children in order for them to be quality-assured. In the records we reviewed, we saw that referrals to children’s social care were variable in their quality. We saw evidence of good, detailed referrals that clearly articulated the practitioners concerns and what was being expected from social care. However, we also saw evidence of poor quality referrals that did not rationalise the risk or what the impact of a parent’s mental health would be on the child. (Recommendation 3.1).
3.18 Adult mental health practitioners do not flag patient records to alert other practitioners of any additional vulnerability for consideration during assessment. There is currently no management oversight of the number of clients that have children who are categorised as a child in need, on a child protection plan, or looked after. Further we saw that the ‘think family’ model is not fully embedded into practice. Practitioners are not currently prompted to ask adult patients questions during their initial or routine risk assessments that will enable them to collect important information about dependent children and of any caring responsibilities. This means that key information might be missed that would affect treatment and care planning in the context of the impact of the adult’s illness on the child. (Recommendation 3.2).

3.19 We saw that adult mental health practitioners routinely visit patients at home. This is a good opportunity to assess the home environment and to validate information, particularly when there are children and young people concerned. We were advised that practitioners are required to complete a separate child protection risk assessment template to help them consider the impact on children and young people. However, in records we reviewed we saw that this is only completed when practitioners have overtly identified safeguarding concerns and is not completed routinely for patients with access to children. The trust recognise this as a gap, and we heard of ongoing plans to place a mandatory question on the mental health risk assessment template on the patient records to prompt practitioners to collect this important information. This is planned to be implemented within three weeks after our visit. As reported above, the new, updated version of the electronic case management database is being launched by the end of this year which has greater functionality to support practitioners to assess risks to children and to add alerts.

3.20 Adult mental health practitioners are invited to pre-birth, child protection and looked after review meetings. However, in records we looked at we saw that not all safeguarding related meetings are attended by practitioners and reports are not routinely being produced to assist the meetings. The absence of information about mental health and its impact on children means that decision making about the welfare and needs of children may be compromised. (Recommendation 3.3).

3.21 The service receives timely minutes from child protection conferences, but these are currently being held in paper records. As before, the updated electronic system due to be launched will enable records to be held in single place so that all practitioners have access to key information. However, in the meantime, the patient records are fragmented and we could not see any evidence of how child protection action plans support clinicians to develop more detailed service plans with adult patients in the context of their family circumstances. (Recommendation 3.3).
3.22 As with the CAMHS service, Adult mental health practitioners have daily access to the SWYPFT safeguarding duty team for advice and support, where there are any safeguarding concerns or queries. We were advised that the introduction of a duty team has shown an increase in practitioners’ responsiveness in dealing with safeguarding cases. The duty team guarantees that they will respond to practitioners within four hours and we saw evidence of this in cases we looked at. This means that practitioners are supported with timely advice and guidance where they have any safeguarding concerns. We saw that, once advice has been provided to individual practitioners, a secure email is sent with a very detailed plan of action. However, we saw that action plans are not always time-bound and they are not copied over to the electronic patient records by practitioners. This restricts practitioners who work elsewhere in the service from having access to key information when needed if they do not have access to the paper records.

3.23 In the contraception and sexual health service we saw that an assessment template had been developed by the team for use on the electronic patient database, the same database as is used by most health service providers and the majority of GPs. This template requires the practitioner to complete mandatory fields that examine risks to young people. This means that questions about sexual activity and risky behaviour are considered at each episode of care for young people aged up to 18. This includes a probing of information about risks of CSE. In the cases we were tracking across services and those we sampled we saw that these assessments were carried out comprehensively on each occasion and that they showed evolving risk over time to reflect changes in the young person’s behaviour.

3.24 Whilst the information created by CASH practitioners was detailed and relevant, the data sharing capabilities of the electronic records system meant that key pieces of information arising from the young person’s engagement with other services was missing. Therefore, practitioners were not able to take full account of the young person’s other health needs. We were assured by the CASH team that if they had had concerns about a person’s engagement with another service then they would follow this up, however, the records did not support this. We have commented in other places in this report about the difficulties in exchanging information as a result of the sharing arrangements of the prevailing system in use in Wakefield. (Recommendation 2.2).

3.25 This was not just an issue confined to the CASH service. In one of the cases we were tracking across services we saw that a young person who presented extreme harmful behaviour was receiving care and support from the CASH service, the school nursing team and CAMHS. In the chronologies prepared for us by those services we noted that there was a disparity between the perception of risk to the young person by different services, particularly in a period around March and April 2015. Such differences mean that the health services cannot be delivered in a coordinated way to best meet the needs of the young person. We have brought this particular case to the attention of the CCG and we understand that they will carry out a review of the information flows between services for this young person.
3.26 We learned that staff from the adult substance misuse service attend child protection conferences when they are able to, often supported by a member of the provider’s Family Support Team. Written reports are submitted in all cases when they are not able to attend. However, in cases we sampled there was no correspondence from the local authority, such as child protection conference minutes or a copy of the child protection plan, logged on either of the electronic systems being used by the service. Staff told us that such correspondence was rarely received even though practitioners generally attend the meetings. Therefore, there is no formal record of the current child protection information or the up to date multi-agency assessment of risks within a family that staff can rely upon for their work with clients and their families. This hinders adult substance misuse practitioners in understanding any observations they have during interaction with their clients and prevents effective decision making about risks to children. This has been brought to the attention of Public Health England.

3.27 In one case we sampled in the adult substance misuse service we saw that escalating concerns about the children of two substance misusing clients had been discussed during a supervision session. All of the children in the family were already subject of a child protection plan but these escalating concerns were numerous and were deemed significant, warranting more robust action. However, only the most significant of the catalogue of concerns was passed on to the family’s social work manager by way of a formal free text letter (which was according to the local procedures for escalation of open cases) and only in relation to one of the children. Therefore, the information passed to the social work manager was incomplete although we accept that these concerns have been shared over time with the social worker during core group meetings. This means that the free text letter was insufficient to convey the impact of the totality of the concerns on each child. This compromises effective decision making about the risks to these children. This has been brought to the attention of Public Health England.
4. Looked after children

4.1 Appropriate arrangements are in place for looked after children in Wakefield to receive timely initial health assessments and health reviews by appropriately qualified practitioners. Initial health assessments are carried out by a paediatrician. Health reviews are carried out by health visitors for children under five years old and by school nurses for children over five and up to 16 years. In a case we looked at in the health visiting service we noted that there was good continuity of information between the initial assessment carried out by the paediatrician and the subsequent actions and then review assessment carried out by the health visitor. This ensured good continuity of care for this particular infant.

4.2 Nurses in the looked after children team carry out reviews for cohorts of children and young people, including those out of education, children over 16, young people in residential care and those placed out of area but within a 50 mile radius.

4.3 The most vulnerable children and young people clearly benefited from the specialist input of the looked after children nurses. We saw good practice by the looked after children nurses who comprehensively review all children moving into residential care to take account of their changing circumstances and increasing vulnerability. We learned how the team are proposing to take on the health reviews of all looked after children from 13 years old so that a more intensive and targeted approach is taken to supporting children as they enter into adolescence. This approach, combined with the enhanced screening around risk, will provide opportunities for earlier identification of need and support.

4.4 Children and young people who refuse health assessments and health reviews are rigorously followed up. Where there is continued non-engagement, a virtual assessment is completed through information gathering and collation. However, this is not yet formulated into a plan or the outcome shared with the young person. It is important that findings from these virtual assessments are consolidated into a plan, especially if non-engagement continues over a prolonged period of time.

4.5 Children and young people looked after by Wakefield are starting to benefit from an improved approach to the way risk is considered during health assessments and reviews. More in-depth screening is being introduced to identify risk taking behaviours and potential vulnerability around exploitation. The looked after children nurses work with the young person to deliver targeted, evidenced based brief interventions for those identified with lower risk or refer onwards to specialist services if more intensive work is required to manage higher risk.

4.6 Children and young people who attend local EDs have the details of their care shared with the looked after children health team and their social worker. We saw evidence of how the attendances are considered as part of ongoing health reviews to help identify any emerging or unmet health need.
4.7 Children and young people looked after by Wakefield also benefit from person-centred health reviews that demonstrate a continuum of their health journey during their time in care. The voice of the child is clear in the majority of reviews we looked at. Young people are given the choice in terms of location and timing of the review to encourage them to start to take responsibility for their health. There is the potential for young people to start to become involved in negotiating their own outcomes in health plans, however, this is not being fully exploited at this time.

4.8 GPs are not routinely requested to contribute to a child or young person’s initial health assessment or health review. Although there are arrangements in place for looked after children nurses or public health nurses to access electronic patient records where sharing permissions are in place, it is important that the GP has the opportunity, as the primary record holder, to provide input to the process. We are not assured that recommendations and health plans are being shared with the child’s GP. Currently, the looked after children health team only send a copy to the child’s social worker who then sends out copies to relevant people. (Recommendation 1.13).

4.9 Most initial health assessments of young children and infants in Wakefield are well informed by parental health histories. However, this becomes less evident in the assessments of older children. Nationally, young people leaving care frequently tell us of the importance of having access to this information as it is part of their identity.

4.10 We also saw that front sheets of health review documentation are missing information around the reasons for a child coming into care, the number of carers the child has experienced and the length of time a child has been in care. Whilst all this information is contained elsewhere in the electronic patient record, this also needs to form part of the health review to ensure as complete a picture as possible is presented in one place. For example, during our visit to the school nursing service we identified one case of a school aged child with complex needs who has been assessed by the looked after children team where the documentation was incomplete. Part B of the standard BAAF form had not been completed and there was no reason recorded to account for why this was so. (Recommendation 1.14).

4.11 In addition, where parental health histories have been obtained, this information is not routinely being brought through to subsequent health reviews. Again, this information is invaluable and should be considered alongside any emerging health need. The importance of this was demonstrated in one case we saw, where foster carers brought to the attention of the GP concerns about a potential squint. In his referral to ophthalmology the GP referred to the family history and occurrence of similar conditions in siblings.
4.12 Health plans arising from health assessments and reviews, although appropriately identifying need, are often not SMART. Plans are not usually outcome focussed, often generic and do not specify timescales for action. During our visit to the school nursing service we identified another case where a review health assessment for a six year old child was completed by a band five nurse. The record showed that there had been no handover to the school nurses of this case from the health visitors or the looked after children nurse who had both had involvement with the child and carers. The health assessment action plan had health needs identified but actions and outcomes were not SMART. There was no evidence of any intention to review the impact of the action plan at addressing the health needs identified for the child. Both this case and the case mentioned above where documentation was incomplete had been subject of a looked after children team quality assurance process that did not identify or challenge these health assessments. (Recommendation 1.15).

4.13 Strengths and Difficulties Questionnaires (SDQ) are currently completed by children’s social workers. The SDQ scores are not shared with the looked after children health team and so do not inform health reviews. This is a missed opportunity to identify need in a review and to monitor a child’s emotional health over the period of time they are looked after.

4.14 We were advised that MYHT policy is that any missed appointment for outpatient services results in removal from the service, even when a child is looked after. In one of the cases we looked at we saw that a letter is sent to foster carers to advise that the child’s social worker will be informed and that re-referral can be made. However, this creates delay in a vulnerable cohort of children where outcomes remain poorer than that of their peers.

4.15 Young people leaving care at 18 are provided with a health summary. These are young people focussed and are shared with the young person, their GP and the leaving care worker. The summary includes any parental health information that is available to the team. This information is important to young people as it helps with their identity and is also useful when they register for health services where questions around family history are often asked.

4.16 We heard of how children’s social care have recently refused to accept a referral of a looked after child, aged 17, who is in the early stages of pregnancy. The reason is because they do not accept any referral until a viability scan has been performed. However, the same young person has also been referred to the Family Nurse Partnership who are trying to engage the young person. Looked after children and care leavers are a priority for the Family Nurse partnership.
4.17 Children and young people who are looked after and are identified as needing additional support for their emotional health can be referred to a dedicated emotional health and wellbeing team. This service is led by a psychologist and provides consultation for professionals and foster carers working with looked after children. The service also carries out therapeutic work with children and young people directly. Where a child is identified as needing more specialist CAMHS input, then the team can facilitate speedy transfer into the service. We saw evidence of where the support of the team was essential in maintaining fragile placements by working with foster carers and their child.
5. Management

This section records our findings about how well-led the health services are in relation to safeguarding and looked after children.

5.1 Leadership and management

5.1.1 We found that the CCG have a robust approach to developing and improving safeguarding practice across Wakefield’s health services. To ensure this approach is effective, we saw that the CCG provide visible and proactive leadership to the network of named safeguarding professionals across the providers and within primary care. For example, we saw that GPs benefit from regular safeguarding lead forums chaired by the Head of Safeguarding and by regular newsletter updates of topical issues prepared by the named GP. GPs said they value the meetings and attend when possible.

5.1.2 We saw that the CCG has a strong internal culture around safeguarding as shown by the accountability processes below under ‘Governance’. This culture enables the CCG to have influence as key strategic partners within the local safeguarding network. In this capacity, for instance, they have been influential in the development of safeguarding policy within the LSCB; such as the policy on a more targeted approach to attending child protection meetings and the development of the LSCB’s neglect and female genital mutilation (FGM) protocols as part of a consortium that includes MYHT.

5.1.3 Further, the CCG’s relationship with the safeguarding leads enables it to take an active role in monitoring and making recommendations for improvement. For instance, we saw that an audit of non-accidental injuries in 2014 provided data and analysis to support recommendations to the health visiting and midwifery teams about their engagement with new mothers and families. Part of those recommendations related to the questioning about and recording of risk of domestic abuse. However, as we have reported in several places above, although questions were asked by practitioners there was still some inconsistent practice in recording keeping about these questions.

5.1.4 The CCG are currently working with community paediatricians to meet the challenge of providing a skilled cohort of medical staff to carry out forensic examinations of children and young people at the recently opened sexual assault referral centre (SARC) used by the agencies in West Yorkshire. This challenge of matching the numbers of paediatricians with the number of examinations required to maintain their forensic competence has arisen since police forensic medical examiners no longer carry out joint examinations of children and young people. This will ensure that forensically viable examinations are carried out by doctors with expertise in child development and with a focus on children’s needs.
5.1.5 We learned from the named GP that the LSCB also has a sitting GP representative. We were advised that this has been helpful in enabling the LSCB to understand the primary care landscape in Wakefield. For example, the CCG designated nurse chairs challenge panels for social care whilst the LSCB’s independent chair chairs the panels with health agencies. Panels take place after the final due date of the last recommendation of each SCR, then again one year on, to see whether they have ‘mainstreamed’ the changes required into practice.

Challenge panels are robust in examining information provided by the agencies. One of the questions in the challenge process is ‘what is the impact on children?’ The CCG told us that the health agencies have been effective in mainstreaming changes into practice by helping to embed a safeguarding culture among senior staff such that the impact on children of such changes has been significant.

For example, one of the recommendations of a SCR was to separate the children’s fracture clinic from the adults clinic so that instances of non-attendance (DNA) can be properly identified and followed-up. As a result of changes implemented any habitual re-arranging of appointments is notified to GPs who are alerted to look in detail at a child’s history and encouraged to consider the rest of the family, particularly for evidence of further DNAs and can respond accordingly.

We learned of an initiative in the Spring of 2015 derived from the West Yorkshire Police and Wakefield Council response to reports published about CSE in Rotherham in 2014. The police and local authority had identified 44 legacy cases which had met certain risk criteria and which required further investigation by the agencies. The health services were asked to review health records of the young people concerned to determine whether all risks had been properly identified. The governance of this information was challenging, particularly since many of the young people were over 18 at the time of the review. As a whole, health economy approach, the CCG worked with providers and GPs to individually audit each case to see if any hidden risk had been missed initially. This led to the safe and meaningful sharing of information from relevant cases.

In this instance, the CCG’s involvement and leadership was key to ensuring a successful outcome to this challenging circumstance.
5.1.6 Safeguarding children has a high profile within the MYHT and staff work within a culture where this is promoted. For example, the named midwife and safeguarding adviser promote and prioritise safeguarding within the maternity services at Pinderfields hospital and are available to provide expert advice and guidance to staff as needed. Additionally, they have good oversight of cases where vulnerabilities have been identified.

5.1.7 The health visiting team have increased in volume in the wake of the ‘Health visitor implementation plan, a call to action’. Practitioners told us their caseload sizes were around 240 and were manageable. This is below the minimum floor standard of 300 as outlined by the Institute of health visiting guidance. As a result, families have a named health visitor allocated to them until the child is aged five and this supports the identification of and response to risk.

5.1.8 As we have outlined in ‘Early Help’ the health visitors work in partnership with GPs in Wakefield through regular meetings albeit to a variable extent and without the benefit of an input from school nursing and midwifery.

5.1.9 The current pathway to review and respond to the gap in paediatric liaison is not robust. We were told that the criteria for sharing of information about ED attendances had changed in response to the challenges around the resources needed to review every ED attendance that the school nursing team received. A more targeted approach was considered to be a solution and we have reported above under ‘Early Help’ about pilot designed to ensure a more focussed approach. This is an ongoing piece of work and is currently in phase two. Our sampling of case has shown that this arrangement is not working effectively and that liaison between the two services is too variable. As a consequence there is a risk that some children and young people had hidden health and wellbeing needs that will not be met whilst others will showing that the service is inequitable. (Recommendation 1.4).

5.1.10 The school nurse team are commissioned to deliver the healthy child programme to children and young people aged five to 18 (19 for those with special needs) and immunisations. The population size is around 63,000 children and young people with diverse needs. The universal caseload size currently exceeds that which is recommended by the guidance from the Community and Public Health Visitors Association.

5.1.11 The universal public health offer has developed further to include more immunisation campaigns. This offers greater health protection for the school aged child with very successful uptakes reported of human papilloma virus and diphtheria, tetanus and polio campaigns. However, this has become part of the core offer and is delivered with no additional workforce. (Recommendation 1.16).
5.1.12 We heard about the significant challenges the school nurses are encountering in response to the demands and complexity of their work with stretched and limited resources. There is additional pressure in the team at present as four experienced members of staff are off work long-term. Staff report that they have been unable to complete incident forms on the datix system due to their workload and this under-reporting has exacerbated the problem. We learned anecdotally that these capacity issues have been escalated to the management team and commissioners although there is a perception among staff that this is not considered an organisational risk. (Recommendation 1.16).

One of the cases we looked at in the CAMHS service showed that differences of opinion between professionals from different agencies are properly escalated through the SWYPFT safeguarding team. In this instance they were escalated in a timely way that ensured the young person was not left at risk for a protracted period. The resulting professional meetings about the risks led to an eventual safer outcome for the young person concerned.

5.1.13 In both CAMHS and adult mental health services, practitioners use both paper and electronic patient records, which the trust recognises as a risk. As we have outlined in ‘Child Protection’ above, the electronic patient records does not currently allow practitioners to scan referral forms, child protection minutes, or any other third party information on to the patient records. We have been advised that a new release of the software is imminent and staff hope that this will support better record keeping and information sharing.

5.1.14 The interim lead looked after children nurse has negotiated IT support and is now able to produce reports on initial health assessments and health reviews. This facilitates more effective scheduling and reporting on compliance with timescales. A balanced scorecard now incorporates performance around initial and review health assessments and exceptions are reported to the designated nurse for looked after children.

5.1.15 Use of new codes on the patient electronic record is helping to develop a more intelligent and accurate health profile of Wakefield’s cohort of looked after children. This will help in commissioning services and evaluating the impact of health interventions.
5.1.16 The predominating electronic patient record system in use across most health services in Wakefield, known as SystmOne, has functionality that allows information about vulnerable children or those at risk to be shared across service boundaries by use of a discrete safeguarding node. However, the sharing arrangements on the system are inconsistently applied and do not conform to any particular data entry standards. For example, the cases we looked at in the health visiting service highlight that the safeguarding node is underutilised by health visitors. We also saw that whilst GPs can view entries on patient records made by other practitioners such as health visitors or school nurses, the same is not true of information entered by other services or by the GPs themselves. Such a variable use of the safeguarding node across all services that used the records system to such an extent that there is a risk of it being an unreliable repository of information. (Recommendation 2.2).

5.1.17 This is exacerbated by the use of several other different electronic records systems used by different health disciplines, often those in the same trust. This does not allow effective oversight of children at risk and inhibits effective collaborative work as information is missed. One particular case we were tracking across services that we have reported on under ‘Child Protection’ highlights the dangers in this arrangement where the risks to the young person are perceived differently by three different services.

We visited the MASH service at Normanton police station and reviewed both the health service’s contribution to decisions made at the MASH as well as the effectiveness of referrals made by health practitioners. We saw that the health information presented to the individual case discussions was extensive, well-researched and comprehensively analysed in terms of its effect on the risk to the child or young person subject of the referral. This means it was also very influential on the MASH decision making processes. This is despite the inherent difficulties in extracting information from six different databases and where information is often hidden between different health services. We saw that the team had developed an extensive range of contacts in the health services in order to help them to interpret information or to obtain information that was hidden from view.

In the cases we sampled where the health services had referred concerns into the MASH team we found that the level of detail was variable. However, each referral was timely and showed vigilance by the practitioners involved. In one particular case we noted that an effective escalation process had been used by the health team and that urgent action had been taken to protect a young person as a result.
5.2 Governance

5.2.1 As shown above, the CCG play a key role in safeguarding governance in the Wakefield LSCB. The CCG’s chief of service delivery for safeguarding (and executive nurse on the CCG board) is the deputy chair of the LSCB whilst the designated nurse for safeguarding and looked after children chairs the Audit sub-committee of the LSCB. There is also representation from the GP community and from midwifery on the LSCB or its sub-groups and this ensures that the health service is in a position of strategic influence within the local safeguarding landscape.

5.2.2 We learned from the CCG that reporting on safeguarding has become systematic as opposed to being by exception. This was borne out by the ready availability of data forwarded to us by the CCG in short, advance notice of this inspection. For example, all referrals of abuse through health that are classified as serious incidents are raised through the serious incident reporting process on STEIS and then discussed at CCG quality board. This ensures robust oversight of safeguarding performance at senior level.

5.2.3 In addition we saw that the CCG audited its safeguarding performance in March 2015. This was in order to determine its compliance with the NHS England accountability and assurance framework for safeguarding two years on from the transition of commissioning arrangements from PCT to CCG. In its report to the CCG’s Integrated Governance Committee of August 2015, the CCG concluded that “NHS Wakefield CCG is in a strong position regarding the revised accountability framework, and will continue to reform and improve provider assurance.” This assertion was based on the assurances obtained from the audit of compliance with all of the requirements of the NHS’ framework.

5.2.4 All strategic governance roles are in place with clear lines of accountability. The designated doctor for safeguarding is part of the medical staff at the MYHT, thus ensuring strategic liaison with the city’s biggest health service employer. The named GP is also a practicing GP and provides one session per week safeguarding duty. Both the MYHT and the SWYPFT have dedicated safeguarding teams lead by named professionals, as does the largest independent health provider, Spectrum C.I.C. Thus there are clear processes that enable safeguarding to be managed at both executive and operational levels. For example, we found that there is a clear governance structure and regular meetings with the MYHT that ensure safeguarding issues within maternity services are reported appropriately to the trust senior management and board. We have been assured that this process is mirrored across all MYHT services.
5.2.5 We also saw that the SWYPFT had a clear and robust structure for managing safeguarding performance in their service provision for both adults and children. Safeguarding was a clear priority for the trust and was part of the remit of the trust’s Clinical Governance and Safety Committee with clear lines of accountability. For example, we looked at the trust’s annual safeguarding plan for 2015 to 2016 which set out key objectives for the executive lead and their deputies, the named professionals and their team of safeguarding advisers and the link professionals that directly support the operational teams. We noted that named people or identified roles in the trust’s safeguarding structure are accountable for key objectives of the plan. These objectives include, for instance, attendance at local safeguarding children’s board meetings, safeguarding training compliance, quality of safeguarding supervision sessions and ensuring that views of children are reflected in assessments and records in individual cases. Monitoring of these objectives is through the trust’s clinical audit and practice evaluation plan (CAPE) which shows that safeguarding is embedded as a key feature at both strategic and operational level of the trust’s functions.

We were interested to hear of a ‘challenge event’ run by the local safeguarding children board of a neighbouring local authority area which is also covered by the SWYPFT (Kirklees) and with a similar demographic. At this event, each of the agencies involved in safeguarding presented to the board the findings of their self-assessment audit carried out to measure the effectiveness of their safeguarding arrangements, in particular, their training and governance arrangements. The trust’s safeguarding team presented the findings on behalf of the Trust. This was followed by interviews by a panel of children and young people about each agency’s performance, including their approach to child sexual exploitation, after which the agencies were ‘scored’ by the panel. We note that the trust’s scores were the highest of each of the agencies represented showing a general level of confidence of young people in the safeguarding service offered by the trust.

Whilst this event relate to a council that bordered Wakefield – a similar event is planned for Wakefield in 2016 – we nonetheless consider it indicative of the overall effectiveness of the trust’s approach to safeguarding.

5.2.6 We saw that SWYPFT consult with a group known as the CAMHS young people’s advisory group to ensure their services meet the needs of young people. This group had been effectively engaged in, for example, CAMHS staff selection. Clinicians of band six and above who were appointed in the last five years had been subject to interviews by young people as part of their selection process. This initiative had provided the trust with assurance that newly recruited staff were focused on the needs of young people and were committed to ensuring good outcomes for them. This was borne out in our discussions with staff and our review of records, where we found that there was an overall child centred culture among the CAMHS staff team and their managers.
5.2.7 All initial and health review assessments of looked after children are subject to a quality assurance process using a standard tool. The looked after children nurses review all completed assessments and peer review each other’s. This helps to ensure that all children and young people benefit from meaningful reviews, including those children and young people placed out of area.

5.2.8 The looked after children nursing team has been in flux for a prolonged period of time with changes in operational leadership and reduced capacity of looked after children nurses due to sickness and maternity leave. We have been advised that these issues are recently resolved. Despite this, the team has worked closely with partners in social care to improve the timeliness of initial health assessments and recent performance shows 100% of assessments have been carried out within 28 days of a child becoming looked after. This is good, as very often the initial health assessment is the first opportunity to fully assess a child’s health and make a plan to improve their health outcomes.

Since April 2015, the two major providers of adult substance misuse services, Spectrum and Turning Point, have combined their operations under a single commissioned umbrella organisation, Inspiring Recovery. The new organisation has made great efforts in a short space of time to ensure that their operating models are aligned. Of note, is the monthly, dedicated safeguarding working group whose role is to produce a new set of procedures and policies and the implementation of a single case management database. In our review of sampled cases we found that staff were knowledgeable of the procedures and had applied them effectively to assess risks to children of, or accessible to their clients.
5.3  Training and supervision

5.3.1  Practitioners caring for vulnerable children and young people in a mental health crisis on the children’s assessment unit or children’s ward at Pinderfields hospital have not had any training in CAMHS. We heard that CAMHS have recently started running monthly briefing sessions available for staff to access. This increases the level of knowledge and understanding about children and young people’s mental health among paediatric staff.

5.3.2  ED practitioners at Pinderfields Hospital have received level three safeguarding training as outlined by the intercollegiate guidance on safeguarding roles and competences for health care staff. However, the majority of staff have only accessed in-house training and that not all ED practitioners have accessed multi-agency training provided by the LSCB. This is not in line with the guidance. (Recommendation 1.17).

5.3.3  We learned that the MYHT safeguarding team have recently introduced dedicated safeguarding supervision across both Pinderfields and Pontefract hospitals. This supervision is separate from routine clinical or other supervision. Children’s ED practitioners have access to quarterly safeguarding supervision, where cases are discussed. However, the impact of these new arrangements has yet to be measured and it is not clear whether part-time practitioners or those on annual leave have the same access to such timely safeguarding supervision.

5.3.4  In the maternity unit we saw that patients’ integrated care pathway documents are noted whenever their case has been subject to discussion at a safeguarding supervision session. Action plans arising from supervision, however, are not incorporated into any patient records, either in paper format or on the electronic database. This means that patient records are incomplete, that any staff who need to use the records are not fully apprised of any relevant issues and the practice does not support auditable decision making. This is contrary to guidance issued by both the Royal College of Nursing and the Nursing and Midwifery Council on good record keeping. (Recommendation 1.18).

5.3.5  Midwives are specifically identified within the intercollegiate guidance as requiring level three training at specialist level (a minimum of 12-16 hours over a three year period) which has a multi-disciplinary and inter-agency component. We were advised that community midwives at Pinderfields hospital are required to attend level three safeguarding training but that hospital midwives are only required to attend level two. This does not comply with the intercollegiate guidance.
5.3.6 Compliance with attendance at the single agency, in-house training is monitored, however the running total of a midwife’s learning over a three year period is not monitored. This would benefit from a safeguarding training element included in annual appraisals so that running total of hours of relevant learning could be discussed and signed off by the line manager and a plan of how to achieve any outstanding hours over the next year developed.

5.3.7 As reported above, multi-agency training opportunities are available through the LSCB but midwives perceive that work pressures and capacity limit their availability to attend. This is a missed opportunity to better understand the roles and responsibilities of other agencies involved in safeguarding children work and also promote the principles of working together for this key group of staff. (Recommendation 1.17).

5.3.8 Safeguarding supervision is offered three-monthly to health visitors in a one-to-one scheduled format and on an ad hoc basis if required. The child health team matron maintains oversight of this and is proactive in ensuring health visitors take their supervision opportunities. Safeguarding supervision is reportedly recorded in the journal of the child’s record and in the safeguarding node on the electronic records. However, in one of the cases we were tracking across services we saw that a record that such a discussion had been held was logged in the safeguarding node of the electronic record but there was no corresponding entry in the child’s journal that showed what actions had been taken or the outcome. In another case we sampled we saw that there was no record of such a discussion shown in the safeguarding node of the electronic record. Team leaders use a dip-sample methodology to quality assure safeguarding cases are but the variability of the use of the safeguarding node shows that this was not effective. (Recommendation 1.18).

5.3.9 Newly qualified health visitors receive a period of preceptorship for a minimum of three months with the option to extend further based on the individual’s need of further development. They are supported by a mentor from their team for day-to-day support and are allocated a safeguarding supervisor soon after coming into post. The health visitor preceptorship lacks a formal structured approach to measure the skills and competences that underpin good safeguarding practice. Newly qualified staff are required to complete LSCB level three multi-agency training within their first year of practice. However, this arrangement could be strengthened if this were prioritised within their first three months of preceptorship to help the early identification of any further areas of development around safeguarding.

5.3.10 Health visitors have over 94% compliance with safeguarding training. They are expected to attend level three training provided by the trust safeguarding team once every three years for a full day. Other than their initial multi-agency training, they are encouraged to undertake training via the LSCB but this is not mandatory. As with the maternity staff, this limits the opportunity to consider and reflect on other agencies roles within safeguarding. (Recommendation 1.17).
5.3.11 Band six caseload holders in the school nursing service receive one-to-one safeguarding supervision from a named supervisor every three months. The process is practitioner driven in that cases are selected for discussion by the case holder which enables the discussion to be focussed on the most appropriate children. Ad-hoc safeguarding discussions also take place as required. We saw examples of the positive impact of safeguarding supervision that contributed to the safety and wellbeing of vulnerable children and also examples of a lack of robust oversight of some cases. This showed that standards of supervision practice were variable.

5.3.12 We were told that band five nurses in the school nursing service are not caseload holders and are therefore not offered the same formal package of one-to-one safeguarding supervision as their band six colleagues. This is despite band five staff delivering early help, looked after children work and safeguarding work at CAF and child in need level. This does not provide band five staff with opportunities to examine cases in more detail and agree formal actions that would benefit the child. Furthermore, it inhibits their learning around a key aspect of their role. (Recommendation 1.19).

5.3.13 The MYHT teams, including the school nursing and health visiting services, looked after children team, community midwifery and family nurse practitioners are undergoing a programme of training in the ‘Signs of Safety’ model of risk assessment and management. At the time of our inspection the trust had already achieved a significant proportion of trained staff across all the disciplines with more places planned. This means that children accessing all of the MYHT services would experience standardised safeguarding practice with the emphasis on their needs.

5.3.14 We also learned that the MYHT include training on the ‘Prevent’ programme as part of their level two and level three safeguarding training refresher courses. This ensures that staff who might have contact with young people, their families and communities are better able to identify young people vulnerable to radicalisation and to respond appropriately.

5.3.15 In all of the GP practices we visited we saw that GPs are trained at level three of the standards set by the intercollegiate guidance. This is currently done through a blended approach where online training augments taught sessions. The online package has a number of modules that require completion such as parental risk factors, unexplained injuries, disabilities and neglect, fabricated or induced illness and substance misuse. In addition, the CCG has recently promoted the use of a bespoke online programme for FGM. Taught sessions are led by the CCG designated nurse for safeguarding who provides level three training for a half-day once every year for each of the seven primary care localities. In this way, bespoke sessions are devised according to the needs of each locality. Over the last year training has included CSE, domestic abuse, FGM, learning from SCRs, private fostering and health of looked after children.
5.3.16 GPs also receive safeguarding updates through quarterly primary care network meetings for practice safeguarding leads. This has included training on MASH and the ‘Prevent’ programme, with occasional speakers from other agencies although attendance at both these events and the CCG annual events is not currently mandatory. GPs are offered LSCB multi-agency training but none of the GPs we spoke with had taken up this opportunity. This means that those GPs who rely solely on the online package are not being trained to the standards set out by the guidance. Nonetheless, we acknowledge that the content of GP training, and its take-up, has improved significantly over the last three years due to a proactive approach taken by the CCG.

5.3.17 In the CAMHS service we found that the levels of support offered to practitioners in relation to safeguarding is meaningful and robust. Not only do staff receive group safeguarding supervision every three months where they can share and learn from case discussion, they also have dedicated one-to-one safeguarding supervision sessions. In addition, each of the SWYPFT CAMHS and adult mental health teams have a safeguarding link practitioner who benefits from additional training and their own peer network. This role is further supported by a lead professional for safeguarding participation for Wakefield CAMHS. This equips link practitioners with knowledge and expertise to act as a point of contact for their team colleagues. Further, the trust’s safeguarding team have a dedicated advice line for practitioners to call at any time for guidance on safeguarding matters, with a firm commitment to call the practitioner back within four hours.

5.3.18 In our review of cases we noted clear documented supervision sessions in the client’s records which set out full details of the particular concerns to a child or young person and an analysis of the risk to the young person. The records also contained a list of agreed and time-bound actions arising out of the advice including a timescale for following up the actions. These entries were completed by the supervisor providing the advice which means that the direction provided was clear, unambiguous and supportive of the staff member. This is best practice.

5.3.19 Similarly, there is an expectation that adult mental health practitioners will access group safeguarding supervision every three months. However, there is currently no formal arrangement for one-to-one safeguarding supervision except for the crisis and mental health liaison teams. We saw that all practitioners have one-to-one line management supervision monthly. This session also includes an element of safeguarding supervision and case management although this is over-reliant on individual practitioners to identify cases for discussion. The trust recognises this as a gap, and we were informed of plans to roll out child safeguarding supervision to all community mental health teams as well.

5.3.20 Like the CAMHS service, adult practitioners who access safeguarding supervision are expected to record outcomes following the discussions in the patient’s electronic records. However, in the cases we reviewed, we saw that this practice is too variable and for those case where there no such record is made decision making is compromised. The trust is also aware of this shortfall and as we have previously reported, a newer version of the patient record software is expected soon. This will allow documents, such as supervision notes, to be scanned into the record to ensure that everyone who uses the notes has access to all information.
5.3.21 Learning from SCRs is sent out to all practitioners in the CAMHS and adult mental health service and this is recorded on training records by the learning and development team. This ensures that staff have access to lessons learned and can consider their practice in light of emerging themes.

5.3.22 All adult mental health practitioners are required to access level three safeguarding training every three years, and this is reported to be in line with the intercollegiate guidelines. We were informed that compliance has been monitored and the trust compliance figures for attendance at mandatory training have increased significantly over the past year.

5.3.23 Adult mental health practitioners have also had access to additional training to support them in their roles to safeguard children and young people. This includes training on FGM, domestic abuse and the ‘Prevent’ programme. All practitioners are provided with a workbook to complete in order to demonstrate their learning and understanding of safeguarding related topics.

5.3.24 We were informed that community psychiatric nurses, midwifery services and health visitors have delivered training on perinatal mental health to a group of professionals in order to raise their awareness. This provides some assurance that practitioners are being trained on how to appropriately support this vulnerable client group especially with the lack of a formally commissioned perinatal mental health service.

5.3.25 The adult substance misuse service provides training for all of its staff at level two. This has either taken the form of a scenario based workbook supported by line manager discussion or face-to-face workshop. This does not meet the requirements of the intercollegiate guidance as all staff may be called upon to assess family life. However, staff also have access to LSCB multi-agency training and the provider plans to roll out ‘Signs of Safety’ training in the coming year. This has been brought to the attention of Public Health England.

5.3.26 We noted that the adult substance misuse service track clients who have access to children by use of a spreadsheet. This is checked by team managers for accuracy and current status during monthly supervision discussions. Whilst this is not formal safeguarding supervision, we were told that the check sometimes triggers discussion on individual cases. Additionally staff can bring concerns to managers or to members of the Family Support Team as and when they arise. In the cases we sampled, we saw that such discussions were documented and time bound actions that arose from those discussions, such as the planned joint visit to a particular family home reported above under ‘Children in Need’. This supports accountable decision making.
5.3.27 In the CASH service we saw that safeguarding supervision is not robust. Supervision is offered as part of a one-to-one meeting between the staff member and a supervisor three times in every 13 month period and also as and when it is required if concerns are identified. During these meetings the supervisor uses a handwritten template to make notes of the meeting and on which the practitioners’ cases under discussion are listed. However, there is no record of the concerns or the discussion about each case and there are no specific time-bound actions recorded. Furthermore, the documents are in a supervision file attributable to the staff member and there was no record of the supervision discussion shown on the client’s records in the cases we looked at. This is not good practice as it does not allow for decisions made about children to be properly audited. Furthermore there is a risk that key decisions might be overlooked. This has been brought to the attention of Public Health England.
Recommendations

1. **Mid Yorkshire Hospitals NHS Trust (MYHT) should:**

   1.1. Develop facilities for the reception, assessment and treatment of children and young people in the emergency department at Pontefract hospital comply with the ‘Standards for Children and Young People in Emergency Care Settings’ issued by the Royal College of Paediatrics and Child Health (RCPCH).

   1.2. Ensure clear information is posted in the ED at both Pinderfields and Pontefract hospitals to inform children and their parents or carers that their hospital attendance may be shared with other professionals.

   1.3. Ensure that the details of adults who accompany children and young people who present at the ED at Pinderfields and Pontefract hospitals is always recorded in the young patient’s ED electronic records.

   1.4. Develop the paediatric liaison arrangements at Pinderfields and Pontefract hospitals to ensure they are effective in enabling vulnerable children to be followed-up appropriately by community health and primary care teams.

   1.5. Implement a process for capturing all information about risks to vulnerable children and young people on the safeguarding node of the electronic patient records.

   1.6. Implement a system to quality assure the level of detail in discharge summaries of children and young people discharged from the ED so that community teams are better informed.

   1.7. Reinforce the protocols for speaking with pregnant women alone during their pregnancy to ensure the risk of domestic abuse is explored fully.

   1.8. Update the current risk assessment tool In use for all children and young people who attend ED at Pinderfields and Pontefract hospitals so that it includes a full exploration of risks, particularly the risk of CSE, and ensure that full records are made of the assessment.

   1.9. Implement a system for capturing and responding to information from adults who present at ED with risk taking behaviours about children they might have access to.

   1.10. Develop arrangements for more effective information sharing between the school nursing service and the education admissions department of the local authority in order to identify additional support needs of children being home schooled, moving schools or those missing from education.
1.11. Ensure that the protocol for reviewing all under one year old non-ambulant babies who attend with burns, head injuries, bruises or fractures at both hospitals is adhered to in relation to the experience and skill of the examining doctor.

1.12. Install a secure exit system from the postnatal ward that complements the secure system already in place for entry to the ward.

1.13. Ensure that the health assessments and health plans of looked after children are shared directly with the child’s GP so that they apprised of all recommendations.

1.14. Ensure that looked after children health assessment documentation is completed fully to enable a complete picture of the child to be conveyed to all practitioners who need to use the records.

1.15. Ensure that quality assurance processes for looked after children health assessments are effective in identifying shortfalls in those assessments and the documentation relating to them.

1.16. Ensure that the capacity of the school nursing service reflects the increase in the demand for its service.

1.17. Ensure that all staff at Pinderfields hospital ED and maternity and also in the health visiting service have access to level three training that has a multi-agency component and that training complies with the intercollegiate guidance.

1.18. Ensure that safeguarding supervision discussions and action plans arising from the supervision of midwifery and health visiting staff are incorporated into patient records.

1.19. Provide the same safeguarding supervision arrangements for band five nurses in the school nursing service as their band six colleagues.

2. **The Wakefield CCG should:**

   2.1 Develop a protocol and tools for use in primary care to enable GPs to make sufficient enquiries of young patients about the risks of CSE.

   2.2 Formalise arrangements for the multi-disciplinary exchange of information between GPs, the community health teams about vulnerable children or those at risk, including the means to ensure a formal note is made of discussions in the electronic patient records which can be shared across the health services.
2.3 Ensure that GP practices follow standardised processes and templates for engaging with safeguarding processes, including the use of templated forms for referring cases to social care and the use of standardised content of reports submitted to conferences.

2.4 Develop arrangements with the local authority for GP practices to be sent copies of updated child protection plans, core group minutes and child in need meeting minutes and plans so that they can be held on the patient records.

3. South West Yorkshire Partnership NHS Foundation Trust should:

3.1 Implement a system to quality assure the level of detail provided in referrals to children’s social care by the adult mental health service, including a clear articulation of the risks to the child or young person.

3.2 Implement a system that enables staff to fully embed the ‘think family’ model into practice in the adult mental health service as well as the management oversight to ensure this is applied effectively.

3.3 Formalise the arrangements in the adult mental health service for providing written information to child protection conferences in lieu of attendance and for using information received from conferences to help plan their clients’ care.

Next steps

An action plan addressing the recommendations above is required from NHS Wakefield CCG within 20 working days of receipt of this report.

Please submit your action plan to CQC through childrens-services-inspection@cqc.org.uk. The plan will be considered by the inspection team and progress will be followed up through CQC’s regional compliance team.
## Executive Summary:

**24 September 2015**

- **Quarterly refresh of Declarations of Interest** were noted in line with the CCG’s Conflicts of Interest Policy and it was agreed this version will be made available via the CCG web-site.
- The reviewed **Audit Committee Terms of Reference** were presented and it was agreed to delegate authority to the Chair of the Audit Committee to approve the revised draft terms of reference before being presented to the Governing Body for approval.
- **Mid-year progress reports from Integrated Governance Committee, Clinical Cabinet, Probity Committee, Connecting Care Executive and Audit Committee** were presented noting that there were no areas of concern, significant issues or areas for escalation to the Governing Body.
- Regular **Governance Exceptions Report** presented noting that there had been a drive during August to encourage declarations in line with the Standards of Business Conduct Policy.
- **A Financial Control and Environment** self-assessment has been undertaken at the request of the Chief Financial Officer for NHS England. The report was approved by the Chief Officer and Chair of the Audit Committee and reviewed by the CCG’s internal auditors.
- Updated **Governance Body Assurance Framework** was noted.
- The regular **Contract Award Update** paper was presented and it was noted that in future this information will be included within the Procurement Register report.
- An update on the **Co-commissioning Transition Plan** was presented providing assurance regarding the transition of co-commissioning functions from NHS England to the CCG.
- An update on **Continuing Health Care** was noted.
- Regular **Internal Audit and Counter Fraud progress report** was presented which included details following the Risk Register Benchmarking Review and the Information Governance Toolkit audit.
- The **Local Security Management Specialist Draft Work Plan 2015/16** was approved.
- Regular **External Audit Technical Update** presented which included a report about risks faced by NHS organisations.
NHS Wakefield Clinical Commissioning Group

AUDIT COMMITTEE

Minutes of the meeting held on 24 September 2015

Present: Sandra Cheseldine (Chair) Lay Member
Dr Adam Sheppard Nominated Clinical Member
Rhod Mitchell Lay Member

In Attendance: Andrew Pepper Chief Finance Officer
Leanne Sobrartee West Yorkshire Audit Consortium
Katherine Bryant Governance and Board Secretary
Linda Wild KPMG
Gemma Reed Senior Governance Officer
Karen Parkin Associate Director Finance, Governance & Contracting
Helen Jones West Yorkshire Audit Consortium
Stuart Dryden Interim Contracts management Lead (paper 15/104 only)
Catherine Wormstone Primary Care Commissioning Programme Manager (paper 15/105 only)
Pam Vaines Minute Taker

15/93 Welcome and Chair’s opening remarks
Sandra Cheseldine welcomed everyone to the meeting

15/94 Apologies for absence
Apologies for absence were received from Eamonn May, Nigel Bell, Clare Partridge, Dr Clive Harries and Jo Pollard

15/95 Declarations of interest
Sandra Cheseldine invited members to declare conflicts of interest. Helen Jones declared that she provided audit support for Locala.

15/96 Minutes of meeting held on 30 July 2015
The minutes of the meeting held on 30 July 2015 were agreed as a correct record.

15/97 Action Sheet from the meeting held on 30 July 2015
The action sheet was noted.

15/98 Declarations of Interest for members of NHS Wakefield CCG
Gemma Reed presented this report as a quarterly refresh in line with the CCG’s Conflicts of Interest Policy. Subject to approval, this version will be made available via the web-site.
The Register of Network Interests (presented in July 2015) is now available on Skyline.

Katherine Bryant informed the Committee that the Register of Procurement Decisions is currently being refined. It will be considered as part of the external audit by Deloitte. A further update will be presented to the December 2015 Audit Committee.

Discussion took place regarding the clinical input into procurement decisions in view of the exclusion of GPs associated with private sector enterprises during procurement discussions, including salaried GPs. Consideration is currently been given to the involvement of out of area GPs.

Katherine also informed the Committee that Wakefield CCG has been selected as one of 10 CCGs to have an external audit by Deloittes in respect of management of conflicts of interest in the commissioning of primary care.

It was reported that all CCGs have received letters from NHS England seeking assurances regarding mechanisms for declaring interests. A copy of the full assurance report was presented to the CCG’s Governing Body on 15 September 2015.

**It was RESOLVED that:**

i. The committee noted the updates included within the report; and

ii. noted the declared interests of members of NHS Wakefield CCG Governing Body and its Committees as at 15 September 2015.

**15/99 Audit Committee Terms of Reference Review**

Katherine Bryant presented this paper which highlighted changes to the Audit Committee Terms of Reference as part of the programme for annual review of the terms of reference of all Governing Body Committees.

Katherine asked that the Committee note the GP Practice Manager member of the Governing Body was not included in the List of Committee Members due to the workload of the nominee and the inclusion of the Local Security Management Specialist (LSMS) in line with the new standards.

From 2016 there will be a requirement for all CCGs to have an Auditor Panel. It is not yet clear when the requirement will become effective. Linda Wild confirmed that she will supply this date when it is known. In the meantime the Committee were asked to note that they will probably fulfil this role, subject to relevant amendments to the Terms of Reference.

Dr Adam Sheppard stated that there had been a robust discussion at Clinical Cabinet regarding the demands on clinical time to attend. Sandra Cheseldine confirmed that the intention in the revised Terms of Reference to include three clinical members on the Audit Committee whilst quoracy only requires the attendance of one clinical member which is aimed at reducing the demands on individual clinicians.

Members of the committee agreed to delegated authority to the Chair of the Committee to approve the revised draft terms of reference before they are presented to the Governing Body.
It was agreed the quoracy element of the Terms of Reference will be amended to require a Lay Member to be in attendance.

**It was RESOLVED that:**

i. the Committee noted the proposed amendments to the Audit Committee Terms of Reference;
ii. noted that further changes will be required to establish the Audit Committee as the CCG’s ‘Auditor Panel’; and
iii. the Committee agreed amendments to the membership and quoracy sections of the Terms of Reference.

**15/100 Progress Reports from Committees**

Katherine Bryant presented the mid-year progress reports for the Integrated Governance Committee, Clinical Cabinet Committee, Probity Committee, Connecting Care Executive and the Audit Committee. These reports will assist with production of the Annual Governance Statement in April 2016. The Committee was asked to note mid-year progress reports for the Nominations Committee and Remunerations Committee have not been prepared due to the infrequency of their meetings during the relevant period.

The reports will all go to the relevant committees at their next meeting, together with a review of their Terms of Reference.

Members of the Committee agreed that there were no areas of concern, significant issues or areas for escalation to the Governing Body.

Sandra Cheseldine asked that the Clinical Cabinet mid-year report is amended to clarify that Clinical Cabinet cannot commit funds under the CCG’s Operating Scheme of Delegation.

**It was RESOLVED that:**

i. the Committee noted the mid-year committee progress reports, including progress made against agreed work plans;
ii. agreed that the mid-year committee progress reports provide appropriate assurance; and
iii. agreed no items for escalation to the Governing Body

**15/101 Governance Exceptions Report**

Katherine Bryant presented this report providing details on a number of governance control mechanisms and gave an update that there had been ten declarations made under the CCG’s Standards of Business Conduct, one rebate scheme approved, two tender waivers and no losses or special payments reported since the last meeting.

Katherine advised that there has been a drive during August to encourage declarations in line with the Standards of Business Conduct Policy.
Katherine confirmed that the ‘grant waiver’ details were included because although grants are not subject to procurement rules the CCG should demonstrate a transparent process equivalent to that required by EU procurement rules.

It was RESOLVED that:

i. the Committee noted the paper and the governance control exceptions detailed

15/102 Financial Control and Environment Assessment

Katherine Bryant confirmed that this self-assessment was undertaken at the request of the Chief Financial Officer for NHS England. The report had been approved by the Chief Officer and Chair of the Audit Committee. The self-assessment was reviewed by the CCG’s internal auditors. The report was presented to the Governing Body on 15 September 2015.

It was RESOLVED that:

i. the Committee noted the new NHS England requirement for all CCGs to complete a rapid review of their financial stewardship arrangements; and
ii. noted the process followed to complete the NHS Wakefield CCG self-assessment checklist and noted the outcome of which was submitted to NHS England in August 2015.

15/103 Governing Body Assurance Framework

Andrew Pepper presented the paper and acknowledged the scheme of work during Quarter 3 to progress the Governing Body Assurance Framework. It was noted that the Governing Body Assurance Framework is a live document and it will continue to develop and evolve.

It was RESOLVED that:

i. the Committee noted the development of the Governing Body Assurance Framework; and
ii. noted the updated 2015/16 Assurance Framework for NHS Wakefield Clinical Commissioning Group which was approved by the Governing Body on 15 September 2015.

15/104 Contract Award Update

Stuart Dryden attended the meeting to present this paper.

There were two health care contracts awarded, one under review and one to be drafted ready to share with Providers.

One non-healthcare contract was awarded in August 2015.

It was agreed in future the information detailed within this report will be included within the Procurement Register report.
It was RESOLVED that:

i. the Committee noted the contents of the Contract Award Update

15/105 Co-commissioning Transition Plan Assurance update

Catherine Wormstone attended the meeting to present this paper which provides assurance to the Audit Committee regarding the transition of co-commissioning functions from NHS England to the CCG.

The report set out the outstanding issues and lessons learned to date. Catherine outlined some of the mechanisms to keep staff updated though the ‘hot topics’ List and a programme risk register.

It was RESOLVED that:

i. the Committee noted the Co-commissioning Transition Plan Assurance update

15/106 Continuing Health Care Update

Karen Parkin presented the Continuing Healthcare Legacy Provision report, commenting on the different format from previous reports with the aim of describing the variables involved in calculating the proposed change in provisions.

Three options to estimate remaining restitution claims were presented to the Committee. Following a lengthy discussion it was agreed that the Committee would support option 2 – which would reduce the overall provision at this stage - with the potential to move to option 3 at a later date.

It was RESOLVED that:

i. the Committee noted that the current assessment of the overall provision is maintained from Q1 and noted that future assessments are likely to further reduce the overall provision in line with adopting option 2 at this stage.

15/107 Internal Audit and Counter Fraud progress report

Leanne Sibratee presented this paper which covered a number of elements.

The Risk Register Benchmarking Review provides data ascertained from 14 CCGs from West Yorkshire and Greater Manchester. Andrew Pepper commented the report has proven a useful document and has already been reviewed against the CCG Risk Register to identify gaps or omissions. Katherine Bryant commented that assurance can also be gained from the Internal Audit review of the Risk Register process which took place in November 2014.

The Financial Control Environment Assessment Checklist was a verification exercise and concluded that the CCG provided adequate evidence to support the CCG self-assessment scores in all five areas.
The Information Governance Toolkit audit generated a lengthy discussion, particularly in relation to the RAG rating scheme assigned. Linda Wild and Helen Jones gave assurance that the CCG findings were not unusual at this stage in the financial year. It was agreed that in future years, two audits should take place prior to the submission of the Toolkit to ensure that any learning/development is identified and embedded prior to submission.

The NHS Protect self review tool for NHS Wakefield CCG was completed in July 2015. This is an active piece of work and Helen Jones confirmed that other CCGs are at the same stage in relation to this topic.

It was RESOLVED that:

i. the Committee noted the Internal Audit and Counter Fraud progress report.

15/108 Local Security Management Specialist Draft Work Plan 2015/16

Helen Jones presented this paper and a detailed discussion took place regarding the delegation of roles and responsibilities from NHS Protect to CCGs. It was proposed Andrew Pepper should raise concerns at a national level where possible.

The work plan for the LSMS is currently at the draft stage and will be presented to a future Audit Committee for comment and approval.

It was RESOLVED that:

i. the Committee approved the Local Security Management Specialist Work Plan 2015/16

15/109 External Audit Technical Update

The update report was presented by Linda Wild. She noted a section included in the report about risks faced by NHS organisations. Members of the committee noted a focus on cyber-security, Katherine Bryant confirmed the Information Governance Toolkit includes a focus on cyber security.

It was RESOLVED that:

i. the Committee noted the content of the External Audit Technical Update

15/110 Any other business

No further business.

15/111 Date and time of next meeting

Thursday, 3 December 2015, 9.00 to 11.00 am, Seminar Room, White Rose House.
**Title of meeting:** Governing Body

**Date of Meeting:** 12 January 2016

**Paper Title:** Integrated Governance Committee: presentation of minutes and items for approval by Governing Body

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

**Committee chair:** Rhod Mitchell – Lay Member

**Meeting minutes enclosed:** 15 October and 19 November 2015

**Recommendation:**
It is recommended that the Governing Body receive and note the minutes of the Integrated Governance Committee held on 15 October and 19 November 2015.

**Executive Summary:**

15 October 2015
- **Urgent Care** – presentation providing an analysis of performance, activity and patient flow.
- Regular **Integrated Quality and Performance Report** presented and key highlights noted including a Falls Summit was taking place at MYHT today, 15 October 2015. The CCG is awaiting MYHT’s response to observations made about length of time people are waiting for surgery in the Patient Safety Walkabout report. A&E performance at MYHT has not met the required standard for month and year to date with the position deteriorating from the previous month. The CCG has incurred two further breaches in the 52 week Referral to Treatment pathway.
- **Patient and Public Engagement 2014/15** – report presented including details on consultations and engagement activities that have been completed during 2014/15.
- **Digital Road Map** – detailing the progress of the project including the determining of the footprint and the providers within that footprint. An initial project plan and timeline are to be developed.
- Revised **Integrated Governance Committee Terms of Reference** were presented and it was agreed they would be presented to the November 2015 Governing Body for approval.
- **Information Governance Update** – noted, including the approval of the Information Governance Strategy and Strategic Vision, the Privacy Impact Assessment Checklist, the Internet and Email Policy and the Information Security and Asset Risk Management Plan.
- **Freedom of Information Update** – noting all but one of the FOI requests received a response within the statutory deadline, the late response was sent to the requester one day late.
- Regular **Information Governance SIRO update** noting that there are currently five requests open.
- Quarter Two **Health and Safety report** noting four health and safety incidents were reported but no trends were identified. Revised Health and Safety policy noted and it was agreed this to be presented for approval at the November 2015 Governing Body.
- Month 6 **Finance Report** detailing a breakeven position to date and at year end. All key performance targets are green with the exception of QIPP year to date delivery. Key issues discussed – MYHT undertrade position; Mental Health Services overspend; Continuing Health Care overspend; Children’s Complex Care challenge of cost to clarify what cost relates to health element of care. Risk and Opportunities also discussed in detail.
- Regular **YHCS Transition Update** noting 28 staff would be transferring to the CCG. Commissioning Support Unit Resilience meeting continue to be held on a two weekly basis where issues can be flagged regarding service provision.
- Verbal update provided on the **Long Term Financial Plan** was noted.
- Regular **Contract Governance and Assurance update** providing details of guidance and a suite of contract management standards and templates which are to be rolled out across the Crown Commercial Service to
enable them to be used by government departments and wider public sector organisations for the management of their contracts.

- **Individual Funding Requests update** noting that during the period 1 April to 7 September 2015, 161 requests were submitted and 66 were approved. Wakefield CCG is currently in the process of commissioning the MRI scanner in Leeds so there will be no requirement for an individual funding request.

- **Verbal update** was given on the **Moving on Policy** developed by MYHT.

**19 November 2015**

- Regular **Integrated Quality and Performance report** presented with key highlights noted. September data shows a slight improvement of the A&E 4 hour performance target. The Referral to Treatment target continues not to be met, however MYHT is forecasting that the 18 week position will be recovered by March 2016.

- **Personal Health Budgets – Children** policy approved.

- **Personal Health Budgets – Adults** policy approved.

- The Integrated Governance Committee supported the **MYHT Moving on Escalation policy**

- **Stroke Improvement Summit Report** – details of the summit shared, noting an action plan is to be produced to facilitate improvements

- **Maternity Services Assurance Report** presented providing an update on the actions taken by MYHT.

- **Infection Prevention and Control Report** presented, noting three Wakefield resident MRSA Bacteraemia cases have been reported from Public Health England since 1 April to 30 September 2015. MYHT reported a total of 21 post 72 hour Clostridium Difficile Infection cases to the end of September 2015.

- Quarter Two **Workforce Services Report** noted.

- **Security Policy** approved.

- Regular **Risk Register** update noted.

- Quarter Two **Incident Report** noting 16 incidents had been reported during the quarter two period.

- Month 7 **Finance Report** presented providing a year to date position as at 31 October 2015. It was noted that the CCG currently has a £2.2m challenge and discussions have been held with the NHS England Regional Director of Finance and agreement reached for the CCG to go through an internal turnaround process with the aim of delivering a balanced position for 2015/16.

- **YHCS Transition** – verbal update confirming that in housing of YHCS staff is underway and hosting agreements have been arranged for certain services. The Lead Provider Framework bids have been submitted and the results of the outcome are awaited from NHS England.

- Paper presented detailing the updated position for **System Resilience Group assurance and winter preparedness**. Winter Plan now complete and details will be presented at the January 2016 Governing Body meeting.

- **Mental Capacity Act** – revised policy approved.

- **Safeguarding Children and Adults Commissioning** – revised policy approved.

- **MYHT Staffing Issues** – Presentation of the progress made including details of the workforce models and the risk management processes that are in place.
NHS Wakefield Clinical Commissioning Group

INTEGRATED GOVERNANCE COMMITTEE

Minutes of the Meeting held on 15 October 2015

Present:  Rhod Mitchell (Chair)  Lay Member
          Dr David Brown  Nominated Clinical Member
          Dr Phillip Earnshaw  Nominated Clinical Member
          Sharon Fox  Governing Body Nurse Representative
          Stephen Hardy  Lay Member
          Andrew Pepper  Chief Finance Officer
          Jo Pollard  Chief of Service Deliver & Quality

In Attendance:  Sandra Cheseldine  Lay Member
                 Karen Parkin  Associate Director of Finance, Governance & Contracting
                 Liz Goodson  Commissioning Accountant
                 Alison Sugarman  Practice Manager
                 Pat Keane  Director of Strategy and Organisational Design (item 15/267)
                 Jenny Feeley  Urgent Care Transformation Lead (item 15/267)
                 Laura Elliott  Head of Quality and Engagement (items 15/268, 15/269)
                 Jess Weatherill  Planning and Performance Manager (item 15/269)
                 Dasa Farmer  Senior Associate – Engagement YHCS (item 15/269)
                 Richard Main  Informatics Integration Lead (item 15/270)
                 Gemma Reed  Senior Governance Officer (item 15/271)
                 Samantha Byrnes  Associate Information Governance Specialist YHCS (item 15/272)
                 Kirsty Box  Governance Officer (item 15/273)
                 Louise Handley  Senior Associate Governance and Risk YHCS (item 15/275)
                 Caroline Foy  Contract Manager (item 15/279)
                 Angela Peatfield  Minute taker

15/262 Apologies for Absence

Apologies for absence were received from Jo Webster, Dr David Brown, Dr Avijit Biswas, Stephen Hardy, Sharon Fox and Katherine Bryant.

15/263 Declarations of Interest

Dr Phil Earnshaw and Dr Pravin Jayakumar declared an interest in respect of item 15/279 – Contract Governance and Assurance regarding their connection with Novus Health Limited.
Minutes of the Meeting held on 22 September 2015

The minutes of the meeting held on 22 September 2015 were approved as an accurate record with one amendment:

Page 5 - Finance Report Month 5

The last sentence should read “The Planning and Delivery group are concentrating on the £5.1m red and looking ahead into 2016/17.”

Action Sheet from the Meeting held on 22 September 2015

All actions were noted.

Matters Arising

There were no matters arising.

Urgent Care - Presentation

Pat Keane and Jenny Feeley attended the meeting to give a presentation on Urgent Care. Pat explained that the presentation provided an analysis of performance, activity and patient flow advising that the data had been sourced from trading reports, MYHT reports and national returns.

Pat advised that regarding Emergency Department attendance there was a drastic dip in the 4 hour A&E Performance in December 2014 which was similar to other areas nationally. However, unlike the national picture this has not recovered. Following discussion, Dr Phil Earnshaw commented that more communication is needed to advise patients regarding the extra hours now available in primary care.

It was noted that Emergency Department admissions to MYHT remain lower than previous years, although there has been an increase in the numbers waiting due to patient choice and care home placement.

Analysis of the reason for four hour breach indicates the main reason to be ‘waiting for bed’ showing that pre December 2014 this was 49.0% and post December 2014 is 67.6%.

Jo Pollard agreed to raise the issue with the Emergency Care Improvement Support Team (ECIS) and suggest that a Patient Safety Walkabout is undertaken at the same time as the ECIS review to track a patient from A&E right through to the Ward. It was agreed that a verbal update would be presented at the November IGC with a detailed update at the December meeting.

A discussion followed and it was noted that the CCG are supporting MYHT to interpret the data and implement the improvement plan following the Care Quality Commission report.

Pat summarised the key findings highlighting that Output pressures (flow through and out of the Emergency Department) rather than input pressures (numbers and acuity)
appear to be contributing to poor performance.

It was RESOLVED that:

i) the Committee noted the presentation

15/268 Integrated Quality and Performance Report

Laura Elliott and Jess Weatherill attended the meeting to present the Integrated Quality and Performance (IQP) Report providing an update against the CCG strategic objectives, quality premium and details of key exceptions and successes.

Quality
Laura advised following a Care Quality Commission inspection Attlee Court Care Home have placed a voluntary embargo on their EMI Unit and an action plan has been agreed to move patients from the Unit. Laura commented that as care homes put an embargo on their EMI units this impacts on the EMI beds available in the district.

With regard to Serious Incident reviews Laura confirmed that the number of reports MYHT are reviewing has reduced and the throughput of Serious Incidents has improved.

A summary will be included in the November IQP report of the Stroke Improvement Summit with MYHT held on 30 September 2015 where discussions focussed on further improving standards, addressing staffing shortages and psychology provision. Sandra Cheseldine and Stephen Hardy attended the Summit and Sandra felt that progress was being made advising that the Stroke Nurse position is now protected within the Service. Dr Phil Earnshaw advised that he would be raising the issue at a Senior Management level to clarify what is required to provide a Hyper Acute Service and seek clear regional leadership.

Laura advised that details of the Hip Fracture Audit recently undertaken would be discussed in detail at a future MYHT Executive Quality Board. The CCG is awaiting MYHT’s response to observations made about length of time people are waiting for surgery in the Patient Safety Walkabout report.

Laura also advised that a Falls Summit was taking place today and a report would be included in a future IGC report.

Karen Parkin queried the intelligence regarding the delays in receiving correspondence from the Continuing Health Care (CHC) service and whether this meant the service was deteriorating? Gemma Reed confirmed that there were some administrative delays regarding correspondence in respect of retrospective cases and it was acknowledged that the delays were getting worse. Jo Pollard advised that the staff working on retrospective cases are on short term contracts and are leaving as they secure permanent contracts and it has not always been possible to re-fill these short term contracts.

Dr Phil Earnshaw advised that Station Lane Surgery have received their draft report following a CQC inspection and have achieved an ‘all green’ report.
Performance
Jo Weatherill advised that:

- the CCG continues to meet all cancer standards for the second month running and for year to date;
- A&E performance at MYHT has not met the required standard for month and year to date for the ninth month with the position deteriorating from the previous month;
- the CCG has not met the required standard for the 18 week Referral to Treatment (RTT) incomplete pathway for the first time this financial year;
- the CCG has incurred two further breaches in the 52 week RTT pathway

It was RESOLVED that:

i) the Committee noted the current performance against the CCG strategic objectives and Quality Premium; and
ii) approved the actions being taken to address areas of performance.

15/269 Patient and Public Engagement 2014/15 Report

Laura Elliott and Dasa Farmer presented the Patient and Public Engagement Report for 2014/15 which includes information on consultations and engagement activities that have been completed during 2014/15, including any started before 1 April 2014 which are not yet completed. Details of consultations and engagement activity planned for 2015/16 is also included.

There was an excellent response to the Primary Care Access Survey with 1237 responses received. The members of the Patient and Public Engagement Committee will be included in taking forward the findings of this survey.

Laura advised of a ‘board game simulation’ that is in development which will be used at Patient and Public events to help the public understand how the finances of the CCG are utilised.

Dr Phil Earnshaw commented that the Governing Body need to have more interface with the public as well as the ‘patient stories’ that are being presented at the Public Governing Body meetings.

It was noted that preparations are well underway for engagement supporting the development of the CCG’s commissioning priorities for 2016/17.

It was acknowledged that this report will also be presented at the next Clinical Cabinet and Public Governing Body meeting.

It was RESOLVED that:

i) the Committee noted the content of the report for information; and
ii) public engagement will be considered and undertaken for all commissioning intentions.
Digital Road Map

Richard Main attended the meeting to present this paper explaining that the NHS England programme is for Primary, Urgent and Emergency Care and for key transfers of care to be delivered using paper free integrated records by 2018 and that all publicly funded providers of health and care will have integrated digital care records by 2020 to enable health and care to be “paper free at point of care”.

The Connecting Care Executive and Clinical Cabinet have been given delegated authority to oversee this work on behalf of the Governing Body.

Richard advised that planning and governance arrangements for the required work are to be advised by NHS England by the end of October followed by completed Roadmaps submitted by April 2016. It was noted that at present there is no funding associated with this work, although NHS England are seeking funding through the current Treasury CSR round.

Dr Phil Earnshaw queried whether South West Yorkshire Partnership Foundation Trust are included in the footprint and Richard confirmed that they are, however Local Care Direct are not. Further providers may be included as the project continues.

The paper details the progress of the project including the determining of the footprint and the providers within that footprint. It is recommended that an initial project plan and timeline are developed so the CCG will be in a position to document the desired future states for July 2017 and July 2020. It is suggested that the governance for this project is based upon the existing district-wide ICT group reporting as detailed in the paper.

It was RESOLVED that:

i) the Committee acknowledged the contents of this report and agreed the proposed governance approach

Integrated Governance Committee Terms of Reference Review

Gemma Reed presented the Integrated Governance Committee Terms of Reference advising that as part of good governance all CCG committee terms of reference are being reviewed during September and October 2015 to ensure that they are up to date and fit for purpose.

It is proposed that the revised terms of reference will be presented to the Governing Body for approval in November 2015.

It was RESOLVED that:

i) the Committee considered the revised terms of reference; and
ii) recommended that they are presented for approval at the November Governing Body meeting.
**Information Governance Update**

Sam Byrnes attended the meeting to present this update which details the activities undertaken in the last quarter. Following the review of the Information Governance Toolkit undertaken by Internal Audit details of the recommended actions are included in the update.

Sam also advised that the following Information Governance policies have been reviewed and updated. Amendments have been highlighted in yellow for ease of reference:

- Information Strategy and Strategic Vision
- Privacy Impact Assessment Checklist
- Internet Policy
- Email Policy

A couple of minor amendments to the above policies were highlighted and noted.

**Internet Policy**
A discussion took place regarding the Internet Policy and in particular the section entitled “Unacceptable Internet Usage”. It was agreed that point 5.3.10 would be amended to read “Downloading or installing unauthorised software on CCG desktops and laptops without prior consent”.

**Email Policy**
Dr Pravin Jayakumar raised a query regarding the Email Policy and the section entitled “Best Practice”. Point 6.4.2 details that all emails sent externally via the CCG’s email system must contain a disclaimer. An automated disclaimer is added to all external emails. However, it was noted that in some instances the automated disclaimer is not being added. It was agreed that this will be investigated.

**IG Compliance Checks September 2015**
It was noted that in order to be assured that staff are compliant with national and local Information Governance requirements the Yorkshire and Humber Commissioning Support IG team undertook spot checks at the CCG. The results of the compliance checks provide high assurance that the CCG’s staff recognise the importance of data protection and comply with the CCG’s Information Governance policies and procedures.

**Health and Social Care Act 2015**
Details of the Health and Social Care Act 2015 were included in the update which introduces new duties to share service user information and use of the NHS number across the health and social care landscape, coming into effect from 1 October 2015.

It was RESOLVED that:

i) the Committee noted the content of the Information Governance update report; and

ii) approved the Information Governance Strategy and Strategic Vision, the Privacy Impact Assessment Checklist, the Internet and Email Policy and the Information Security & Asset Risk Management Plan.
15/273  Freedom of Information Update

Kirsty Box attended the meeting to present the Freedom of Information Update advising that from July 2015 to September 2015 all but one FOI request received a response within the statutory deadline of 20 days. The late response was sent to the requester one day later.

It was noted that the disclosure log for FOI requests has now been uploaded to the CCG’s website.

Kirsty advised that four exemptions were applied to Freedom of Information Requests for the months of July and August 2015.

Andrew Pepper acknowledged Kirsty’s work and the improvements to compliance that have been made.

It was RESOLVED that:

i) the Committee noted the CCG’s compliance against the statutory deadline for responses to FOI requests

15/274  IG SIRO Update

Andrew Pepper presented the IG SIRO Update providing an update on requests received to 1 October 2015. It was noted that there are five requests currently open.

It was RESOLVED that:

i) the Committee noted the report

15/275  Health and Safety Report

Louise Handley attended the meeting to present this quarter two report noting there are no health and safety risks identified on the risk register at the time of this report. The report includes figures for staff training as at 31 August 2015 noting that face to face fire safety training has been arranged through South West Yorkshire Partnership Foundation Trust. Face to face training sessions in respect of health and safety and practical manual handling took place during August 2015.

In quarter two, four health and safety incidents were reported but no trends were identified.

The revised Health and Safety policy was presented noting that the amendments were mainly due to organisational changes.

It was RESOLVED that:

i) the Committee noted the actions in the quarter two Health and Safety report ensuring compliance with relevant Health and Safety Executive legislation, national priorities and guidance; and
ii) noted the amendments to the Health and Safety policy and recommended that the policy is taken to the November Governing Body for approval.

15/276 Finance Report Month 6

Liz Goodson presented the Finance Report for month 6 which details a breakeven position to date and at year end. This is including achievement of the required surplus of £5,935k. All key performance targets are green with the exception of QIPP year to date delivery.

MYHT
Liz advised that the position to date is an undertrade, however the year end position at this point is breakeven to allow for pressures later in the year. It was noted that MYHT audiology Any Qualified Provider is showing underspent as any activity to date is currently included in the core contract line.

Mental Health Services
Liz advised that the position to date is an overspend due to two highly complex long term out of area packages of care where provision is not available in Wakefield. Work is still ongoing to identify areas where improvements can be made.

Continuing Health Care
Liz advised that adults continuing care overspend has increased and a detailed analysis has shown that many of the standard care packages are remaining stable, however there has been an increase in the forecast of Interim Funded packages and this has been flagged as a priority work area.

Children’s Complex Care
It was noted that at the end of August 2015 the whole £2.2m of budget had been committed for packages that had been approved and will continue until the end of March 2016. The CCG panel working with the Local Authority are challenging costs to ensure that the cost incurred for patients relates to the Health element only. Work is still ongoing to ensure the process continues to be robust.

Risk and Opportunities
Andrew Pepper referred to the Risks and Opportunities section of the report and provided an update on the mitigations highlighted at the previous meeting:

1. Review of allocation adjustment
   Andrew advised that no allocation has been received as yet for Offender Health in MYHT. As this is a national allocation this is being chased with NHS England.

2. Budget and Technical Review
   A ‘stop the line’ process is in place and Capita has been tasked with reviewing 2015/16 budgets. The Senior Management Team are also working with the budget lines and this will be risk assessed when completed.

3. QIPP review of red schemes
   Prescribing and Specialised Commissioning is currently being reviewed.
4. Review of non-recurrent opportunities
   Andrew advised that five schemes have been identified with MYHT; Pain Management; Clinical Ophthalmology; Dermatology; Pathway tracker and FCP testing. Andrew advised that the Stop the Line discussions are continuing and further progress is still to be made.

5. Prescribing
   It was acknowledged that there have been significant prescribing changes with costs increasing. It was noted that a new CCG prescribing lead will be starting in November 2015.

A discussion took place regarding the Better Care Fund and it was noted that this fund does not currently include all Local Authority costs for Social Services. It was suggested that Melanie Brown, Director of Integrated Care, attend a future IGC meeting to provide a further update on the Better Care Fund.

It was RESOLVED that:

   i) the Committee received and noted the content of the report

15/277 YHCS Transition Update

Karen Parkin gave a verbal update confirming that all Yorkshire and Humber Commissioning Support staff had now received their TUPE letters. Karen confirmed that 28 staff would be transferring to the CCG, 19 of which are Continuing Health Care staff. Consultation meetings and one to one meetings with the transferring staff will be arranged.

Karen confirmed that the in-house service was approved, however it may take until March 2016 to resolve all the systems issues, e.g. the risk management system. Sue Allan, Headquarters Manager, is currently looking at the accommodation issues.

Karen advised that she continues to attend the CSU Resilience meetings on a two weekly basis where issues can be flagged up regarding service provision.

With regard to Business Intelligence and the Patient and Advice and Liaison Service the Lead Provider Framework guidance pack has been received and has been disseminated to designated staff. Bids will be received via BRAVO on 28 October for CCG evaluation.

Karen advised that stranded costs across West Yorkshire currently amount to £773k, the CCG’s share is £127k. The methodology for this has been agreed across all West Yorkshire Chief Finance Officers but final numbers have yet to be agreed.

A communication to General Practices regarding the changes will be issued.

It was RESOLVED that:

   i) the Committee noted the verbal update

15/278 Long Term Financial Plan

Andrew Pepper gave a verbal update advising that discussions had taken place at a
Governing Body Development Session earlier this week regarding the five year financial plan.

It was agreed that a further Governing Body Development Session should be scheduled to continue the discussions from the Governing Body Development session earlier this week.

It was RESOLVED that:

i) the Committee noted the verbal update

15/279 Contract Governance and Assurance Update

Caroline Foy attended the meeting to present the Contract Governance and Assurance Update which identifies the commissioning procurement decision timetable and contract re-negotiation process by service and provider. Caroline confirmed that there were 21 contracts requiring signature and these will continue to be chased.

Rhod Mitchell queried if consideration of whether any of the contracts should be discontinued had taken place. Andrew Pepper responded confirming that the Planning and Delivery Group do consider whether contracts should continue.

Pravin Jayakumar commented that the MYHT contract was included in the Amber section of the report and queried what discussions had been held at the MYHT Executive Contract Board? It was agreed that Pravin would speak to Andrew Pepper outside of the meeting.

The update provided details of guidance and a suite of contract management standards and templates which are being rolled out across the Crown Commercial Service (CCS). Their design enables them to be used by government departments and wider public sector organisations for the management of their contracts.

It was RESOLVED that:

i) the Committee noted the content of the report; and
ii) acknowledged the guidance given by the Crown Commercial Service on contract management standards.

15/280 Individual Funding Requests Update

Sandra Cheseldine presented the Individual Funding Requests Update which detailed the Individual Funding Requests (IFRs) received during the period 1 April to 7 September 2015 noting that 161 requests were submitted and 66 were approved. The highest number of IFRs received was Cosmetic Surgery.

Sandra advised that the requests for open MRIs have increased considerably over the past 18 months. The unit at Leeds offers a fully open scanner where patients are seated and the scanner moves around them. Wakefield CCG is currently in the process of commissioning the MRI scanner in Leeds so there will be no requirement for an individual funding request.
Sandra referred to treatment of stammer and it was acknowledged that this used to be provided through the MYHT Speech and Language Therapy Service but is no longer provided. It was suggested that the CCG consider if this is a service that requires re-instating.

It was RESOLVED that:

i) the Committee noted the Individual Funding Request update report

15/281 Minutes of meetings

The minutes of the following meetings were shared for information:

(i) Mid Yorkshire Hospitals NHS Trust Executive Contract Board – minutes of meeting held on 20 August 2015
(ii) Mid Yorkshire Hospitals NHS Trust Executive Quality Board – minutes of meeting held on 20 August 2015
(iii) System Resilience Group – minutes of meeting held on 27 August 2015
(iv) Quality Intelligence Group – minutes of meeting held on 15 September 2015
(v) NHS 111 West Yorkshire Clinical Quality Group – minutes of meeting held on 16 September 2015
(vi) Public Involvement and Patient Experience Committee – minutes of meeting held on 25 June 2015
(vii) Patient Participation Group Network – minutes of meeting held on 17 June 2015

15/282 Consider future topics for Deep Dive

• Dementia

15/283 Items to refer to Probity Committee

No items need to be referred to the Probity Committee.

15/284 Any other business

Moving on Policy
Jo Pollard gave a verbal update advising that a Moving on Policy was currently being developed and was seeking delegated authority to Jo Webster and Jo Pollard to approve this policy once completed.

Following discussion it was agreed that Stephen Hardy, Lay Member, would also be included in reviewing and approving the policy alongside Jo Webster and Jo Pollard.

Jo Pollard confirmed that the policy would be shared at the Integrated Governance Committee meeting for information.

Change of Membership of the Integrated Governance Committee
The Committee were advised that Dr Avijit Biswas would be standing down as a nominated clinical member of the Integrated Governance Committee and Dr Pravin Jayakumar would become a nominated clinical member of the Committee with effect
from 15 October 2015, subject to approval by the Governing Body.

15/285  **Date and time of next meeting:**

Thursday, 19 November 2015, 9.00 am to 12 noon in the Seminar Room, White Rose House.
NHS Wakefield Clinical Commissioning Group

INTEGRATED GOVERNANCE COMMITTEE

Minutes of the Meeting held on 19 November 2015

Present:
Rhod Mitchell (Chair) Lay Member
Dr Pravin Jayakumar Nominated Clinical Member
Sharon Fox Governing Body Nurse Representative
Stephen Hardy Lay Member
Alison Sugarman Governing Body Practice Manager Representative
Jo Webster Chief Officer
Andrew Pepper Chief Finance Officer
Jo Pollard Chief of Service Delivery & Quality

In Attendance:
Sandra Cheseldine Lay Member
Katherine Bryant Governance & Board Secretary
Jess Weatherill Planning and Performance Manager (item 15/301)
Andrew Singleton Quality Coordinator (item 15/301)
Morna Cooke Senior Commissioning Manager (item 15/302)
Linda Chibuzor Clinical Quality Manager (item 15/303)
Jane O’Donnell Head of Health Protection (item 15/307)
Suzie Paradine HR Business Partner (item 15/308)
Steve Nicholls Local Security Management Specialist (item 15/309)
Pam Vaines Associate Governance and Risk – YHCS (item 15/310 and 15/311)
Michala James Systems Resilience Manager (item 15/314
Mandy Sheffield Head of Safeguarding (item 15/315 and 15/316)
David Melia Director of Staff and Patient Engagement – MYHT (item 15/318)
Dawn Parkes Deputy Chief Nurse - MYHT (item 15/318)
Angela Peatfield Minute taker

15/296 Apologies for Absence

Apologies for absence were received from Dr Phil Earnshaw, Dr David Brown and Karen Parkin.

15/297 Declarations of Interest

No declarations of interest were declared.

15/298 Minutes of the Meeting held on 15 October 2015
There were no actions noted.

**Action Sheet from the Meeting held on 15 October 2015**

All actions were noted.

**15/267 – Urgent Care Presentation**

Jo Pollard gave a verbal update on the Patient Safety Walkabout and Emergency Care Improvement Support Team (ECIST) visit that had taken place last week at MYHT. The A&E department was visited between 4.00 pm and 7.00 pm and the department was very busy. Performance in the department had not been good during the day, although as a patient the service was excellent due to the professionalism of staff. Operational procedures were put in place to improve the flow. Following the visit a targeted action plan has been produced and will be discussed at the System Resilience Group meeting this afternoon.

It was noted that the recent ‘breaking the cycle’ event had seen an 8% improvement in the discharge process but A&E performance had not seen any initial improvement.

**15/300 Matters Arising**

There were no matters arising.

**15/301 Integrated Quality and Performance Report**

Jess Weatherill and Andrew Singleton attended the meeting to present this paper providing reports against the CCG strategic objectives, quality premium and details key exceptions, successes and action plans.

Jess highlighted the key performance headlines:

- The CCG met 8 out of 9 cancer standards for September, with the 9th only missed by 0.1%. MYHT have given assurance that this will be rectified next month
- Newly released September data shows a slight improvement regarding the A&E 4 hour performance target although still under target and a performance notice has been issued
- Referral to Treatment (RTT) target continues not to be met. A performance notice has been issued for the RTT performance and action plans for each of the 13 failing specialties have been received. MYHT is forecasting that the 18 week position will be recovered by March 2016

It was noted that the Care Quality Commission inspection report for The Grange has been received and an overall rating of “requires improvement” was given. Station Lane received an overall rating of “good” and Ferrybridge Medical Centre and Friarwood Surgery received an “outstanding” rating. Support from the CCG will be provided to The Grange regarding quality issues and best practice will be shared.
The system wide quality measure exception report regarding smoking at the time of delivery was discussed noting that:

- Establishment of an active District task group and action plan
- Midwives have received additional refresher training on smoking cessation over the summer
- Information leaflet targeted at young women produced and distributed to GP practices
- Practices have been offered training from the Stop Smoking Service

Following discussion it was suggested that a Public Health presentation to a future meeting would be arranged to present what plans are in place for the next 12/18 months.

It was RESOLVED that:

i) the Committee noted the current performance against the CCG strategic objectives and Quality Premium; and
ii) approved the actions being taken to address areas of performance.

15/302 Personal Health Budgets - Children

Morna Cooke attended the meeting to present the paper explaining that this policy was developed last year to facilitate the production of personal health budgets for children as required by national policy and legislation.

Morna advised that the policy may require change as Wakefield CCG develops and extends its local offer for personal health budgets in line with expectations by April 2016. However for the time being there are no changes required and it is recommended that the policy rolls forward for a further year whilst plans are developed.

Sandra Cheseldine commented on the references in the policy to Yorkshire and Humber Commissioning Support and it was agreed that these would be amended to reflect the new arrangements whereby the Personal Health Budget will be managed by Doncaster CCG on our behalf.

It was RESOLVED that:

i) the Committee approved the policy subject to the amendment referred to above

15/303 Personal Health Budgets - Adults

Linda Chibuzor attended the meeting to present this paper and advised that the policy has been subject to a routine review and now includes information that the CCG has transferred operational responsibility for the delivery of Personal Health Budgets to NHS Doncaster Clinical Commissioning Group but that the CCG remains the organisation with statutory responsibility.
This policy has been amended to reflect the decisions on PHBs will be made by the CHC Resource Panel and there will no longer be a separate PHB Resource Panel. A discussion followed regarding the changes in legislation and the process for managing the contingency. Linda confirmed that this would be managed by the hosted team and reviewed annually. Jo Pollard advised that a meeting was scheduled for next week with the PHB team to discuss the development of a policy on delegated authority and a verbal update will be provided at the December Integrated Governance Committee meeting.

It was RESOLVED that:

i) the Committee approved the policy

15/304 Moving on Escalation Policy

Jo Pollard presented this policy advising that this has been developed in order to facilitate a standardised process for the management of inpatients waiting for onward care placement and has been developed in consultation with North Kirklees CCG, Wakefield CCG, Kirklees Local Authority, Wakefield Local Authority and Mid Yorkshire NHS Trust.

The policy aims to standardise the process for managing those patients who have declined an offered service or placement and continue to remain in hospital after the multidisciplinary team have agreed they have reached their medical optimum.

Following discussion it was agreed that a report will be presented at six monthly intervals to ensure the policy is being properly applied.

It was RESOLVED that:

i) the Committee supported this Mid Yorkshire NHS Trust policy

15/305 Stroke Improvement Summit Report

Jo Pollard presented this report which provides a summary of the outcomes of the Stroke Summit that took place on 30 September 2015 and an overview of parts of the stroke pathway; the first 72 hours, post 72 hours and after hospital care. The key developments and areas of challenge were detailed.

Sandra Cheseldine and Stephen Hardy both attended the Stroke Summit and felt it did give assurance that some improvements were being made. Sandra referred to the improvements required regarding the availability of therapy services and it was acknowledged that this has been a longstanding issue.

Jo Pollard advised that an action plan to facilitate improvements will be presented at the December Integrated Governance Committee.

It was RESOLVED that:

i) the Committee noted the outcome of the Stroke Summit;
ii) noted the improvements intended as a result of the Stroke Summit; and
iil noted that the Stroke action plan and progress report will be presented at the December 2015 Integrated Governance Committee meeting.

15/306 Maternity Services Assurance Report

Jo Pollard presented this report which provides an update on the actions taken by Mid Yorkshire Hospitals Executive Quality Board (EQB) to gain assurance of the quality of MYHT maternity services. It was noted that EQB members agreed they are assured of the quality of care provided.

The report details the actions agreed to ensure continued assurance in the context of significant service change and the impending Care Quality Commission inspection report.

A discussion followed and it was acknowledged that new clinical leadership is now in place with the appointment of a new Head of Midwifery and the EQB will continue to monitor the progress of the action plan through the period of service transformation.

It was RESOLVED that:

i) the Committee noted the actions taken by MYHT EQB to gain assurance of the quality of maternity services at MYHT;
ii) noted that MYHT EQB members agreed they were assured on the quality of care provided; and
iii) noted actions agreed to ensure continued assurance through a period of service transformation.

15/307 Infection Prevention and Control Report

Jane O’Donnell attended the meeting to present this report which provides details of how risks related to healthcare associated infection (HCAI) are being addressed, together with actions from Post Infection Reviews (PIRs).

Three MRSA Bacteraemia cases have been reported from Public Health England (PHE) as being Wakefield residents since 1 April to 30 September 2015. Following the PIR process, one has been assigned to the CCG, one to MYHT and the case reported in September will be submitted for third party arbitration.

MYHT reported a total of 21 post 72 hour Clostridium Difficile Infections (CDI) cases to the end of September 2015 against a national objective of no more than 26 cases. Jane advised that as the number of cases was above the planned trajectory a recovery plan has been developed to reinforce and build upon the CDI action plan for 2015/16.

It was RESOLVED that:

i) the Committee noted the Infection Prevention and Control Report

15/308 Workforce Services Quarter Two Report

Suzie Paradine attended the meeting to present this report containing a range of workforce information and intelligence relating to the directly employed Wakefield
CCG workforce together with key workforce headlines.

Suzie confirmed that 31 staff are to be in-housed from YHCS and an induction programme which includes mandatory training has been arranged.

Suzie advised that the Staff Forum arranged a “Get Ready for Winter” event on 7 October 2015 which received positive feedback.

It was noted that the CCG are taking part in the national NHS Staff Survey which will close on 4 December 2015. Following the results of the survey an action plan will be developed in partnership with the staff forum and partnership working group.

A discussion followed regarding long term sickness and it was noted that a robust process is in place and line managers have received training to support them with the process. It was acknowledged that staff, including managers, receive good support from HR with the sickness absence process.

It was RESOLVED that:

i) the Committee noted the content of the Workforce Services Quarter Two Report

15/309 Security Policy

Steve Nicholls attended the meeting to present the updated Security Policy following new standards for commissioners issued earlier in 2015 by NHS Protect. West Yorkshire Audit Consortium has been engaged to provide a Local Security Management Specialist (LSMS) service. This role is undertaken by Steve Nicholls, the CCG’s Local Counter Fraud Specialist who is qualified as an LSMS.

Steve advised that a workplan outlining planned LSMS activity at the CCG was approved by the Audit Committee in September 2015.

It was RESOLVED that:

i) the Committee approved the Security Policy

15/310 Risk Register Update

Pam Vaines attended the meeting to present the Risk Register update. Part of the review cycle for Senior Managers includes checking that the guidelines have been followed and also includes a requirement to identify and inform the Clinical Lead of relevant risks. All Clinical Leads have access to the risk register.

Following the Executive Team moderation review the A&E 4 hour risk has been included twice and this requires further consideration regarding the impact and likelihood assessment. It was agreed that Jo Pollard and Andrew Pepper would review the risks and scores outside of the meeting.

Jo Webster suggested that consideration should be given as to whether a risk regarding availability of care homes placements needs to be included on the risk register.
It was RESOLVED that:

i) the Committee noted the Risk Register Update

15/311 Incident Report

Pam Vaines attended the meeting to present the Incident Report advising that during quarter two there were 16 reported incidents, this level of reporting is more in line with the expectations of an organisation the size of the CCG and shows an improvement in the reporting/risk awareness culture of the CCG.

It was RESOLVED that:

i) the Committee noted the Incident Report

15/312 Finance Report Month 7

Andrew Pepper presented the month 7 Finance Report which provides a year to date position as at 31 October 2015.

Andrew tabled an updated copy of the Risks and Opportunities section of the report and this was discussed in detail noting that there has been a deterioration between months 6 and 7. Andrew advised that the CCG currently has a £2.2m challenge and discussions have been held with the NHS England Regional Director of Finance. An agreement has been reached for the CCG to go through an internal turnaround process with the aim of delivering a balanced position and risks and opportunities for 2015/16.

It was RESOLVED that:

i) the Committee noted the content of the Finance Report Month 7

15/313 YHCS Transition Update

Andrew Pepper gave a verbal update confirming that the in housing of YHCS staff is underway and an induction programme has been arranged.

Hosting agreements have been arranged for certain services and the Memorandum of Understandings have been circulated and discussed.

Andrew advised that stranded costs will be invoiced to the CCG in December and this will be included in the organisation’s risks and opportunities.

With regard to the Lead Provider Framework it was noted that bids have been submitted and this process is being managed by NHS England to ensure value for money.

It was RESOLVED that:
i) the Committee noted the verbal update

15/314 Winter Assurance

Michala James attended the meeting to present this paper detailing the updated position for System Resilience Group (SRG) assurance and winter preparedness.

On 2 September 2015 a self-assessment was submitted to NHS England (NHSE). Following regional moderation NHSE were not assured of the Mid Yorkshire health economy winter preparedness. An action plan was put in place to strengthen the CCG’s arrangements and following re-submission on 30 September 2015, NHSE were partially assured of our winter preparedness. It was noted that this assessment was comparable across Yorkshire and the Humber as no SRG has achieved full assurance from NHSE.

Michala advised that a deep dive on patient flow would be discussed at the SRG meeting being held on 19 November 2015.

Michala confirmed that the Winter Plan is now complete and a discussion will take place outside of the meeting regarding presentation of the plan at the January 2016 Governing Body meeting.

It was RESOLVED that:

i) the Committee noted the SRG assurance position submitted to NHS England on 30 September 2015; and

ii) noted the progress made against the winter preparedness action plan.

15/315 Mental Capacity Act

Mandy Sheffield attended the meeting to present this paper explaining the policy applies in England and Wales to everyone who provides care, treatment or support for people over 16 years of age who may lack the capacity to make decisions for themselves.

It was noted that the policy has been subject to a routine review and now includes relevant case law changes, primarily the changes made subsequent to the P versus Cheshire West and P and Q versus Surrey County Council high court decision in March 2014 in relation to the Deprivation of Liberty Safeguards (DoLS) 2009.

It was RESOLVED that:

i) the Committee approved the revised policy

15/316 Safeguarding Children and Adults Commissioning Policy

Mandy Sheffield presented this revised policy which includes updates to reflect the changes following the introduction of the Care Act 2014 and reflects the mandatory reporting requirements introduced by the Department of Health in relation to Female Genital Mutilation.
It was RESOLVED that:

i) the Committee approved the revised policy

15/317 Minutes of meetings

The minutes of the following meetings were shared for information:

(i) Mid Yorkshire Hospitals NHS Trust Executive Contract Board – minutes of meeting held on 17 September 2015
(ii) Mid Yorkshire Hospitals NHS Trust Executive Quality Board – minutes of meeting held on 17 September 2015
(iii) NHS 111 West Yorkshire Clinical Quality Group – minutes of meeting held on 14 October 2015
(iv) Quality Intelligence Group – minutes of meeting held on 13 October 2015
(v) Mid Yorkshire System Resilience Group – minutes of meeting held on 29 September 2015
(vi) YAS Contract Management Board – minutes of meetings held on 19 August and 16 September 2015

15/318 MYHT Staffing Issues - Presentation

Dawn Parkes and David Melia attended the meeting to give a presentation on the MYHT Staffing Issues and the progress that has been made.

It was noted that a national review of the one nurse to eight patients ratio is being undertaken with the suggestion that in some wards/areas this ratio could change.

As part of Recruitment and Retention the following initiatives have been put in place:
- Rolling Trust wide recruitment
- Health Care Assistant recruitment
- Ward/Unit specific recruitment
- EU and Non EU recruitment
- Return to the ‘NHS’ programme
- Return to Nursing programme
- Recruitment and Retention Strategy
- Competency Framework – basic care for nursing
- Listening into action event for new starters

Dawn also discussed the workforce models and the risk management processes that are in place.

Sharon Fox commented that the nurse staffing issue is a wider issue than just MYHT. Stephen Hardy queried how confident MYHT are that they can recruit the additional nurses required. Jo Webster commented that the Care Quality Commission, Trust Development Agency and the CCG are happy with the processes that have been put in place, acknowledging that improvements have been made regarding the staffing challenges.

Pravin Jayakumar raised the issue of Community Nursing and it was suggested that a
deep dive into Community Nursing should take place at a future Integrated Governance Committee meeting.

15/319 Consider future topics for Deep Dive

- Public Health
- Community Nursing

15/320 Items to refer to Probity Committee

No items need to be referred to the Probity Committee.

15/321 Any other business

No other business raised.

15/322 Date and time of next meeting:

Thursday, 17 December 2015, 9.00 am to 12 noon in the Seminar Room, White Rose House.
Wakefield Clinical Commissioning Group

Title of meeting: Governing Body

Date of Meeting: 12 January 2016

Paper Title: Clinical Cabinet: presentation of minutes and items for approval by Governing Body

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

Committee chair: Dr Adam Sheppard, Assistant Clinical Leader

Meeting minutes enclosed: 22 October and 26 November 2015

Recommendation:
It is recommended that the Governing Body receive and note the minutes of the Clinical Cabinet held on 22 October and 26 November 2015.

Executive Summary:

22 October 2015

- **IAPT Option** final outcome specification was presented and Chair’s action was agreed to approve the paper prior to presentation at the Governing Body for formal approval.
- **Revised Clinical Cabinet Terms of Reference** noted and agreed to present to Governing Body for approval.
- **2014/15 Patient and Engagement Report** presented for information.
- Presentation of **Transient Loss of Consciousness and Cardiology Pathways**.
- Presentation of **National Paediatric Diabetes Audit**.
- Topics for **Target 2016** were presented noting there will be ten Target sessions over the 12 month period.
- Update on the **Planned Care Programme Development for 2016/2019** was presented. The report and next steps were approved.
- An update on the main themes and highlights of **Clinical Engagement for QIPP** was noted.
- **Planned Care Assurance** update was presented and noted.
- **Planning Priorities for 2016/17** were shared for information.
- **Connecting Care (Non recurrent investment)** update was shared for information.
- **CCG Regional Collaboration – Working Together (South Yorkshire)** Updates were shared for information regarding the **Review of Hyper Acute Stroke Units and Children’s Work Stream**.
- An update on the specification for the **Children’s and 0-19 service** was discussed with regard to possible conflict of interest when going out to tender. It was agreed this would be further discussed outside of the meeting.

26 November 2015

- **Upright MRI Scanner and MRI Guidelines for GP Referrals** paper was noted and the recommendations approved subject to further review of audit and MSK transformation information.
- **Diabetes Service review** was presented and the recommendations were approved.
- **Wakefield CCG Financial Position** – Chief Officer attended the meeting to update members on the ‘internal turnaround’ which was being implemented.
- A proposed framework and timescales for the **Primary Care Strategy and Extended Hours** was presented and approved.
- An update on the **Urgent Care Practitioners Scheme** was presented noting that the service is not meeting the criteria under the Meeting the Challenge programme nor value for money, therefore with the approval of the Executive Team the service has been exited based on activity and outcomes.
- A paper on **Emergency Department Transformation** was presented and the next steps were noted.
- **Patient Transport Service Review** – update presented. A further update including the service review report and recommendations will be presented at a future Clinical Cabinet meeting.
- An updated on **2015/16 Commissioning Priorities** was presented including the outcome of the first Commissioning Maze game around the 2015/16 Commissioning Priorities.
- **Planned Care Assurance update** was noted including an update on the development of the 2016/19 programme.
- **Planning Priorities 2016/17** – an update was presented including the tabling of the five year organisational plan around the Primary Care Strategy and Integration.
- A paper was shared for information following the **MYHT Self-Assessment – Eight Key Priorities** noting that MYHT had responded to NHS England. Further detail would be presented at a future Clinical Cabinet meeting.
NHS Wakefield Clinical Commissioning Group

CLINICAL CABINET

Minutes of the Meeting held on
Thursday, 22 October 2015
09.00 – 12.30 pm
Seminar Room, White Rose House

Present:
Dr Phil Earnshaw Clinical Chair, WCCG (Chair)
Dr David Brown GP, WCCG
Dr Pravin Jayakumar GP, WCCG
Dr Debbie Hallott GP, WCCG
Dr Ann Carroll GP, WCCG
Dr Avijit Biswas GP, WCCG
Dr Clive Harries GP, WCCG

In Attendance:
Dr Som DeSilva GP, WCCG
Dr Tim Dean GP, WCCG
Michele Ezro Associate Director, Service Delivery & Quality, WCCG
Janet Wilson Senior Principle, Public Health (representing Dr A Furber)
Simon Rowe Senior Commissioning Manager, WCCG (Item 11)
Vicky Walpole Planned Care Programme Lead, WCCG (Item 11, 13)
Katherine Bryant Governance and Board Secretary, WCCG (Item 6)
Dasa Farmer Senior Associate – Engagement, WCCG (Item 7)
Gillian Richardson Senior Principle, Public Health (Item 8)
Dr Sue Gardiner Consultant Paediatrician, Lead Clinician for Paediatric Diabetes (Item 9)
Simon Dale OD Practitioner and Programme Lead, Ways of Working (Item 12)
Mike Thorogood Health & Wellbeing, Capita (Item 12)
Liz Goodson Commissioning Accountant, WCCG
Vicky Hoyland Finance Assistant, WCCG
Kate Trevelyan Senior Management Support, NHS WCCG (minutes)

1  APOLOGIES FOR ABSENCE

Apologies were received from Dr A Sheppard, Jo Pollard, Andrew Pepper, Dr A Furber, Dr P Wynn, Stephen Hardy

Members noted that the meeting was not quorate and therefore the actions would be ratified at the next meeting or via Chair’s action for those which required an immediate decision.
2 DECLARATIONS OF INTEREST

Declaration of Interest were noted during the meeting:

Item 8 Cardiology – Dr Som De Silva. Dr De Silva works as a GP WSI in Cardiology at MYHT

3 MINUTES OF THE MEETING HELD ON 23 JULY 2015

Minutes of the last meeting for 24 September 2015 were agreed as correct record with the exception of the Item 18 last paragraph which would be agreed and amended in the 24 September minutes in readiness for ratification of the at the Clinical Cabinet to be held in November 2015.

4 ACTION LOG

The Action Log was reviewed and updated accordingly.

5 IAPT Option Final Specification

Michele Ezro introduced this item and gave a brief overview of the background around the hard work which had been undertaken by Alix Jeavons over the last 18 months indicating the level of engagement particularly networks and GPs to bring together a final specification which matched all the requirements. Members acknowledged the excellent work done.

Alix Jeavons reported that it was an outcome specification not a detailed specified model. The challenge was around the target to meet the national requirement with an integrated pathway shift from exclusion to inclusion which would stop people falling through the gaps in provision with a stepped care model, self referral, direct support, therapy etc.

The requirement now was for a shift change to proactive joint working and partnerships through primary and secondary care to set out the local position with a lead provider.

Alix indicated that here were a specific set of outcomes against national guidelines which would be used to set a local target of 6800 people entering treatment, receiving the right service to which in turn would allow early intervention and better engagement with GPs.

Alix took members through the process of treatment. Dr Som DeSilva queried the process of referrals and Alix indicated that it was geared to accept referrals from anyone and updated members with further detail. Members queried the level of data capture and Alix referred to the national guidelines standard with a need to get good retention rates working in partnerships to raise escalation. Dr Harries elaborated further on the issue of data capture.

Dr DeSilva referred to Page 1 Item 2.3 Local Defined Outcomes and targets – Alix responded that it related to 75% of people beginning treatment within two weeks.

Dr Carroll queried capacity/ funding around changes and Alix responded that it would affect the level of productivity on a per head basis (SWYPFT, Rightsteps). Members agreed that
there was a need for a review to demonstrate level of efficiency required and Dr Harries elaborated further about process to formalise.

Dr Earnshaw commented that it should be inclusive of vulnerable groups and queried the commissioning responsibility for the prison population which Alix advised related back to those engaging in IAPT treatment in prison, who then struggle to engage in therapy following release. It was noted that Asylum seekers are eligible for emergency care but not eligible for routine medical services. Dr Harries indicated that this would need to be reviewed and co-ordinated with providers.

Dr Biswas queried whether there was any access flexibility and it was noted that because it was an outcome specification, scenarios can be shared with different providers.

The recommendation was:

i) It is recommended that the Clinical Cabinet approve the Service Specification;

Members agreed that the paper should be signed off by Dr Sheppard as a Chair’s action, before progressing to Board for formal approval.

Dr Harries highlighted the joined up working on pages 17/18 of the report. It presented an opportunity for the outcome specification to be tested with providers so that there was no overlap to manage.

Dr Carroll commented on the ongoing collaboration with Ian Holdsworth and Future in Mind. There are significant developments in the Childrens’ Mental Health provision.

IT WAS RESOLVED:

i) The paper was noted;
ii) The paper was recommended for sign off by Dr A Sheppard as a Chair’s action; and
iii) After sign off, paper to be progressed to the Board for formal approval.

Clinical Cabinet Revised Terms of Reference

Katherine Bryan attended to present the updated Terms of Reference to those presented to Clinical Cabinet in September 2015.

The recommendations were noted as:

i) consider the current Clinical Cabinet Terms of Reference and discuss whether any further amendments are required, in particular:

- Membership
- Role and function section
- Responsibilities section.
ii) Note the mid-year progress report which was presented to the Audit Committee in September 2015 and agree it is operating effectively, have complied with their terms of reference and fulfilled their delegated duties.

Members acknowledged that it was a useful reference tool. Comments included the requirement to have a Nurse Lead to sit on Clinical Cabinet with more than one practice nurse and it was noted that Kerry Munday was actively working on this. Katherine responded that she would discuss with Kerry.

Members indicated approval of the updated paper which would be processed to Board.

**IT WAS RESOLVED:**

i) To note the paper; and

ii) Indicated approval of the updated version of the Clinical Cabinet Terms of Reference.

7 **2014-15 Patient & Engagement Report**

Dasa Farmer attended to present the 2014-15 Patient and Engagement Report highlighting that it included information on consultations and engagement activities that have been undertaken and completed during 2014-15 which included clinical events and service reviews. There was an ongoing process to develop engagement mechanisms and training to increase awareness including PIPEC, commissioning priorities, primary care access (huge piece of work that included the 1:1 discussions, Extended Opening Hours and King Street Walk in Centre).

The recommendations were:

i) Note the content of the report for information, and

ii) Ensure public engagement is considered and undertaken for all commissioning intentions.

Members indicated that the final version should be shared with Clinical Cabinet when complete.

Dr Harries thought that it was positive around experience, but there was a need for patient ownership as it was very mixed. Dr Earnshaw thought that there was a problem with the contact interface with GPs and appointments. Dr Brown referred to the GP survey around the percentage return querying Healthwatch and access.

Members noted that the rich data source was pulled together from various sources including Patient Safety Walkabout reports and quality intelligence.

Dr Carroll referred to the ongoing work around Connecting Care and measure of results which members noted were linked in with the evaluation.

Members acknowledged that the paper was for information and agreed that it gave a snapshot of the work being undertaken.
8 Transient Loss of Consciousness (TLOC) and Cardiology Pathways

Dr DeSilva introduced a presentation to give members an overview of the main themes:

- TLOC pathway
- New angina referral pathway
- NICE update
- Encourage GPs to use the guidelines
- Community Heart Failure Clinics
- Community Diuretics Service
- MYDiagnostick and community cardiology update. (Gillian updated members on the use of this tool and the background indicating that it was in use in 26 practices with an outcome of 200 screens, 11 positives and 3 definite new cases)
- e Consultation for cardiology was going well

Dr De Silva referred to the community cardiology website which members noted could be shared and details would be available via Skyline.

Members commented that there was need to get messages out via network meetings and sharing stories within a virtual clinic. Gillian Richardson stated that extra support was need and Dr Earnshaw responded that this should be discussed outside of the meeting.

Members noted the contents of the report and presentation acknowledging that there had been good developments.

IT WAS RESOLVED:

i) To note the contents of the presentation and report

9 National Paediatric Diabetes Audit

Dr Carroll gave a brief overview and introduced Dr Sue Gardiner (Consultant Paediatrician – Lead Clinician for Paediatric Diabetes) who was presenting the National Paediatric Diabetes Audit.

Dr Gardiner indicated that she was attending to share the 2013-14 audit and highlighted the main themes and issues.

Members queried the targets, referrals and the specialist service for schools supporting children with insulin injections. Janet Wilson updated members on the meetings being held which covered engagement. There were issues around care processes and screening but overall the information reflected a positive position although there was a query around funding of external screening which was carried out at King Street.

Members noted that there were challenges around data collation and timing. Member’s queries including integration and age parameters acknowledging a need to focus on key areas.
The recommendations were noted as

i) Team to look at communication courses such as motivational interviewing;
ii) Structured education this year focussing on diet and exercise;
iii) Information re waiting areas to be disseminate to staff in charge of waiting areas; and
iv) Policy to be written re diabetes/school nurses.

Members noted that the two key areas were IT and transition from childhood to adulthood and indicated that Dr Gardiner should contact GPs for help.

IT WAS RESOLVED:

i) To note the content of the presentation and recommendations

10 Target topics for 2016

Dr Brown introduced the paper highlighting that there will be 10 Target sessions in 12 months. Two of which will be district wide and two or three will be network events.

The topics for the district and Network target sessions should be aligned with CCG priorities and agreed at Clinical Cabinet. It was noted that the suggested topics for the district sessions were:

- New NICE cancer guideline
- Referral Management Pathways

Members noted that two Peer Review sessions had been suggested for the network session and comments included:

- Cancer guidelines
- Clinical Threshold Management workshop
- Working Together
- Referral Pathways
- Secondary Care engagement
- Hot Topics via workshops (keeping it short and snappy to maintain concentration)

After detailed discussion, members acknowledged the need to support Dr Brown and noted that the network sessions budget should be extended to 3 network sessions and 2 Peer Reviews. Members comments included that the decision on which peer reviews they should undertake, should be left with networks and could be delayed until later next year when the MDT was ready re Care and Child Protection.

11 Planned Care Programme Development for 2016-2019

Vicky Walpole updated members on the progress made and the current position to draw a conclusion in 2016/17 planning in terms of transformation and specialties rationale. Vicky highlighted the modelling for the Clinical Threshold management speciality work was really useful as it related to many GP referrals.
Members acknowledged that the clinical lead was not present and that Gastroenterology and ENT were two key areas where modelling was a great opportunity. Vicky referred to an engagement discussion at ICG two weeks ago where early findings had been discussed and Dr Earnshaw emphasised that clinical input prioritisation was important.

Simon Rowe advised of his approach to ascertain what Clinical Threshold Management and Community Services can be implemented to achieve referral reduction targets. This approach will provide the basis for clinical discussions around what would have to be achieved to reduce referrals to MYHT. Members discussed issues around intelligence, success rate, referrals and data collection.

Michele Ezro commented that the work feeds into the next item re clinical engagement for QIPP.

Members approved the content of the report and next steps.

**IT WAS RESOLVED:**

i) To approve the content of the report and next steps

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**12 Clinical Engagement for QIPP**

Simon Dale (OD Practitioner and Programme Lead, Ways of Working) and Mike Thorogood (Health and Wellbeing, Capita) attended the update members on the main themes and highlights around the Clinical Engagement for QIPP. Mike updated members around adverse financial position next year which needed to be addressed by efficiency savings.

Mike indicated that the level of efficiencies to be achieved would need to be via:

- Practices
- World Class Commissioning
- Commissioning for value
- Health economies (try to hit national levels)
- Halting initiatives previously agreed which did not deliver

Dr Earnshaw felt that the problem was bigger than articulated linking it with partners, public health cuts, secondary care cuts, and Mid Yorkshire indicating that any initiatives to stop the activity would intensify the problem and elaborated on this point. Dr De Silva referred to working in different ways with services and cost savings in Primary Care.

Mike Thorogood explained that they were presently exploring opportunities within non recurrent funding and Dr Earnshaw expressed concern around YAS /UCP emphasising the danger around `embedded` funding.

Members commented on community services and nursing acknowledging the possibility of savings. Mike emphasised the need to receive new ideas for efficiencies to be worked into a robust plan.
Simon updated members on the ideas around costs diverted to Mid Yorks and layering across the Wakefield area. Liz Goodson referred to a plan allocation and a possible saving of around £1m.

Dr Harries thought that commissioning services were very light on GP based services. It was agreed that Dr Harries would discuss further with Mike Thorogood outside of the meeting.

Members noted the update.

IT WAS RESOLVED:

i) To note the update

13 Planned Care Assurance and Update

Vicky Walpole presented the Planned Care Assurance and update highlighting the issues around red items explaining that some of these would be sorted when GP led services were re-procured.

Vicky further commented on the need for an identified clinical lead in respect of ENT and DVT work and the need to know Clinical Cabinet’s view around priorities.

Dr Carroll referred to a Clinical Champions meeting which was taking place in the afternoon and Dr Earnshaw suggested a mix of input from the networks might help. It was agreed that Vicky would discuss leads for ENT and DVT with Dr Earnshaw outside of the meeting.

IT WAS RESOLVED:

i) Note the planned care assurance and update

14 Planning Priorities 2016/17

Michele Ezro introduced this item, referring to the email which Esther Ashman had shared as an update on Planning Priorities for 2016/17 which highlighted Reconciliation and focus. Michele asked members to contact Esther directly with any comments.

Members noted the contents of the update.

15 Clinical Network

There was no update to record.

16 Any items for escalation to Probity Committee

There were no items identified to progress to Probity Committee.
17 Connecting Care (Non recurrent investment)

Michele introduced the Connecting Care (non recurrent investment) paper which was for information only.

Members noted the contents of the paper with comments around the Care Homes Vanguard and the possible effect on patient flow.

IT WAS RESOLVED:

i) Note the contents of the paper

18 CCG Regional Collaboration – Working Together (South Yorkshire)

18.1 Review of Hyper Acute Stroke Units (HASU)

Members noted the contents of the paper and that Pat Keane attends the regional meeting. Members acknowledged that the Hyper acute stroke unit activity mass now go to Pinderfields instead of Barnsley. The papers were for information and any comments/issues should be discussed outside of the meeting.

18.2 Children’s Work Stream

Dr Carroll felt that there would be provider problems for Childrens in respect of workforce expertise towards bringing childrens’ surgery together. Dr Carroll elaborated on the complexities of this issue.

19 Minutes from Sub Committees

No minutes to note.

24 Any Other Business

24.1 WCCG0-19 Update

Michele referred to the paper from LA and indicated that comments would be recorded under Any Other Business.

Dr Harries queried the HV sub contract to Mid Yorks re business as usual. Dr Hallott and Dr Carroll commented around Children’s and 0-19 specification going to tender with a possible conflict of interest r.

Michele indicated that she would take back the comments to Jo Pollard re the CCG position.

Action: Michele to discuss CCG position with Jo Pollard
Members discussed the impact on clinical work which needed to be further discussed with John Wilson and Dr Andrew Furber. Dr Carroll advised that she would respond to the mail re conflicts of interest and members discussed issues around engagement. Dr Harries felt that there was a risk around serious case reviews and Dr Carroll responded that this had been raised at the Safeguarding Board.

**Date and time of the Next Meetings:**

**Informal Clinical Cabinet:**
Thursday, 3 December 2015
12.00 noon – 1.30 pm
Boardroom, WRH

**Clinical Cabinet:**
Thursday, 10 December 2015
09.00 – 12.30 pm
Seminar Room, WRH
NHS Wakefield Clinical Commissioning Group

CLINICAL CABINET

Minutes of the Meeting held on
Thursday, 26 November 2015
09.00 – 12.30 pm
Seminar Room, White Rose House

Present:
Dr Adam Sheppard  Assistant Clinical Chair, WCCG (Chair)
Dr Phil Earnshaw  Clinical Chair, WCCG
Dr David Brown  GP, WCCG
Dr Pravin Jayakumar  GP, WCCG
Dr Debbie Hallott  GP, WCCG
Andrew Pepper  Chief Financial Officer, WCCG

In Attendance:
Dr Som DeSilva  GP, WCCG
Dr Tim Dean  GP, WCCG
Dr Chris Barraclough  GP, WCCG
Dr Andrew Furber  GP, Director of Public Health
Dr Patrick Wynn  GP, WCCG (part meeting)
Michele Ezro  Associate Director, Service Delivery & Quality, WCCG
Elly McGraw  Practice Nurse, Riverside Medical Centre (Network 1)
Jo Webster  Chief Officer, WCCG (Item 5)
Lyndsey Clayton  Medicines Safety Officer, WCCG (Item 5)
Gill Day  Public Health Manager, Public Health (Item 6)
Tracy Morton  Senior Commissioning Manager, WCCG (Item 5)
Jenny Feeley  Urgent Care Transformation Lead, WCCG (Item 9, 10, 11)
Vicky Walpole  Planned Care Programme Lead (Item 13, 18)
Kate Trevelyan  Senior Management Support, NHS WCCG (minutes)

1    APOLOGIES FOR ABSENCE

Apologies were received from Jo Pollard, Dr A Biswas, Dr A Carroll, Dr C Harries

2    DECLARATIONS OF INTEREST

Declarations of Interest were noted during the meeting from:

Item 8 – Primary Care Strategy and Extended Hours – All GPs

3    MINUTES OF THE MEETING HELD ON 23 JULY 2015

Minutes of the meetings held 24 September 2015 and 22 October 2015 were approved as a correct record.
Michele advised that because the last meeting was not quorate, the IAPT item was progressed to Board via Chairs action.

4 ACTION LOG

The Action Log was reviewed and updated accordingly.

5 Upright MRI Scanner and MRI Guidelines for GP Referrals

Dr Patrick Wynn introduced the paper which relates to those patients in Wakefield who were unable to use a conventional MRI scanner. At the moment funding is approved through the IFR process and if the proposal is accepted it would change to an e-Referral option. Tracy updated members on the details and noted that there were no additional costs involved.

Dr Brown asked about the triage of referrals and Tracy responded that a consultant had to sign off first. Members emphasised that GPs would need some engagement to inform with assistance around the actual process and information should be available on Skyline. Clarity was also required around the ICE template with a reminder note around the weight restrictions.

Action: Tracy to ensure that the detail of the process for referral is made clear in the policy and communicated appropriately. Tracy also to look at updating e-Referral to include relevant referral criteria and instructions in line with the policy and also investigate whether referrals could be made via ICE.

Tracy also informed members that MRI Guidelines for GP Referrals had been reviewed with a view to re-publishing to keep this up to date and to remind GPs about these guidelines. It was noted that minor adjustments had been made and that there were no additional costs involved.

Dr Earnshaw suggested an audit of GP referrals would be very useful so that the CCG and GPs could better understand referral volume, patterns of referral and costs. This could be shared with practices.

Tracy advised that there is a national tariff for MRI which is included in the service specification which Tracy would share.

Action: Tracy to share cost data with members

Dr Wynn suggested that data from the MRI audit undertaken previously should be looked at in the first instance rather than undertaking a fresh audit. Members agreed this was a good idea.

Action: Tracy to circulate the previous audit and MSK Transformation information relating to MRI

Members indicated approval of the recommendations which were to:
i) Approve the commissioning policy for upright MRI scanning; and
ii) Approve the guidelines for GP referral for routine adult MRI.

It was suggested by Dr Earnshaw that Pat Keane should make contact with Neil Jenkinson (Pathology).

IT WAS RESOLVED:

i) The paper was noted;
ii) The recommendations were approved subject to further review of audit and MSK transformation information.

6 Diabetes Service Review and Recommendations

Gill Day attended to present the Diabetes Service Review and Recommendations and updated members on the new diabetes model which had a dual purpose providing both consultation and specialist case reviews. Gill stated that the review had included a patient engagement event and a patient survey, a practice survey was completed and network meetings were attended. The review identified some gaps in the diabetes service - care homes and young people who were no longer engaging with the diabetes services and both areas are being reviewed. Training was also being reviewed within primary care and the community. Dr Sheppard felt that it was necessary to maintain the level of knowledge and also to increase the use of e consultation.

Pat Keane expressed financial concerns explaining that the CCG position was not capturing everything and there was a gap in respect of the required investment. Dr Sheppard thought that the Vanguard was perfect to link with regarding diabetes and care homes and the upskilling of the multidisciplinary team around diabetes. It was noted that the management of people with Type 1 diabetes was in secondary care and now would be available in the community via Primary Care with a Diabetes Specialty Nurse to look after those who did not want to go into hospital. Dr Furber commented on the prevention programme and the lifestyle services to be agreed which was around doing things differently to reap good results and the next phase could be GPs looking at different ways of prevention.

Andrew Pepper queried the commissioning stances and Gill Day responded on this point with members acknowledging that it was an area of rapidly growing costs.

The recommendations were:

i) It was recommended that the Clinical Cabinet note the progress of the Diabetes Service Review and the recommendations for commissioning which will be implemented through the commissioning stances and the primary care commissioning programme.

IT WAS RESOLVED:

i) To note the paper and progress made; and
ii) The recommendations were approved.
WCCG Financial Position (additional item added at the meeting)

Jo Webster attended to inform about the financial position and update members on the background to the ‘internal turnover’ which was being implemented to address the adverse position (as agreed with the Board). The approach taken should be sustainable for commissioning including care in line with planning guidance. It was noted that a new recovery plan was required to avoid an ‘external turnaround’.

Andrew Pepper then took members through the financial position around challenges for next year and post 16/17 highlighting necessary cost saving actions.

Members were reminded of their shared responsibilities and acknowledged that it was the corporate responsibility of Clinical Cabinet to evaluate, manage and deliver QIPP which had not recently been achieved. Dr Brown queried how pain management and pathology tests were counted. It was noted that MYHT spend for ongoing years would be taken through contract negotiations. Andrew Pepper emphasised the issues and Dr Sheppard indicated that the membership meeting next week would be used to get the messages out.

Dr Furber commented around the social care funding and that Public Health had the same issues as the CCG. Pat Kean referred to a profile of spend and the need to focus on the weak areas and smarter ways of working. Dr Hallott asked about temporary contracts and Dr Earnshaw responded about protecting primary care but at the same time building the most efficient Primary Care commissioning model within the primary and community sectors. Dr Dean asked about guidance on how this would be done and noted that it would be via corporate messages to network meetings.

Lyndsey Clayton attended the meeting to update members about the savings that can be generated in general practice from prescribing and that it required the backing of CCG clinicians. There are few opportunities for quick win switching initiatives and the ones that remain are more complex to deliver as we need to assure ourselves that patient care is not compromised.

The initiatives being proposed are stopping acute paracetamol being issued on NHS prescription, patients on ten or more medicines having medication reviews with a view to stopping at least one medicine (deprescribe) and taking PRN medicines off repeat. Dr Barraclough gave an overview of the medication savings achievable and promoted the paracetamol poster that will be circulated to practices. Members agreed that league tables showing which practices prescribe the most paracetamol items would be beneficial.

Dr Earnshaw updated members on the MYHT medicines list which Jo Fitzpatrick had shared which had been passed to Stephen Eames and there was a meeting set up next week to progress. Members discussed the valid switch with the intention that GP members would champion on this and update the ‘drop’ list. Dr Dean emphasised the need to communicate with care on the ‘changes’ to patients and it was noted that a generic letter would be drafted by next Wednesday together with the corporate message.

Action:

- Communication to GPs via the Membership meeting next week;
- Letter to patients to support to be draft out by Wednesday next week;
- League table to be devised and issued to Practices; and
Ongoing track of progress

Members agreed that an update would be brought back to Clinical Cabinet on the 10 December with a discussion to take place outside of the meeting on planning guidance.

Jo W thanked members for their valued support.

Action: Planning & Finance Management to be scheduled on the December agenda

IT WAS RESOLVED:

i) To note the update and support

8 SEND Strategy

Due to the additional item on the agenda, Marium Haque was unable to present the SEND paper. Michele Ezro asked members to review the paper (which was self-explanatory) and provide Kate Trevelyan with any comments by Friday next which could then be shared with Marium Haque.

Action: Members to review the SEND paper and email comments from a children’s services perspective back to Kate Trevelyan by next Friday, 4 December 2015.

IT WAS RESOLVED:

i) To review the SEND papers outside of the meeting and submit comments before Friday, 4 December 2015.

9 Primary Care Strategy and Extended Hours

Pat Keane presented this paper which proposed a framework and timescales in which the CCG will support and enable effective membership led commissioning alongside the development and commissioning of high quality general practice for Wakefield. Pat highlighted that it was a high level framework implementation linked to strategies based around Primary Care to deliver specialist healthcare and it was emphasised that it was a key part of the collaboration.

Members noted that the purpose of the Probity Committee was to provide strong support and protect GPs in respect of conflict of interest. Pat updated members on the background around membership led commissioning, co-commissioning, MDF support re Networks, Network agendas, Target sessions, prescribing, practices working together to support extended hours; all of which was to create a Primary specialist community which would include the Vanguard models of Care.

Members’ comments included

- The need for Public Health involvement;
- Utilisation of Primary Care could be done in the community but there was the issue around GP Capacity;
- Data issues;
• Concerns re training for non GP workforce; and
• Joint contracting infrastructure to support 7 day working.

The recommendation was:

i) That the Clinical Cabinet discuss and agree actions and timelines outlined within the draft strategy.

Members indicated that they were happy with the direction of travel and that the draft document could become the finalised version.

IT WAS RESOLVED:

i) To note the content of the paper; and
ii) In agreement with the direction of travel and approved the document as a final version.

10 Urgent Care Practitioners – update

Jenny Feeley presented the paper on the UCP scheme, which forms part of the urgent care strategy and the urgent care programme of Meeting the Challenge. The scheme went live in November 2014 as a pilot until March 2015, which was then extended with a requirement to review during the course of the financial year. Funding in 2015-16 was made through SRG. It was noted that the UCP service is not meeting the criteria under MTC nor value for money, therefore with ET approval, the service has been exited based on activity and outcomes.

The recommendations are:

i) To note the outcome of the in-year assessment of value for money;
ii) Gain assurance that the evaluation was completed, as requested in March Clinical Cabinet, and has been acted upon; and
iii) To acknowledge the proposed next steps.

Dr Brown commented on GPs workforce and secondment working and noted that a workforce plan had been requested from YAS. The issue of training was discussed around who supports Vanguards working on secondment and it was suggested that it should be a shared workforce. Jenny Feeley noted that workforce development is an enabling spoke of the West Yorkshire Urgent and Emergency Care Vanguard. Dr Earnshaw commented on the 999 response indicating that going forward it would need to be a different model.

IT WAS RESOLVED:

i) to note the contents of the paper,

11 ED Transformation

Jenny Feeley introduced this paper and advised that previous papers on the Integrated ED have been presented to Clinical Cabinet. Jenny highlighted the current paper had been prepared for the programme executive of Meeting the Challenge outlining the development timescales of the integrated ED compared to urgent care centres.
Development of Urgent care centres are discussed in line with the national recommendations through the Keogh review. Work was underway in the Integrated ED model and the new ways of working through this will be in line with moving to urgent care centres. Jenny outlined the involvement of the Urgent Care vanguard, indicating that the model would progress to consultation and procurement through the West Yorkshire Urgent and emergency care vanguard development. It was proposed that the work on the integrated ED continues with MYHT.

The recommendations were noted as:

i. Note the feedback on the progress with the redesign of the emergency departments and timescales for delivery of the integrated Emergency departments and Urgent care centres;

ii. Note the two plan stages for implementation a) short terms continuation of implementation of the integrated EDs, b) longer term to develop urgent care centres where this is deemed appropriate; and

iii. Agree next steps.

All members declared an interest.

Dr Sheppard updated members around the future of the Walk in Centres in Dewsbury and Wakefield with the extended 7day access work in progress.

Members queried if the new GP contract would give practices independence and noted that NHS England had allocated money to liberalise extended access. Probity agreed last Tuesday to progress working with providers to develop an extended access model. Members wondered how it would be delivered and acknowledged that the debate requires clinical engagement.

IT WAS RESOLVED:

i) To approve the content of the report and next steps.

12 PTS Service Review Update

Nyasha Mareya attended to update members on the West Yorkshire wide YAS PTS review (led by NHS Calderdale CCG) which was approved by 10CC in March 2015. The timeline delay and potential implications on NHS Wakefield CCG was noted. The review outputs are expected imminently and this will be discussed at the Yorkshire & Humber CCG CFO Monthly Meeting and subsequently at 10CC meeting. Members noted the possible issues around:

- Current contract end date
- Mid-Yorkshire Dedicated Discharge service
- Extra contract activity
- Cost implications re QIPP
- Provider and Risk resilience
- Wider potential implications across other YAS services
Nyasha advised that a paper would be brought back with the service review report with recommendations and members requested a formal report be brought to the next Cabinet in December.

**Action:** Formal PTS Service Review paper to be brought to the December Cabinet

**IT WAS RESOLVED:**

i) To note the update.

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### 13 2015/15 Commissioning Priorities

Members noted the update from Michele Ezro updated members on the outcome of the first Commissioning Maze game around the 2015/16 Commissioning Priorities.

Although the attendance numbers were not good, Michele indicated that the game did trigger useful debate about prioritisation of the money allocation for next year with feedback including views on the IVF offer and 7 day extended access. Those who attended agreed that the game had given them an understanding around the limitation of the money allocation.

Members’ comments included:

- IVF feedback 0-3 cycles could be based more on personal experience of someone close;
- General move towards 1 rather than 3 or 0
- Would sensible discounts from NHS for 2 or 3 cycles work?

It was noted that there were further sessions to be held at Kinsley today and Pontefract next week. Michele indicated that taking the game to network meetings might be considered.

**IT WAS RESOLVED:**

i) To note the update

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### 14 Planned Care Assurance and Update

Vicky Walpole presented the Planned Care Assurance and update highlighting the issues around the delivery of the CCG’s agreed Planned Care Programme and to provide an update on the development of the 2016-19 programme. Members were asked to note the contents of the report.

Andrew Pepper updated members on the discussions taking place outside of the meeting around cross referencing of costs.

Pat Keane highlighted that the paper which emphasised key areas of working and ongoing developments. The paper was presented for assurance.
IT WAS RESOLVED:

i) Note the planned care assurance and update

15 Planning Priorities 2016/17

Pat Keane tabled the 5 year organisational plans around Primary Care Strategy and Integration involving SRG around the cross working with other CCGs, Primary Care, Community Networks. The work was linked to Health and Social Care integration and earlier discussions around stroke, diabetes opportunities and challenges. North Kirklees are working to affect co-commissioning. It was noted that the detail will be presented at the 10 December 2015 meeting.

16 CCG Regional Collaboration

There were no issues to note.

17 Clinical Network

Members commented on this item and highlighted discussions in the various networks around extended hours, primary care strategy, pathology, District Nursing and vanguards.

18 Any items for escalation to Probity Committee

There were no items identified to progress to Probity Committee.

19 MYHT Self-Assessment – Eight Key Priorities

Members noted that the paper was for information as Mid Yorks had responded to NHS England in October.

The content was discussed and members’ queries were around NICE guidance, cancer pathways/commissioning intentions and the CCG/provider alignment process. It was agreed that Dr Abdul Mustafa and Michelle Ashbridge should attend Clinical Cabinet to bring a formal update to provide an understanding on the processes in place.

Action: Dr Abdul Mustafa/Michelle Ashbridge to attend Clinical Cabinet to bring a formal update to provide an understanding on the processes in place

IT WAS RESOLVED:

i) Note the contents of the paper;
ii) Dr Abdul Mustafa/Michelle Ashbridge to attend Clinical Cabinet to bring a formal update to provide an understanding on the processes in place.
20 Minutes from Sub Committees

No minutes to note.

21 Any Other Business

Members noted that the next Clinical Cabinet had been scheduled to the 10 December 2015 as the normal timeline for the meetings clashed with Christmas Eve. There was a clash in members diaries with a Network meeting/Connecting Care and it was agreed that the timing of the Clinical Cabinet should be changed to 10.00 am – 12.00.

It was also agreed the Informal Clinical Cabinet which was scheduled on 3 December 2015 should be cancelled due to a clash with the Membership Meeting.

Action: Timing of the next Clinical Cabinet to be changed to 10.00 am – 12.00 noon.
Informal Clinical Cabinet scheduled on 3 December to be cancelled

Date and time of the Next Meetings:

Informal Clinical Cabinet:
Thursday, 3 December 2015 (cancelled due to clash with Membership Meeting)
12.00 noon – 1.30 pm
Boardroom, WRH

Clinical Cabinet:
Thursday, 10 December 2015
10.00 am – 12.00 noon
Boardroom, WRH
<table>
<thead>
<tr>
<th>Title of meeting:</th>
<th>Governing Body</th>
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<tbody>
<tr>
<td>Date of Meeting:</td>
<td>12 January 2016</td>
</tr>
<tr>
<td>Paper Title:</td>
<td>Connecting Care Executive: Presentation of minutes and items for information to the Governing Body</td>
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<tr>
<td>Purpose (this paper is for):</td>
<td>Decision Discussion Assurance Information ✓</td>
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<tr>
<td>Report Author and Job Title:</td>
<td>Melanie Brown, Programme Commissioning Director Integrated Care</td>
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<tr>
<td>Responsible Clinical Lead:</td>
<td>Dr Ann Carroll, Governing Body Lead Connecting Care</td>
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<td>Responsible Governing Board Executive Lead:</td>
<td>Jo Webster, Chief Officer</td>
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<tr>
<td>Recommendation:</td>
<td>It is recommended that the Governing Body receive and note the minutes of the Connecting Care Executive meetings held on 10 September, 8 October and 5 November 2015</td>
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**Executive Summary:**

**10 September 2015:**

- **Children and Young People Commissioning Overview:**
  - Paper presented a review of areas that future joint commissioning between WCCG and WMDC for Children and Young People could be progressed.
- **ASD Pathway:**
  - Paper presented outlining the recovery process for the ASD Pathway; including details of seven options considered to support additional capacity;
  - The options proposed and agreed will cost £100k (assuming recruitment is achieved quickly) and work will continue to negotiate with partners to develop a model for funding those options, however due to the urgency to progress this, WCCG have agreed to comment this work with MYHT.
- **Care Home Vanguard Service Specification:**
  - WCCG commenced a four week consultation process for the Care Home Vanguard Service Specification. This closed on 23 September 2015;
  - A Value Based Proposition submitted in July 2015 has now been approved;
  - NHS England expect all New Models of Care sites to have plans in place for April 2016, however Wakefield plan to bring these timescales forward to contribute towards winter 2015/16 system resilience plans with some services commencing November 2015 for 12 settings.
- **July 2015/16 Better Care Fund Financial Reporting:**
  - Paper presented outlining the financial summaries of all three schemes within the Better Care Fund.
- **SEND Strategy:**
  - Paper presented by Marium Haque on the SEND strategy being developed in consultation with key stakeholders;
  - The strategy details a collective vision of where Wakefield District wish to be in terms of providing Special Education and Disability;
  - The strategy presented is the first draft;
  - The CCE agreed the SEND strategy would be presented at October’s Clinical Cabinet meeting and the final version presented at a future CCE meeting.
- **MsCP Vanguard Business Case:**
  - The Value Based Proposition is still pending approval and noted that the delay in approval has been escalated via NHS England.
• **NOVA VCS Funding Decision:**
  - Paper presented requesting further funding for 2015/16 within a jointly commissioned approach for £140k; funded equally between WCCG and WMDC;
  - The CCE supported the paper and recommendations outlined including the commissioning and funding for 2015/16;
  - An action was agreed for financial consideration to be given for 2016/17.

• **Governance Arrangements for Vanguard:**
  - Paper presented outlining the proposals for a Vanguard Commissioning Group; a sub-group to the CCE;
  - The CCE specifically discussed the proposed reporting structure and some changes were suggested.

**8 October 2015:**

• **Dementia Pathway Redesign:**
  - Paper presented outlining the proposed approach to redesigning the pathways and services for those requiring and living with dementia; adding that these proposals will make links to the Care Home Vanguard;
  - Specifications are expected to be completed by 31 March 2016; with procurement and transitional implementation throughout the next financial year and a new model of care in place by September 2016;
  - The CCE supported and endorsed the dementia redesign.

• **Assurance and Governance for SWYPFT Transformation Programmes:**
  - Paper presented providing details of 16 transformational programmes underway at SWYPFT;
  - The CCE agreed all 16 programmes should be assured and the process shared with other commissioners to promote consistency.

• **Family Drugs and Alcohol Court (FDAC):**
  - Paper presented outlining the details of this pilot scheme; adding that Judge Hillier wishes the pilot to be live by February 2016;
  - Noting the possible foreseen difficulties regarding recruiting a child psychologies/psychiatrist to chair weekly intervention planning meetings, access to adult psychiatry, a non-local authority venue and support regarding match funding, the CCE endorsed this pilot scheme;
  - A further update is to be provided at a future CCE meeting.

• **Care Home Vanguard Service Specification:**
  - Paper presented detailing the blueprint for the service specification and asked the CCE for approval of the service specification for the Care Home Vanguard model. This has been finalised after the end of consultation process;
  - The CCE approved the Care Home Vanguard service specification.

• **Better Care Fund Plans for 2016/17:**
  - It was confirmed there will be a Better Care Fund for 2016/17 however details on the process to be followed is still pending;
  - Paper presented detailed a high level timeline to prepare for the 2016/17 Better Care Fund, though the NHS England submission date is still to be confirmed pending planning guidance;
  - The CCE agreed to commence 2016/17 planning as soon as possible.

• **Integration Agreement:**
  - Paper presented was an initial early draft of a Wakefield Integration Agreement for the Connecting Care approach for 2016/17;
  - The CCE approved the paper as an initial draft agreement.

• **Integrated Community Equipment Scheme (ICES) Update:**
  - Paper presented providing an update on the pressure care equipment review and overspend on ICES budget; noting progress made to date and a request for CCE approval to trial new equipment;
  - The lack of equipment reviews following equipment being issued was noted as a concern; the CCE agreed this required further investigation;
  - The CCE agreed to the pressure care equipment trial taking place.

• **Public Health Consultation Update 2015/16 Implications:**
  - Outcome of national consultation still pending, however there is a commitment by WMDC to present to CCE the outcomes following the consultation as soon as possible.
• **Better Care Fund Financial Reporting:**
  o Paper presented outlining the expected spend from the Better Care Fund; noting further discussions are to take place between WMDC and WCCG.

5 November 2015:
• **Wakefield Children Integration Scoping:**
  o Paper presented advising a process to review the arrangements for complex care has been identified and terms of reference have been developed between WMDC and WCCG to govern the review process.
• **Future in Mind Submission:**
  o Paper presented providing an update on the Future in Mind submission, details of funding allocation for Wakefield 2015/16 Eating Disorder Services, implementation of the transformation plan and an allocation of £160k being announced for CYPIAPT Programme, therefore a total funding allocation of £850k;
  o The CCE agreed an action for a draft dashboard of key indicators to be created to show the value added in terms of Children and Young People in Wakefield.
• **Joint Commissioning Mental Health and Learning Disabilities:**
  o Paper presented was for noting, however it highlighted the approaches currently undertaken following joint discussions between WCCG and WMDC. More discussions are underway about future joint commissioning in this area.
• **Digital Roadmap and Unit of Planning Update:**
  o Paper presented outlined the details and requirements of a Digital Roadmap submission to be made to NHS England by April 2016;
  o Richard Main also advised on a requirement for all Providers to complete a Digital Maturity Index for January 2016;
  o The CCE agreed details of both the digital roadmap and maturity index should be advised at Connecting Care Health and Social Care Partnership meeting on 5 November 2015; noting that the completion of both should be governed via the District Wide ICT Strategy Group.
• **Community Anchors:**
  o Paper presented detailing the rationale for closer working with communities;
  o The CCE agreed an action for a paper to be written outlining future recurrent investment requirements.
• **Joint Planning Framework Update and Next Steps:**
  o Paper presented providing an update following several joint planning and commissioning meetings; including details on vision, principles, risks and next steps;
  o The CCE agreed a collective view should be obtained regarding governance, risks and conflicts of interest to ensure there is a degree of robustness for the future.
• **Communications and Engagement Review:**
  o Papers presented which included details on organisational development;
  o The CCE noted future consideration should be given to how Community Anchors can help engagement with communities who can be hard to reach for statutory organisations;
  o The CCE agreed to the recommendation of a connecting care re-launch event.
• **Better Care Fund Pooled Financial Monitoring Report:**
  o Paper presented outlining the financial summaries of the Better Care Fund;
  o The CCE agreed an action for further discussions to take place regarding the Care Act Capital Funding between WCCG and WMDC.

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<th>Link to overarching principles from the strategic plan:</th>
<th>Citizen Participation and Engagement</th>
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<tbody>
<tr>
<td></td>
<td>Wider Primary Care at Scale including Network development</td>
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<td>A Modern Model of Integrated Care</td>
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<td>Access to the Highest Quality Urgent and Emergency Care</td>
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<td>A Step Change in the Productivity of Elective Care</td>
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<td>Specialised Commissioning</td>
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<td>Mental Health Service Transformation</td>
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<td>Maternity, Children and Young People Transformation</td>
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<td>Organising ourselves to deliver for our patients</td>
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<td><strong>Outcome of Impact Assessments completed (e.g. Quality IA or Equality IA)</strong></td>
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<td><strong>Outline public engagement – clinical, stakeholder and public/patient:</strong></td>
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<tr>
<td><strong>Management of Conflicts of Interest:</strong></td>
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<td><strong>Assurance departments/organisations who will be affected have been consulted:</strong></td>
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<td><strong>Previously presented at committee / governing body:</strong></td>
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<td><strong>Reference document(s) / enclosures:</strong></td>
<td>Connecting Care Executive meeting minutes from September, October and November 2015</td>
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<td><strong>Risk Assessment:</strong></td>
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<td><strong>Finance/ resource implications:</strong></td>
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Meeting Minutes:

1. **Welcome and Apologies:**

   Andrew Balchin (AB), Jo Webster (JoW), Michele Ezro (ME), Dr Ann Carroll (DrC), Andrew Furber and John Wilson (JW) submitted their apologies.

2. **Minutes from 13 August 2015 meeting:**

   The minutes were accepted as an accurate record.

3. **Action Log:**

   Reviewing the action log, the following updates were given:
   - 20150611-022: The Public Health spending consultation has recently closed, however the outcomes are not yet known and this is not expected until mid-October 2015.
   - 20150611-024: SRG budgets are currently being reviewed, therefore ICES ‘Out of Hours’ Service funding is still pending SRG approval,
however there are ongoing discussions with SRG partners regarding this and an update will be advised as soon as possible. MB confirmed the CCE has however, made a commitment to continue the ICES ‘Out of Hours’ Service.

- 20150409-003: The expected date for the ICES Workshop session is November 2015.

- 20150611-021: MB confirmed a s256 agreement was signed by AB, however discussions are taking with AN regarding additional funding which has been agreed by the CCE i.e. the Care Home Vanguard; advising there are some resources for evaluation which need to be confirmed for Healthwatch and a conversation is required to agree the best way forward i.e. new s256 agreements for additional funding or inclusion as part of the current s256 agreement? ACTION: MB to discuss further with Karen Parkin and AN outside of today’s meeting.

4. **DISCUSSION ITEM: Children and Young People Overview:**

   HS advised the paper presented has been tabled previously, there is little change, though there were some gaps and inconsistencies which have now been addressed. HS explained some of the changes, advising one of the key services (Children’s and Mental Health Services) was originally out of scope, however after further discussion, a decision has been that these should now be in scope; adding they were initially out of scope and when consideration was given to whether they would be part of an ‘all age’ mental health specification, it was felt the specification fitted better within Children’s integration work.

   HS asked the CCE to confirm if the items indicated as being in scope for a potential future integrated commissioning specification are agreed with; adding, the project group would (in the interim) present a further paper outlining where consideration would be given to a joined up specification and in the meantime, the project group would like integrated governance arrangements for anything in scope in the integrated service delivery and where expected service changes are to be made, these would be presented to the CCE.

   The CCE approved the recommendations as outlined in the paper. In addition, MB confirmed the commissioning approach and high standard provided for in the Children and Young People’s paper, is the approach which all future joint commissioning areas should adopt.

5. **DISCUSSION ITEM: ASD Pathway Update including Options Appraisal and Quality Impact Assessment:**

   Referencing his supporting paper, IH talked the CCE through a recovery
process for the ASD Pathway; advising a contract query notice was issued with MYHT in February 2015 and since then a number of interventions have been put into place to reduce the waiting list, reduce capacity and support ASD assessments. However MYHT have now internally reached the maximum number of assessments possible, though there is still a gap between the number of children on the waiting list, the number of assessments required and the number of children joining the waiting list month on month. Therefore some additional work has taken place in the interim to develop a range of options to support additional capacity to add to the assessment support process. IH talked the CCE through each of the seven options considered; confirming the following had been approved:

1) Clinical Psychologist through SWYPFT to add to baseline capacity;
2) Clinical Psychologist through the Educational Psychologist Service to add to the non clinical pathway and provide additional capacity; and
3) To fund a Play Therapist role to support MYHT to free up their clinician time and add capacity to the system.

IH also confirmed the costs for these agreed options for the remainder of 2015/16 is approximately £100k (assuming recruitment is achieved relatively quickly) and that IH continues to work and negotiate with partners to develop a model for funding these options, however it was noted these three options have been approved as the recommended approach for recovery by WCCG.

Discussing the ASD pathway, AP advised he had written to SWYPFT, MYHT and JW at WMDC regarding equal contributions to fund the £100k recommendation costs; adding SWYPFT and MYHT are still to formally reply, however both have verbally advised they were warm to the idea of funding the recommendations options, however JW has declined on behalf of WMDC. The CCE discussed this further during which HS advised, WMDC do wish to contribute (and continue to do so) however the query for JW was a request for additional funding in addition to non delivery of an existing contract and recovering that funding was therefore a concern. AP acknowledged this concern, agreeing there was an issue regarding application of penalties which would definitely reduced the overall costs to the system and needed to be taken forward, however AP still believed there would be a net cost required.

The CCE continued to discuss funding. NH advised it is an historic issue that WMDC would not ordinarily appoint Clinical Psychologists however, a Clinical Psychologist has been appointed via SEND reform monies which are not sustainable. HS added there were two options for consideration; the number of assessments a Clinical Psychologist (with SEND funding) would be undertaking versus the number of assessments WMDC felt that person could undertake. HS advised there was quite a significant difference therefore, WMDC did consider whether an additional person was required or if they needed to ensure they got best value from the
person already in post which could potentially alleviate the requirement for somebody additional. HS confirmed this is something JW is open to exploring and will continue to discuss, however in terms of WMDC being able to source additional funding, the current situation does not allow for this.

AP noted this was a really helpful comment in terms of better value for money through existing investments and will definitely take forward the issue regarding contract sanctions, however AP proposed that both Commissioners are experiencing financial constraints; this is a system problem for the children of Wakefield and Commissioners should continue to work together. **ACTION**: AP to discuss equal contributions further with JW and raise contract sanctions where required.

In the meantime, IH confirmed the initial work regarding recruitment will continue.

Concluding the discussions, the CCE noted the recommendations.

**Quality Impact Assessment (QIA):**

IH advised with WMDC and MYHT colleagues, a QIA has been worked through to understand the level of risk with the current waiting list, demand for service and how to immediately mitigate moving forwards before setting out clear recommendations, actions and options for recovery which precedes the work undertaken to inform and develop the options appraisal.

IH added MYHT had previously conducted a QIA, however it did not reflect the whole system challenge on risks, solutions, recommendations or mitigation and was not a joint approach on how to move forward, however this recent QIA was jointly owned and was a very positive piece of work; with positive feedback received from both WMDC and MYHT on the outcomes achieved. IH added the QIA has been included as an appendix to his supporting paper, which supports the options appraisal in place and sets out some of the risks; adding where clear risks have been identified, there is clear mitigation and options to improve in place.

The CCE supported the paper.

**8. FOR DECISION: Care Home Vanguard Service Specification:**

MB advised on 26 August 2015 WCCG commenced a four week consultation process for the Care Home Vanguard service specification which will include a number of engagement opportunities (including a Provider Event on 22 September 2015) before the consultation closes on 23 September 2015.
Providing context, MB advised a Value Based Proposition (VBP) was submitted to NHS England (NHSE) for consideration on 31 July 2015 and was approved last week, though cannot be announced publically until 21 September 2015.

MB continued to advise NHSE are expecting all the New Models of Care sites to have something in place for April 2016, however, Wakefield are bringing timescales forward in order to contribute to system resilience plans for this winter which also supports bringing forward as many Meeting the Challenge (MtC) strategy schemes by 6 months as possible.

Referencing the supporting paper and draft service specification, MB advised both are consultation documents and comments are currently being received therefore this should be considered when reviewing the papers. MB also confirmed the aim is to have a model in place by 1 November 2015 across 800 beds which is 12 Care Homes across seven networks.

During discussion regarding communications to the Care Homes, MB advised the 12 Care Homes have been invited to attend a dedicated session at the provider event on 22 September 2015 before joining other Providers in the afternoon. MB added responses from the networks regarding this work has been very positive; advising the Network Chairs have been involved in selecting the 12 Care Homes therefore there will be parity of who is taking forward this new model for the winter together with a plan for 2016/17 of a phased approach into all Wakefield Care Homes.

The CCE discussed the £1.1m financial implication for the Care Home Vanguard; particularly asking if these monies have to be spent this year. AP confirmed the monies have not yet been received, however are expected to be transferred into WCCG allocations as a whole; adding this project is for two years, however the national transformation fund only lasts for this year, therefore there is pressure nationally to extend and grow the transformation fund into next year. AP highlighted an issue which needs working through which is:

a) Upon receipt of the £1.1m allocation, a way of deploying these funds this year needs to be found which also presents a risk into next year until next year is agreed (as a CCG allocation, there is a CCG risk also);

The CCE approved the recommendations in the report.

7b. **FOR DECISION: July 2015-16 Better Care Fund (BCF) Financial Reporting:**

Referencing his supporting paper, AR talked CCE members through the key figures noted on the summary reports of all three schemes within the BCF;
specifically highlighting the commentary on variances for each scheme and the following:

- A solution is still to be found regarding the £1.3m Social Care Act Implementation funding which was discussed at last month’s CCE meeting. **ACTION:** To progress this, AP requested Care Act costs are provided by WMDC to AP.
- In terms of projection of expenditure versus the funding available, there is a £1.5m funding gap made up of the £1.3m shortfall and £209k forecast spend across all the schemes;
- Scheme 1 has a projected under spend of £1m, however £700k of that is due to moving £700k of re-ablement costs into Scheme 2;
- Scheme 3 has shown an increase in overspend and this is now projected at £838k.

The CCE discussed ICES and the Care Act pressures with AP confirming these two schemes are the main challenges for the BCF (though there is now an action plan in place for ICES), however AP emphasised if these two issues can be tackled, the others will manage themselves.

The CCE noted the recommendations and supported the paper.

6. **FOR DECISION: SEND Strategy:**

Introducing the supporting paper, MH advised:

- The SEND strategy is being developed in consultation with key stakeholders;
- Following the implementation of new legislation which came into effect in September 2014, there is no official requirement to have a SEND strategy in place, however, it is considered good practice;
- WMDC have been advised an Ofsted Inspection for Special Education and Disability is being developed for implementation from January 2016. This will mostly involve a pre desk top exercise to review how the vision for the district is shared with the public;
- Whilst the inspection will be hosted and led by WMDC, the Ofsted for SEND is a Wakefield District inspection, therefore the strategy details a collective vision of where Wakefield District want to be for Special Education and Disability and whilst it will be hosted via the District’s local offer, it will be a strategy which effectively ties Partners into ensuring it is a shared vision and is collectively delivered;
- The strategy has been deliberately produced so that it is short, simple and clear as it will available for parents, carers and young people to use. It also includes phrases, terms etc. which have come from workshops where there is a high level of parent and carer engagement (there are also contributions by children and young people) and uses areas which have been indicated as high priority for them whilst marrying with the requirements of the SEND legislation which
stipulates what we must do separately and collectively;
• The strategy presented today is a first draft.

In discussion, IH confirmed ME and Morna Cooke have already provided feedback on the strategy. It was also suggested the SEND strategy is presented to Clinical Cabinet. The CCE also asked if a self assessment of the Ofsted review was to be undertaken. MH advised the framework has not yet been received, however confirmed a self assessment around the SEND legislation is periodically undertaken (the DFE visited in August 2015). MH added she felt regular assessments are likely considering the high performance being achieved on all indicators and Wakefield’s local offer is extremely good and is being held up nationally. In discussion IH asked if there was further joint working which could be done to prepare for any inspection. MH advised there are two areas which Wakefield need to demonstrate more strongly; progress regarding personal budgets in all areas (this has been highlighted as a risk) and our move to integrated service delivery. In view of these areas, three workstreams have been set up:
1) Inspections and engagement;
2) Integration;
3) Personal budgets.

**ACTION:** IH to assist MH in arranging for the strategy to be presented at October’s Clinical Cabinet. **ACTION:** Ofsted Framework and final version of SEND strategy is to be presented at a future CCE meeting.

The CCE supported the recommendations of the report.

**FOR DISCUSSION:** MsCP Vanguard Business Case:

DrJ and SF provided an update on the position of the VBP and an understanding the resources available for the MsCP Vanguard; advising the VBP was submitted several weeks ago and is still pending approval despite calls being made to NHSE for an update.

In discussion, DrJ advised there are two other VBP in the same position as MsCP and concerns are building regarding approval delays in the view that funds for this Vanguard terminate at the end of March 2016. MB added concerns regarding the delays have been escalated via NHSE however suggested if DrJ has not received approval by the end of next week, to advise MB so that it can be escalated again/further.

The CCE discussed the VBP approval delays during which SF suggested that any slippage is carried over into the first quarter of the next financial year as the work needs to continue and the money cannot be slitted into any other programme etc. It was also suggested (to add ‘heat into the system’) that DrJ and SM clearly describe what effect the MsCP Vanguard
would have on winter resilience and that the national spot light on this health economy be emphasised during escalation conversations; adding that if the MsCP Vanguard was in place, it would provide a significant winter resilience scheme.

DrJ advised it is a consequence of the funding going through WCCG that it has to be governed by WCCG processes, however NHSE are advising to ‘get on and do it’. In discussion, DrS commented there cannot be a delay of 3 months for a procurement process; adding there is an emergency care improvement programme coming and therefore asked if there was some form of emergency commissioning arrangements which could be considered as things need to move at pace for this health economy. MB advised, at a Commissioning Event held in June, there was a clear message given that there would be no exemptions to procurement regulations for those going through the models of care programme and therefore due process will need to be followed. However, MB added for the third sector there are levers which are new to NHS Commissioners which can be used i.e. The Grant Funding Agreement which has been available since February 2015 and for VCS the CCG have recently used this for the first time with Age UK. Other contract mechanisms will be utilised if provision is being delivered by the Provider Alliance through contract variations of existing contracts.

West Wakefield Health and Wellbeing (WWHWB) Ltd highlighted as funding is only confirmed until March 2016 it is unlikely Providers will go through a procurement process for something which ends on 31 March 2016. WWHWB Ltd have existing contracts already in place for key enablers and there are opportunities for extension/change; adding, that West Wakefield have contracts in place already for pharmacy, physiotherapy and social prescribing and all of these have already been extended until December 2015 which is when NHS Prime Ministers Challenge Fund (PMCF) resources end.

Regarding the financial details and challenges DrJ and SF advised these are underway. The CCE acknowledged from the update given, all is being done in terms of the VBP approval process; however there was a request that JoW, AP and MB be kept sighted on this in case there is anything else which could be done.

DrS retrospectively declared a conflict of interest with this agenda item.

DH raised the issue of communication with practices to ensure they are kept informed; particularly those which are not as closely involved with West Wakefield as Network 6. In discussion, SF confirmed updates are regularly given at Network Chair meetings however, would welcome advice on how best to engage. DrJ added he is in regular contact with all Network chairs, however admitted the initial focus has been regarding
extended hours. DrJ advised there is an engagement event on 23 September 2015 (attended by Practices, Providers etc.) to discuss the MsCP Vanguard.

7a. FOR DISCUSSION: Section 256 Arrangements and Legacy Joint Funding:

The CCE reviewed the figures provided. AP asked if the Diabetes Foot Care Scheme was being funded from one of the legacy funds. JW advised it has been agreed this scheme would be funded from the under spend in the Health and Inequalities fund.

Regarding the s256 agreement and discussions held earlier, MB asked if the other costs such as Gateway to Care (G2C) need to be captured in different s256 agreements or if they can be captured as part of the existing. ACTION: NH to discuss with AN.

10. FOR DECISION: NOVA VCS Funding Decision:

Nichola Esmond declared an interest and left the meeting for this item.

Referencing his supporting paper, LB advised the paper underlines the important contribution the third sector makes to the local health and social care economy and highlights the work undertaken by NOVA Wakefield District as a lead infrastructure organisation. In addition, the paper details some previous approval processes and seeks further funding for 2015/16 within a jointly commissioned approach to the total of £140k; £70k funded each by WCCG and WMDC.

In the absence of AB, MB asked if WMDC have confirmed their contributions to this funding. LB advised following a discussion with Antony Sadler (AS) who in turn has spoken to Maureen Cummings, WMDC have confirmed the funding. LB also confirmed funding for 2015/16 is the third year of a three year agreed programme for NOVA.

LB advised the paper outlines details of the NOVA work programme; effectively showing the increasing importance NOVA have in delivering Wakefield District VCS objectives and recommended the funding is approved by the CCE.

In discussion, JoP supported the continued funding of this programme; noting its strategic importance and recommendation by the WCCG Clinical Cabinet Chair that funding continues from discussions that took place in 2014/15 Clinical Cabinet.

In terms of the contract arrangements, LB advised WMDC are Lead Commissioners and WCCG are involved in quarterly contract discussions and LB represents the CCG in these contract meetings.
The CCE supported the paper and recommendations outlined including the commissioning and funding for 2015/16.

Concluding discussions, MB asked if consideration had yet been given to the options available for 2016/17 given the financial constraints of both WCCG and WMDC. **ACTION:** LB to consider (with Antony Sadler) and present a future report for 2016/17 arrangements.

11. **FOR DECISION: Governance Arrangements for the Vanguard:**

MB confirmed the funds flow for all Vanguard resources will go through WCCG allocations and therefore governance arrangements need to be in place to manage the process. Following the discussion of possible ideas at last month’s CCE meeting, MB advised further meetings have taken place since and it is proposed to slightly change the CCE Terms of Reference (ToR) with the inclusion of a CCE subgroup to manage the Vanguard arrangements. This proposal will also be presented to WCCG Governing Body and the Health and Wellbeing Board (HWBB).

Referencing her paper, MB talked the CCE through a proposed draft Vanguard Commissioning Group advising:

- The formal subgroup will support the commissioning funds flow of MsCP and Care Home Vanguards;
- MB will co-chair the subgroup with DrJ and DrC;
- The subgroup will consider the issues and priorities for 2015/16 and 2016/17 spend;
- Advice will be obtained from officers who support CCG procurement, contracting and finance mechanisms;
- The draft ToR for the sub group are currently out for consultation;
- The mobilisation of the subgroup will happen as soon as possible.

The CCE discussed the proposed structure. DrS noted he did not see where WCCG’s Probity Committee fitted in; adding that anything regarding Primary Care should be aligned. MB highlighted where in the ToR the Probity Committee is referenced and provided assurance any decisions regarding Primary Care would go to Probity Committee. It was also noted that Children’s transformation needed to be added. **ACTION:** ALL

Any further comments to be forwarded to MB.

12. **FOR INFORMATION: Better Care Fund Progress Performance: Quarter 2 Outturn:**

This agenda item was noted.
13. **FOR INFORMATION: Facilitated Session: Joint Commissioning (WCCG and Local Authority) Update:**

   This agenda item was noted.

14. **FOR INFORMATION: Items of Interest re: Single Agency Commissioning that may impact on partners:**

   No items raised.

15. **FOR INFORMATION: Proposed Work Programme:**

   This agenda item was noted.

16. **FOR INFORMATION: Integrated Community Equipment and Wheelchair Services: Update report August 2015:**

   This agenda item was noted.

17. **Any other Business:**

   No items were raised.

18. **Date and Time of Next Meeting:**

   Thursday 8 October; 9.00am to 11.00am; Seminar Room, White Rose House.
Connecting Care Executive meeting

Thursday 8 October 2015
9.00am to 11.00am
Seminar Room, White Rose House, Wakefield

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<tr>
<td>Andrew Balchin (AB) Chair</td>
<td>Director of Adults, Health and Communities, WMDC</td>
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<td>Melanie Brown (MB)</td>
<td>Programme Commissioning Director Integrated Care, WCCG</td>
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<td>Jo Pollard (JoP)</td>
<td>Chief of Service Delivery and Quality, WCCG</td>
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<tr>
<td>Neil Hardwick (NH)</td>
<td>Finance Manager, Children and Young People Services, WMDC</td>
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<td>Dr Adam Sheppard (DrS)</td>
<td>Assistant Clinical Chair, WCCG</td>
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<td>Adam Robertshaw (AR)</td>
<td>Finance Manager, Strategic Projects, WCCG</td>
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<tr>
<td>Janet Wilson (JWi)</td>
<td>Public Health Principle Support to Health and Wellbeing Board, WMDC</td>
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<td>Nichola Esmond (NE)</td>
<td>Director, Healthwatch Wakefield</td>
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<td>Michele Ezro (ME)</td>
<td>Associate Director, Service Delivery and Quality, WCCG</td>
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<td>John Wilson (JW)</td>
<td>Director of Children and Young People Services, WMDC</td>
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<td>Dr Ann Carroll (DrC)</td>
<td>GP Board Member, WCCG</td>
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<td>Jayne Beecham (JB)</td>
<td>Communications Lead, WCCG</td>
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<tr>
<td>Alix Jeavons (AJ)</td>
<td>Senior Commissioning Manager Mental Health, WCCG</td>
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<tr>
<td>Michelle Cogan (MC)</td>
<td>Dementia Co-ordinator, WCCG and WMDC</td>
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<td>Mark Stonnell (MS)</td>
<td>Service Manager, Safeguard and Family Support, WMDC</td>
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<tr>
<td>Lesley Carver (LC)</td>
<td>Project Lead, Care Home Vanguard, WCCG</td>
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<tr>
<td>Martin Smith (MS)</td>
<td>Programme Manager, Connecting Care, WCCG</td>
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<tr>
<td>Sharon Wallis (SW)</td>
<td>Programme Manager, Connecting Care, WCCG</td>
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<td>Michelle Domoney (md)</td>
<td>Minute Taker</td>
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Meeting Minutes:

Action:

1. Welcome and Apologies:

Andrew Furber (AF), Jo Webster (JoW), Andrew Pepper (AP), Angela Nixon (AN) and Antony Sadler (AS) submitted their apologies.

2. Minutes from 10 September 2015 meeting:

The minutes were accepted as an accurate record.

3. Action Log:

Reviewing the action log, the following updates were given:

- 20150910-045: JW advised AP had not yet discussed ASD contributions and contract sanctions with him. ME to pick up with JW.
4. **FOR DECISION: Dementia Pathway Redesign:**

AJ and MC presented a paper outlining the proposed approach to redesigning the pathways and services for those requiring and living with a diagnosis of dementia; advising:

- Pathway redesign has been on the action plan for approximately 18 months after being identified as an area for development in 2014;
- There has been some unforeseen delays in progressing this piece of work, however dedicated resource (via MC) is now in place to push this piece of work forward;
- A standard CCG pathway redesign process will be followed, however there are some differences in the fact that there are two commissioned services in existence:
  - Diagnostic services; which are wholly health funded;
  - Post diagnostic support services; which are commissioned via a combination of WMDC contracts, CCG contracts and CCG contributing into contracts which WMDC holds;
- The paper ensures all aspects have been covered with respect to how these services are going to be re-procured going forward;
- A process mapping session identified some of the opportunities, challenges, barriers, differences of opinion etc. between service users, carers and professionals;
- A number of areas for improvement have been identified including:
  - Changing the way in which people receive their diagnosis;
  - Improving people’s experience of the memory clinic;
  - Ensuring when people get their diagnosis, they do not then disappear;
- A whole series of engagements are planned regarding understanding what service users and carers want from a diagnostic pathway and a post diagnostic pathway will begin to develop commissioning principles, outcomes and KPIs which will be proposed to be used in two ways:

With the exception to action 20150910-046 which is still underway, all other outstanding action updates were noted as agenda items.
o The co-production of a memory clinic specification with SWYPFT as the encumbered provider;

o To build a procurement approach for service specification for post-diagnostic support (this would be put out to competitive tender).

The CCE discussed the paper and proposals. In discussion AJ confirmed there is one Admiral Nurse in Wakefield, advising this Nurse was not commissioned by WMDC or the CCG, instead the post was campaigned for by Dementia UK who approached MYHT and agreed to a two year 50/50 funding split. AJ also confirmed the dementia re-design will be taken into Care Homes therefore links to the Care Home Vanguard will need to be made, however AJ advised of some difficulty engaging with GPs and suggested a conversation with DrC is held outside of this meeting to discuss possible GP engagement strategies; perhaps suggesting GPs who may like to be involved in some of the detailed work to take place.

The CCE continued to discuss the service re-design, acknowledging the challenges to develop a cohesive and seamless service. AB advised WMDC are currently involved in commissioning services and also provide some residential care which focuses quite heavily on people living with dementia and felt an open approach should be taken to ensure the provision WMDC provide is included in the scoping of this work and equal consideration should be given to whether that provision is correct, is with the right provider and is being supported in a way which supports the overall design pathway. For the record, AB advised he would welcome a friendly critical challenge regarding how this provision fits with the pathway redesign and invited AJ to approach him for any additional information required.

Discussing timescales, AJ advised specifications should be completed by 31 March 2016 with procurement or transitional implementation throughout the next financial year and a new model of care in place by September 2016. In addition, AJ suggested it would be useful to build into the timescales feedback as work progresses and progress with any quick wins which become apparent as the programme moves forward.

The CCE also discussed performance monitoring. In discussion AB suggested this programme would be of interest to the Health and Wellbeing Board (HWBB) and suggested that AJ/MC provide details on what success looks like; particularly for patients after diagnosis and therefore suggested it would be beneficial to get a balanced view in terms of future economic performance reporting. AJ advised a carer and service user session was being planned for late October 2015, with a professional session arranged for November 2015 and feedback from both sessions would be presented to HWBB in December 2015 or January 2016.

Continuing the discussions regarding the pathway redesign, JoP asked if
the redesign would also focus on working with MYHT; noting that an acute bed (and long stays in acute beds) is not the best place for dementia patients. AJ advised there are two elements:

1) Integrated care, early supported discharge and what they look like, what delayed transfers of care look like, how these affect what happens in the hospital, what the environment looks like in the hospital, what skills and competencies of the nursing teams look like are all involved and being considered as part of this piece of work;

2) Understanding what and how the pathway relates to when patients attend hospital; what does the front and back end look like and when are patients coming back out of hospital.

The CCE supported and endorsed the Dementia Redesign Pathway.

5. **FOR DECISION: Assurance and Governance of SWYPFT Transformation Programmes:**

AJ advised following conversations with a number of individuals, a need to ensure consistent, transparent and clear governance and assurance processes of SWYFT transformation programmes has been identified.

Referencing the supporting paper, AJ advised:

- There are 16 transformation programmes currently underway within SWYPFT split into 4 main categories (not all apply to Wakefield and not all are services commissioned by WMDC or the CCG);
- The paper asks which of the 16 (if not all) does the CCE wish to assure using the process outlined;
- Both Lisa Wilcox (WMDC) and Andrea Wilson (SWYPFT) are supportive of the proposed approach presented; advising they felt it was very lean but effective;
- Implementation is proposed to take place between 2nd (design) and 3rd (delivery) phase of the SWYPFT approach to transformation. Signing off each of the assurance frameworks is also expected between these two phases.

The CCE discussed the recommendations and proposal including who would be the lead commissioner and if overarching governance would sit with the lead commissioner. In discussion, AJ advised the proposal presented is in lieu of another process already in place, however a lead commissioner is still be confirmed.

Continuing discussions, concern was expressed that commissioners were not sighted on SWYPFT Transformation Programmes up until a couple of months ago and when considering the consultation and engagement which was part of Meeting the Challenge and Connecting Care, the same level of transparency does appear to be present. In discussion, ME added:

- AJ has done a really good piece of work; a lot of which has been around
developing that relationship with SWYPFT who as a Foundation Trust SWYPFT are not bound by the same processes, however SWYPFT have voluntarily agreed to go through an assurance process. ME felt this was the reason Calderdale (as lead commissioner) have not been undertaking that assurance has it was not mandatory to have in place;

- The work AJ has done has included the Local Authority therefore the process has incrementally been improved and feels the CCG are in a good place to have a more structured way of obtaining the required assurance

CAMHS services were also discussed after it was highlighted that a different offer is in place between Wakefield and Kirklees; Wakefield have a Children’s Crisis Team who prevent children being admitted when there is no medical problem and are seen by a child psychiatrist within 4 hours, Kirklees do not have this service. DrC added this position is confusing for clinicians working in the system, however it is understood by CAMHS this position will not change. AJ advised Ian Holdsworth is fully sighted on this and the risks which the CCG are carrying because of inequity across the district, however AJ does not feel the SWYPFT Transformation Programme will address this concern. AJ felt this was something commissioners need to be working with Kirklees and Calderdale with; in terms of messages and clarity about the service offer.

AB advised he felt this work would provide an assurance framework, however suggested a conversation takes place in another forum regarding expectations going forward for any provider contemplating significant change processes and how they relate to expectations of commissioners. AB also suggested exploring as commissioners (and with the Provider Alliance) setting some ground rules to ensure commissioners and providers are clear regarding assurance and although it was acknowledged that services will not want to discuss every internal service change, it was felt there was a threshold where significant service change of scale could have a potential major impact.

Continuing discussions, JoP advised she had escalated the position to JoW so that a one to one conversation could take place with Calderdale’s Chief Officer. In addition, JoP suggested that an offer could be made to the Provider Alliance for a joint presentation regarding commissioner expectations for the health and local economy regarding scope.

AB added a lot of work has previously gone in to developing the business rules which set a framework for how Commissioners and Providers work together and therefore suggested these required further development to bring clarity.

Referring back to the supporting paper, NH asked if it was the same lead commissioner for all 16 transformation programmes. AJ confirmed:
• The learning disability contract sits separately for Wakefield so we are the commissioner for LD services;
• Mental Health contract sits across Calderdale, Kirklees and Wakefield. This would be programme one, including CAMHS of that block contract so that is Calderdale
• General Community Services are different in each patch, therefore other than the Health and Wellbeing workers and the health trainers which are commissioned via Public Health, they are the only general community services which we commission from SWYPFT so that is a separate contract on its own, so Public Health would be the lead commissioner;
• Forensic Services is NHS England (NHSE);
• So primarily the lead commissioner arrangement is the Mental Health Programme.

Discussing the recommendations, AJ advised although the lead commissioner for Forensic Services is NHSE, AJ felt it had an impact on how we then escalate patients upwards from our inpatient beds as well as bring people down and it has an impact on Local Authority Social Work teams, and therefore recommended that Forensic Services is one of the programmes to be assured.

The CCE agreed that all programmes should be assured and the process shared with other commissioners to promote consistency.

6. FOR DECISION: Family Drugs and Alcohol Court (FDAC):

Referencing the supporting paper, MS provided background information on the FDAC, details on additional pilot areas (including West Yorkshire), the implementation of a Steering Group across 5 local authorities and the implementation of a Wakefield Operations Group adding:
• Dr Mike Shaw (who was involved in the original pilot) is a member of the Regional West Yorkshire FDAC Steering Group and has suggested the following as essential criteria for the FDAC team:
  o Manager;
  o Senior Social Worker;
  o Drug Therapist;
  o Administrator;
  o Non Local Authority venue which is seen as quite important for the parents;
  o Child Psychiatrist/Child Psychologist to chair the weekly intervention and planning meetings;
• Timescales for this further pilot is a concern, with Tavistock and Coram teams looking to train the FDAC team (including Judges) between 12 and 15 January 2016 and Judge Hillier wanting the programme to go live by 1 February 2016;
The project should be able to evidence (even in year one) that savings can be made (which would cover any costs) and Brunell University and The Centre for Justice and Innovation have both been appointed by the Department for Education (DFE) to work with Wakefield on evidencing the savings the FDAC team would make for this district.

MS advised he would like the CCE to endorse the project; noting the possible foreseen difficulties which would require assistance from the CCE:
- A Child Psychologist or Psychiatrist to Chair the weekly Intervention Planning meetings;
- A route to access to advice from Adult Psychiatry;
- Consideration regarding a non-local authority venue;
- Support with match funding.

The CCE discussed the approach presented. NE confirmed she welcomed the model and would recommend it coming to West Yorkshire and Wakefield in particular; adding there is a consortium of women’s centres working across West Yorkshire who work with the entire probation contract; working with women prisoners and therefore suggested MS and FDAC links with this consortium.

DrC also endorsed the programme; noting that morally it is the right thing to do for these families, however asked if there had been any discussion with Ian Holdsworth regarding a Child Psychologist or Psychiatrist. MS advised some preliminary discussions have taken place with Ian regarding how FDAC could link to the ‘Future in Mind’ agenda also, however conversations are in the early stages. MS added that all 5 pilot authorities are struggling with finding a Child Psychologist/Psychiatrist, however added there could be an opportunity to approach SWYPFT considering they also cover Calderdale and Kirklees as well.

ME also endorsed the model, however asked if the financial benefits can be moved to where they are necessary and asked if there was agreement to move the monies saved across the system. MS confirmed the process has not got to this stage as yet, however will note and take forwards. Regarding the clinical psychologist/psychiatrist post, ME suggested if this was a role which the whole of West Yorkshire was struggling with, perhaps resources could be pooled in order to recruit across West Yorkshire as a whole.

The CCE confirmed they supported the programme and the look of the project, however asked for more detail on what might be possible, to clarify match funding expectations and what the recurring position on that might be. In discussion, NH advised there would not necessarily be a request for additional monies; but a redirection of existing resources.

**ACTION:** Match funding expectations, SWYPFT discussions regarding West Yorkshire wide Clinical Psychologist and if savings made can be redirected
to be discussed and a brief update presented to the December CCE meeting.

In discussion, NE offered to speak to Alison Haskins at Nova regarding a non Local Authority venue; suggesting one of the Community Anchor sites might be able to offer something. MS welcomed this suggestion. ACTION: MS/NE MS to provide NE with information on venue size and NE to speak to Alison Haskins regarding a non local authority venue.

7. FOR DECISION: Care Home Vanguard Service Specification:

Introducing her supporting paper LC confirmed:

- The Care Home Vanguard business case was submitted to NHSE on 1 July 2015;
- Wakefield has been successful in securing funding of approximately £1.1m for the first 6 months of the vanguard;
- The service specification has been out for consultation for one month and will conclude on 23 September 2015;
- A provider event, attended by 32 colleagues from across Wakefield District, was also held on 22 September;
- The specification presented includes all the comments and recommendations received and is the final version

LC talked the CCE through the blueprint elements of the service specification before asking the CCE to approve the overall service specification for the Care Homes Vanguard model.

The CCE discussed the specification; specifically risks and care home closures after the national picture regarding care homes (75 care homes closing in the next few weeks, though none in Wakefield) was highlighted as a concern, particularly as the closures involves 3 major providers; all with a presence in Wakefield district; all signalling they are experiencing severe financial problems and are therefore reconsidering their business models. In discussion, the CCE acknowledged that care home/nursing home closures were a real risk and would have an impact on the whole health economy.

Whilst discussing the risks and impact of care home closures, it was suggested that conversations take place now (in tandem with the Care Home Vanguard) to consider what is the future of residential care, that a health and social care discussion takes place to discuss how to keep care home beds available and that it would be beneficial to understand the whole financial mode of care homes for non-funded/local authority residents; believing that the current position is not sustainable. Debate regarding care home risks to be continued in another forum; engaging with all partners in that discussion.
8. **FOR DECISION: Better Care Fund Plans for 2016/17:**

MS confirmed to the CCE there will be a Better Care Fund (BCF) for 2016/17; advising no information is currently available on the process to be followed, however it is expected to follow a similar path as last year. However, planning for next year needs to start and this work will include re-affirming the vision; including what do Wakefield District really want to put into the BCF, are there things to be done differently etc.

Referencing the supporting paper, MS talked the CCE through the high level timeline which has already been drafted, however MS highlighted that the final BCF plan submission date to NHSE is still to be confirmed as planning guidance is yet to be received.

MS asked the CCE for agreement that the work should commence as soon as possible.

The CCE discussed retaining the vision. In discussion, there was a plea that the process of planning for next year’s BCF does not start from scratch. AB advised there is a strong vision already in place; a vision which has been developed and refined over the last few years, however agreed an updated approach now needs to be taken given how things have changed so dramatically over the last 18-24 months.

MB added a decision was made last year that the BCF plan would not to include any non-recurrent resources, however MB advised this needs to be thought through for next year and suggested initial discussions should take place between AB, MB, JoW and other colleagues to begin considering the scope of the BCF moving forward. **ACTION:** BCF scoping meeting to be arranged.

9. **FOR DECISION: Vanguard Commissioning Group Terms of Reference:**

This agenda item was deferred to a future meeting.

10. **FOR DECISION: Integration Agreement:**

MB confirmed the supporting paper is a very early draft of the Wakefield Integration Agreement which is being worked on with the Provider Alliance for the Connecting Care approach for 2016/17 and asked that the paper is not circulated wider than to CCE members as additional changes are required.

Providing her update, MB advised:
- Chief Executives from the Provider Alliance met with DAC Beachcroft to understand what an alliance contract would mean for the Provider Alliance and their individual contracts moving forward for 2016/17;
It is hoped a completed Integration Agreement will be available to circulate formally to colleagues in the Provider Alliance in November 2015;

The agreement sets out some principles regarding the vision for connecting care and highlights the connecting care outcomes to be delivered;

It is an umbrella legal agreement that sits over the top of existing service contracts;

Further work will be required after the integration agreement has gone out for consultation with colleagues who manage contracts within the local authority and in the CCG to ensure there is a ‘read across’ between the integration agreement, funding agreements and service contracts;

All work is on track and a future report will be present to the CCE at a later date.

The CCE discussed the agreement including if there was an intention to do the same for Children’s services in the future. In discussion, MB advised through the Adults and Children and Young People Commissioning and Contracting Group meeting, members of that group have discussed this and are keen on the principles of this approach, however it is recognised there is further work to be done with Children’s integration agenda.

The CCE also discussed signatories particularly federated GPs and if discussions had taken place with the LMC. MB advised WCCG and WMDC will issue the agreement to the Providers listed, however MB and Dr Phil Earnshaw (DrE) are to discuss GP signatory further; noting that when this process started, concern was expressed regarding how the process could be followed and completed across 40 GP practices. MB advised some solutions have materialised themselves with some GP practices federating, however MB acknowledged not all GPs are federating and MB will get a steer from the Chair of the CCG regarding how to progress this.

The CCE also discussed how the Provider Alliance feels about the agreement. MB advised there were questions and comments regarding how it would work in practice against service contracts, however there was no sense of negativity. AB added that members of the Provider Alliance seemed to understand the principles behind the agreement and were supportive of that. I was also felt that the Provider Alliance understood this approach fits with the messages coming from providers regarding balancing the need for some rigour and assurance as commissioners whilst, at the same time, reflecting that collaboration is still developing within the Provider Alliance and was something that works within the grain of existing contracts rather than fundamentally shifting peoples responsibilities.

During the CCE discussion it was suggested that Providers consider how
they can get the Integration Agreement approved within their own governance; acknowledging that that process can take some time.

The CCE were happy to approve the paper provided as a draft Integration Agreement.

11. FOR DECISION: ICES Update:

Referencing the supporting paper, SW gave an update on pressure care equipment and overspend on rentals; talking the CCE through the progress made since the previous update before asking the CCE to approve a trial use of new equipment from November 2015 following a ‘Show and Challenge’ session with manufacturers taking place on 15 October 2015.

Members of the CCE were pleased with the update and progress made to date, however in discussion, JoP advised the products being reviewed should also be reviewed in terms of clinical quality and outcomes for patients; advising that a piece of equipment is not to be introduced if it increased a patients risk of developing pressure sores. SW acknowledged the main aim of this piece of work was to review costs, however clinical effectiveness and outcomes for patients is also a priority. In addition, SW advised there is currently no evidence to show that the equipment currently in use is more effective and that a balanced view is being sought and that a by product of this work, any new products should be cheaper.

The CCE also discussed education and the role of ‘gatekeeper’. SW advised, despite education regarding using clinical judgement, high end products are still being chosen on default as a result of the assessment tools in place and therefore a ‘gatekeeper’ role is required. In addition, SW expressed concern regarding the limited amount of monitoring which takes place once equipment is out in the community and feels some sort of protocol needs to be set up to track equipment after issue, however SW added that she has only investigated mattresses therefore is unable to advise if there is monitoring in place for other equipment.

The CCE discussed the lack of monitoring and agreed it was something that needed to be looked into further.

The CCE also discussed existing stock of the higher end products. In discussion SW confirmed the current focus is on rentals and whether rentals can be reduced, however SW advised the high end products in stock are getting old; therefore there is a benefit to be had regarding what equipment is bought in the future and the proposed trail will support in buying cheaper, but effective stock and therefore costs of the equipment in stock should reduce also. SW confirmed existing stock will continue to be used, however as it is replaced, it will be replaced with cheaper and
hopefully a more effective product.

SW also advised the information the CCE would receive in the future would be more of a focus on the costs; backed up by the clinical findings; and might be something that Ian Campbell wants to get more involved with now; SW has been considering the clinical side.

The CCE agreed to the equipment trial taking place.

12. **FOR DISCUSSION: Public Health Consultation Update 2015/16**

**Implications:**

On behalf of AF, JWi advised the outcome of the DoH consultation is still awaited and is not expected until October 2015 therefore there is nothing current to advise, however possible options are being considered and within departments there is not expected to be any direct impact on current services for 2015/16.

AB added at the last meeting JoW raised the question of WMDC advising on the detail of DoH intentions and what is going on at the earliest opportunity. AB confirmed that commitment is one that AF and AB will make and therefore will present to this group when information is available.

13. **FOR DISCUSSION: Better Care Fund (BCF) Financial Reporting:**

AR tabled a paper detailing what is expected to be spent from the BCF; noting that the paper tabled is a work in progress whilst further discussions take place with WMDC financial colleagues.

AR talked the CCE through the paper advising:
- The services WCCG commission are blocked therefore there is little movement on the forecast versus the original plan submitted; in most cases any movement is due to the delay in developing the plan and getting contracts signed, however the movement which there is, is favourable;
- The numbers highlighted in pink, AR has been able to infer the high level variances from the information received from WMDC, however it is not fully understood what is driving the variances and suggested a wider understanding is obtained.

The CCE discussed the paper presented; acknowledging this was a helpful start and that further discussions need to take place with AN to work through the variances, if there are any.

AB suggested a joint discussion would be very useful in order to obtain a clear and shared approach to dealing with the risks and would also
provide an opportunity to discuss what the BCF and its process could look like from next year; adding that fundamental decisions will need to be made regarding the extent at which resources are pooled to ensure they are done so in a more substantive way, the level of reporting and financial management, amalgamation of schemes and projects etc.

AB thanked AR for the paper, however suggested that an update is presented for the next meeting. **ACTION:** More discussions are to take place

14. **FOR INFORMATION:** Items of Interest re: Single Agency Commissioning that may impact on Partners:

This agenda item was noted.

15. **FOR INFORMATION:** Joint Legacy Funding:

This agenda item was noted.

16. **FOR INFORMATION:** Local Digital Roadmap:

This agenda item was noted.

17. **Any other Business:**

No items were raised.

18. **Date and Time of Next Meeting:**

Thursday 5 November; 9.00am to 11.00am; Seminar Room, White Rose House.
# Connecting Care Executive meeting

**Thursday 5 November 2015**

**9.00am to 11.00am**

**Boardroom, White Rose House, Wakefield**

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<tr>
<th>Present:</th>
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<tr>
<td>Andrew Balchin (AB) Chair</td>
<td>Director of Adults, Health and Communities, WMDC</td>
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<tr>
<td>Jo Webster (JoW)</td>
<td>Chief Officer, WCCG</td>
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<td>Melanie Brown (MB)</td>
<td>Programme Commissioning Director Integrated Care, WCCG</td>
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<td>Adam Robertshaw (AR)</td>
<td>Finance Manager, Strategic Projects, WCCG</td>
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<td>John Wilson (JW)</td>
<td>Director of Children and Young People Services, WMDC</td>
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<td>Dr Ann Carroll (DrC)</td>
<td>GP Board Member, WCCG</td>
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<td>Jayne Beecham (JB)</td>
<td>Communications Lead, WCCG</td>
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<tr>
<td>Anna Middlemiss (AM)</td>
<td>Deputy Director Public Health, WMDC (representing Andrew Furber)</td>
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<tr>
<td>Helen Sweaton (HS)</td>
<td>Interim Service Director, Children and Young People Service, WMDC</td>
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<td>Angela Nixon (AN)</td>
<td>Group Finance Manager, WMDC</td>
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<td>Andrew Pepper (AP)</td>
<td>Chief Finance Officer, WCCG</td>
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<td>Debbie Hallott (DH)</td>
<td>Governing Body Member, WCCG</td>
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<th>In attendance:</th>
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<tr>
<td>Ian Holdsworth</td>
<td>Senior Commissioning Manager, WCCG</td>
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<tr>
<td>Chris Makin</td>
<td>Senior Commissioning Manager, WCCG</td>
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<tr>
<td>Lisa Wilcox</td>
<td>Service Manager, Adults, Health and Communities, WMDC</td>
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<tr>
<td>Richard Main</td>
<td>Connecting Care Informatics Lead, WCCG</td>
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<tr>
<td>Lee Beresford</td>
<td>Third Sector Lead/Associate Director Strategy, WCCG</td>
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<td>Alison Haskins</td>
<td>Chief Executive, NOVA</td>
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<tr>
<td>Antony Sadler</td>
<td>Service Director for Communities, WMDC</td>
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<tr>
<td>Michelle Domoney (md)</td>
<td>Minute Taker</td>
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## Meeting Minutes:

### 1. Welcome and Apologies:

Andrew Furber, Michele Ezro, Dr Adam Sheppard, Nichola Esmond, Kevin Dodd and Jo Pollard submitted their apologies.

### 2. Minutes from 8 October 2015 meeting:

The minutes were accepted as an accurate record.

### 3. Action Log:

Reviewing the action log, the following updates were given:
• 20150409-003: MB and Rob Hurren met on 4 November 2015 to discuss next steps. Jon Parnaby, Project Manager will take forward and an update is likely to be presented at the next meeting.
• 20150611-028: The Buurtzorg Study visit will take place late January 2016.
• 20150910-045: JW and ME have spoken. Action now closed.

All other actions are either closed or on the agenda for discussion.

In discussing the outstanding actions, the Connecting Care Executive (CCE) discussed the ICES cost pressure which is currently forecast at £900k. AP expressed some concern despite the work which has been undertaken regarding mattresses and suggested the CCE considers additional actions to recover some of the forecast now.

The CCE discussed the immediate implementation of a new criteria and standing operating procedure; agreeing this approach was needed to prevent financial resources being wasted; adding there is evidence available to show the best approach for managing pressure sores. There was acknowledgement regarding risk, who makes the final clinical decision and governance arrangements etc. however, the CCE felt a safe set of operating procedures which match the clinical recommendations should be implemented.

The CCE also discussed the timeframe to implement this new procedure. JoW suggested there should be no delay if agreed and delegated authority should be given outside of the CCE to DrC, Sharon Wallis (SW), JoW, AB etc. to sign off the new procedure before going through a contractual route with Providers.

AN added because of concerns regarding this budget, WMDC are due to conduct a deep dive into the ICES forecast to ensure it is correct; however added some of the mattresses are leased/rented therefore there might be some notice period to be given if current rental agreements are to cease.

Continuing the discussions, JoW suggested delegated authority be given to AB as lead commissioner and to DrC to sign off the new standing operating procedure. In addition, JoW suggested WMDC deep dive team review what other areas could be considered as part of the national forecast etc. ACTION: New criteria and standing operating procedure to be written, approved and implemented as a priority; with delegated authority given to AB and DrC for implementation.

4. FOR DECISION: Wakefield Children Integration Scoping:

Referencing the supporting paper, IH advised a process to review the arrangements for complex care has been identified and draft Terms of
Reference have been written between WMDC and WCCG to govern the review process. IH also highlighted a couple of the key objectives/responsibilities and methodology of the review to the CCE; advising the intention is for the review to take place during December 2015 with recommendations available early January 2016 before sharing with the Stakeholder Group.

The CCE discussed the review; noting it was a good piece of work, a reciprocal arrangement would take place with NHS Oldham CCG and that some learning from this review could also benefit Adults Continuing Health Care. AB advised he has already had discussions with JW regarding colleagues from Adults attending meetings at appropriate times when feedback, analysis and lessons are being discussed in order to determine what might be transferable.

5. **FOR DECISION: Future In Mind Submission Update:**

Referencing the supporting paper, IH advised the Transformation Plan has:
- been assured today and funding is expected within the next few weeks;
- received very positive feedback from NHS England (NHSE) and Wakefield’s plan is to be used as an exemplar for other CCG’s in other areas as part of their regional development.

From the supporting paper, IH confirmed the funding allocated for Wakefield for 2015/16 for Eating Disorder Services and implementation of the transformation plan and an allocation of £160k has been announced for the CYPIAPT Programme therefore the total funding allocation is approximately £850k. This is expected to be recurrent over the next 5 years. IH also talked the CCE through each of the three national priorities and some of the eleven local priorities.

The CCE acknowledged the good work which has taken place before discussing the transformation plan going forward. In discussion JoW asked if a dashboard of indicators (simple metrics) could be made available to show the value added in terms of Children and Young People in Wakefield in order to be really clear on what success looks like and if targets are on track; feeling this is really important in terms of referring up to the Health and Wellbeing Board and linking to the district outcomes framework.

**ACTION:** AM and IH to work together to draft a dashboard of key indicators.

Discussion on how to develop a model for public services in regard to long term integrated working, the list of Providers and Commissioners involved in this work span the entire gambit and it was felt this message should have great attraction to the wider Local Services Board (LSB) footprint, it was therefore suggested the LSB are presented with the key elements of the paper; focusing on the partnership work. As a member of LSB and in
support of the suggestion raised, JoW proposed the Future in Mind Submission Update be included on the next LSB agenda.

6. **FOR DECISION: Joint Commissioning Mental Health and Learning Disabilities:**

LW and CM introduced their supporting paper in order to get a steer regarding the scope, level and type of integration in terms of commissioning services for Mental Health and Learning Disabilities; advising the paper attached has been updated since it was presented at a recent workshop in order to be clear regarding the next steps and actions.

Noting the stages of integration, LW advised Learning Disabilities and Mental Health are at slightly different stages, however both are on the lower levels of the ‘staircase’ depicted in the supporting paper; adding there has been less formal integration for Mental Health than Learning Disabilities, however there are no clear and formal structures in place.

LW continued to advise some joint commissioning is taking place for Learning Disabilities. In terms of Mental Health there has not always been a clear link between the two organisations in terms of sharing and understanding each other’s agendas, priorities, what already exists and how they may compliment, duplicate etc. LW also highlighted the scale of ambition and next steps before noting the recommendation to work towards a fully integrated joint commissioning.

AB confirmed the paper presented is for noting at this stage, however felt it was important to highlight the approaches being taken following the joint discussions between WCCG and WMDC where a level of agreement has been met regarding moving towards a more proactive future focused shared strategy and, as organisations, to begin a journey which delivers solid integrated commissioning.

The CCE discussed the paper and the work to be undertaken. In discussion it was suggested that Mental Health resources for this piece of work are re-scoped for inclusion into the Better Care Fund (BCF) from April 2016.

As part of a future update, JoW advised she would like to see articulated what the proposed changes are going to achieve at a lower level and asked if there would be a joint learning disabilities commissioning strategy for Wakefield. In addition, JoW felt it was a priority to know what is important to Wakefield and what is the basis in which WCCG and WMDC are developing in order to be able to influence in a positive direction.

In reply, AB commented that the notion of a shared strategy is in place and is at the forefront of colleagues minds as this moves forward; noting the next phase should include being very clear on the explicit outcomes
for this piece of work, the differences it will make, alignment of resources, the involvement of colleagues from children’s commissioning in the initial discussions regarding the scale of the ambition and details on how we commission across people’s lifespan rather than re-enforce traditional divides between commissioning for adults and commissioning for children.

7. FOR DISCUSSION: Digital Roadmap and Unit of Planning Update:

Referencing the supporting paper, RM explained the details and requirements of the Digital Roadmap submission to be made to NHSE by April 2016; advising the roadmap will describe how Wakefield will integrate local health and social care systems of data across Wakefield until 2020; by which time NHSE expect paper free delivery at point of care. RM added that some project management resource is to be taken from The Health Informatics Service (THIS) to deliver this piece of work and it is hoped this resource will be shared across Calderdale and Kirklees as some of the requirements will be common to both districts.

Regarding another associated piece of work, RM advised it was announced on 4 November 2015 that all Providers are to be asked to complete a Digital Maturity Index. This is to be completed by January 2016 before being publically published. The completion of this matrix is quite detailed in that it looks at the level electronic systems use and asks if electronic systems are being used effectively across all services and if the appropriate resources and capabilities in place to integrate internal and external systems.

The CCE discussed RM’s update including if there were any local blockages which needed to be addressed. RM advised in terms of most Providers, there are no blockages however some minor concern was expressed regarding MYHT who may request support from WCCG when they come to understand how much work is involved for the digital maturity index.

The CCE also discussed how this work will influence the Vanguards. RM advised there are benefits and risks. There is a risk for the MsCP vanguard, in that a solution will be purchased to meet their very immediate requirements which does not scale across the district and therefore felt there was a need to ensure the CCG understands what is happening and is kept closely and directly involved. However, RM confirmed he is in contact with Dr Chris Jones and has been involved in writing some of the MsCP specification. Positively, RM noted there may be future opportunities to trial some things at the Waterton Hub which will help inform the digital roadmap. The CCE agreed that the risk outlined should not occur and supported RM in working towards negating this risk.

The CCE also discussed the maturity index; suggesting consideration be given outside of the CCE regarding how joint collaboration can take place
with this piece of work if we are looking to try to develop an index which reflects the state of the district. RM advised when NHSE first raised the idea of a digital maturity index; the intention was for it to be on a local health economy basis; with one maturity index populated by every provider to show what the local community looked like. However, NHSE now intend to send the digital maturity index to NHS Trusts only with a different model (yet to be published) for GP IT Maturity. RM added some of this information will be required across all providers in order to obtain a complete picture; without it, there will be difficulties.

Continuing these discussions, JoW suggested this should be raised at today’s Connecting Care Health and Social Care Partnership (CCHSCP) meeting; so that it can be raised with Provider Chief Executives to advise them that the approach to developing the digital maturity index etc. should be governed through the ICT Group. The CCE agreed to this approach and that it should be documented in order to steer the production of the digital maturity index in the right direction. **ACTION:** JoW

Digital Maturity Index to be raised at CCHSCP.

8. **FOR DISCUSSION: Community Anchors:**

Introducing the supporting papers, LB advised the jointly created paper supports an argument for closer working with communities and for increased levels of investment in the provision of preventative health and social care and support services in the Wakefield district in 3 key areas.

Providing some context, AH advised:
- A Third Sector Strategy is in place within Wakefield District which sets out full commitments regarding the third sector; including:
  - involving citizens at a neighbourhood level more fully in whatever happens within the district and recognises the importance of their contribution;
  - increasing third sector involvement in the delivery of public services;
  - the voice of the third sector being in decision making places and planning
  - ambition regarding infrastructure i.e. NOVA
- The third sector is more than just community anchors and paternalistic.

Giving a presentation on Community Anchors, AH added the following:
- There are currently 20 established anchors in place in the district with a further 20 emerging;
- Wakefield District anchors are relatively small in comparison to other areas;
- A community anchor delivers services itself or in partnership with other organisations.

The CCE discussed Community Anchors, acknowledging previous
discussions regarding children’s mental health, asset based approach to understand what is currently in the system, the need for all agencies to look at prevention and early intervention etc. which all touch on the need to understand what is existing in our communities, what is part of that ecosystem, how that ecosystem can work with us and vice versa, and (with deliberate intent) how organisations look to support, nurture and develop those relationships to take forward to achieve the next steps. In discussion, AM advised work has already (tentatively) begun to see how commissioning levers can be used so that for future contracts (and as part of the services to be delivered) there is a stipulation included for links to be made to community anchors.

The CCE discussed communications and engagement and the third sector. It was suggested there may be a lack of knowledge on what the third sector can offer and therefore there was a need to describe what is meant by third sector. It was also noted the location of all Community Anchor sites may not be known, therefore health and social care sector colleagues may not necessarily be aware of what is available for patients within Wakefield District. In discussion, AM advised on 1 December 2015 a half day conference is taking place with Sir Sam Everington, Chair of Tower Hamlets CCG in East London in attendance to explain the Community Anchor he has been involved in with the voluntary sector. This conference will give the opportunity to hear about what is happening nationally and also provide some of the local examples.

The CCE also discussed the footfall for existing community anchors. In discussion it was suggested that a few of the anchors host a ‘seeing is believing’ type session/tour of what is available and perhaps a future CCE meeting is held at one of the community anchor venues.

The CCE also discussed recurrent investment. After thanking all those involved in Community Anchors and for contributing to the pioneers newsletter which has created a lot of interested nationally, MB noted the challenge ahead, advising that although there are monies from health and inequalities for £250k, Care Home Vanguard for £75k and MsCP for £50k, the challenge is how to continue this investment recurrently and therefore asked if a paper could be presented to a future CCE meeting detailing the investment Community Anchors/third sector would like to see recurrently so that the CCE and Wakefield can look to see how to commit to that as a district. MB acknowledged the current pressures of QIPP, organisational financial pressures etc. however MB felt there needed to be some commitment to this work recurrently. The CCE agreed to this proposal.

**ACTION:** LB to write a paper outlining recurrent investment requirements. 

9. **FOR DISCUSSION: Joint Planning Framework Update and Next Steps:**

Presenting the supporting paper AM advised several joint strategic
planning and commissioning meetings have taken place between WCCG and WMDC from which the mental health and learning disability work has emerged. Providing some national context, AM advised:

- Early indications have been received from NHSE regarding the direction of travel for CCG’s particularly around planning i.e. NHSE are definitely talking about health care systems, not just services and that sustainability in transformation between commissioners and providers working with local authorities therefore for the first time guidance will be sent to local authorities Directors of Adults and Social Care;
- There will also be a requirement to do an operational plan that is agreed across all commissioners and providers regarding quality and outcomes.

AM talked the CCE through the supporting paper, highlighting the vision, principles, risks and next steps.

The CCE discussed joint commissioning and planning, particularly how to deal with conflicts of interest. DrC gave an example of the service level agreement for the 0-19 service where clinicians have appeared to be conflicted. DrC felt this issue needed to be resolved in order to be able to describe and jointly use the expertise across the partnership; particularly when commissioning is changing. AM and HS agreed conflicts of interest is an issue which and needs to be considered within the governance framework, however, WMDC have procedures in place via the governance structure which provides resolutions in such circumstances. HS gave an example whereby at the beginning of meetings members are asked to indicate any interest in any agenda item and at that point a decision is made if it is appropriate for that member to remain for that agenda item. HS felt this policy would work in this instance; there would just be the requirement to ensure that any interest declared is documented, particularly prior to any bidding for any contract, and it would be the responsibility of members to declare any interests.

Continuing discussions, AB advised as joint working and new commissioning arrangements and Provider arrangements start to form in a different way, there is a real challenge regarding governance, risks and conflict of interest and was not sure if these issues have been addressed with the degree of robustness required for the future and suggested that a CCE collective view be considered. It was further suggested that a sense check takes place on future governance plans and proposals in the new year for 2016/17. The CCE agreed to note this report.

10. FOR DISCUSSION: Communications and Engagement Review:

JB acknowledged how much has been achieved in communications and engagement since the strategy was written, however as this was 15 months ago, it was felt now was the right time to do a review and refresh.
JB talked the CCE through the Executive Summary supporting paper, specifically highlighting that organisational development was a really strong theme in the conversations held and that Steven Michael had suggested his OD Framework could be used and rolled out so that some OD work is conducted with middle managers across the patch and therefore suggested this requires further inspection and consideration. Regarding OD, AB advised at today’s CCHSCP meeting, one of the agenda items is regarding Workforce development and therefore suggested there may be an opportunity to link the internal management communication challenge and the workforce project together.

After thanking JB for all her hard work, MB referenced the CCEs earlier discussion regarding Community Anchors. MB acknowledged there is reference to the Community Anchor launch on 1 December 2015 in JB’s Executive Summary paper, however from earlier discussions; it was felt consideration should be given to how Community Anchors can help engage with communities who are more hard to reach by the public sector. MB also noted there may be some challenge from CCHSCP members regarding how we engage with Community Anchors moving forwards. In addition, in terms of Kevin Dodd’s (KD) Communications and Engagement SRO role, could the CCE be clear after today’s meeting KD remit is; adding he is able to support this work and will attend future CCE meetings as SRO to update on progress.

Referencing the recommendations in the supporting paper, JB advised:
- streamlined and simplified messages are needed for all staff to use in the respective organisations;
- re-launch of Connecting Care to our own middle management in organisations i.e. hold a district wide event to launch Connecting Care as a Chartermark at which Chief Officers speak to selected groups of middle managers who are invited to this event to advise them what Connecting Care means to them.

The CCE agreed to the re-launch event for connecting care, however noted the timing will be critical considering what else is taking place. In addition, AB requested when consideration is given to some of the recommendations for future meetings, to try and do a small number of things simply but well, rather than trying to do too much.

Highlighting the opportunities to tie up communications and workforce planning to address the OD questions raised, AB acknowledged the amount of communication received by middle managers and suggested it was more difficult for middle managers to disseminate and determine what is really important and felt if a small number of key priorities can be highlighted for them; that would be really helpful.
11. **FOR DISCUSSION: Better Care Fund (BCF) Pooled Financial Monitoring Report:**

Referencing the supporting paper, AR outlined the history of the BCF, highlighted there is now a £1.85m pressure and advised the Health and Wellbeing Board need to sign off (before 27 November 2015) Quarter 2 BCF return to NHSE; adding the BCF remains at £41.693m for both funding and expenditure. In terms of forecast, £42.24m now needs to be reported to NHSE which would result in a commitment that Wakefield District has £42.24m of funding to pay for that expenditure otherwise it is nonsensical in terms of the return submitted. AN added within the £41.6m original BCF submission, a pressure on funding of £1.3m has been reported; split into two elements (£955k overall and £351k for Care Act Capital Funding). Regarding, the Care Act Capital Funding and forecasting, it is not being forecast to spend that, therefore AN was not sure if it needed to be found as there are no plans to spend it; therefore AN asked if the size of the pool needed to be reduced.

The CCE discussed the BCF. AP noted the national templates do not help our understanding of requirements and a less complex analysis is being worked on to present to the CCE and other groups. There are two elements driving this review; ICES (discussed earlier and there is now a management plan in place to deal with this) and the Care Act.

AP acknowledged AN comments in terms of what are the costs of Care Act implementation and asked what are they both non recurrently and are there any recurrent links to that and therefore suggested before going to Health and Wellbeing Board, this dimension needed to be understood further. In addition, AP also suggested the numbers shown today are what they are and if they satisfy the immediate requirements for month 6 return, any consequences should be dealt with afterwards. AP added he would be reluctant to move away from the headline of £41.7m because it entrenched in everyone’s mind at this point in time.

Given the timescales AR has eluded to and the concerns raised regarding £351k, it was suggested that a discussion takes place in the next week to see if a joint position can be agreed, to agree how to approach any mitigating actions that might be required and to agree how to report both in respect of individual organisations, Health and Wellbeing Board and nationally. The CCE agreed to this action. **ACTION:** Meeting to be arranged between WCCG and WMDC finance colleagues/teams.

**Additional BCF Funding Resource:**

MB informed the CCE information has been provided regarding the possibility of putting forward a submission for additional BCF funding to a maximum of £50k. MB advised:
• Funding has to be applied for based on national conditions and has asked her team to start developing ideas on this;
• A submission should be made by 6 November 2015, though a later submission can be made in one month’s time (however there might not be as much resource available);
• The national conditions have reviewed and RM and colleagues have been doing work on the NHS Identification Number. At the moment WCCG have commissioned some resources in the Joint Legacy Fund to support the NHS Identification Number, therefore if these additional funds are applied for, it will release the initial resources back into the Joint Legacy Reserves pot.

MB asked the CCE to confirm if they are happy for a submission to be made. The CCE agreed to progress the bid.

12. FOR DISCUSSION: Specialised Wheelchair Services:

This agenda item was deferred to a future meeting.

13. FOR INFORMATION: Items of Interest re Single Agency Commissioning that may impact on Partners:

No items of interest were raised.

14. FOR INFORMATION: Joint Legacy Reserves:

Referencing the supporting paper, AN highlighted there is a shortfall on ICES and the BCF and that some potential resource to cover this may be available within the reserves. The CCE agreed the reserves are to be considered as part of the BCF Quarter 2 submission discussions.

15. FOR INFORMATION: Vanguard Commissioning Sub Group Actions:

MB confirmed the next meeting is taking place on 13 November 2015, and the actions from the first meeting are noted on the supporting paper. If the CCE feel this format is helpful, this will continue.

In discussion, AP advised the paper provided is very helpful, however asked if a focus could also be given on financial values to give a sense of scale.

AB also suggested it would be helpful, given the importance of some of the activity being tested via Vanguard, that this information is reported to the CCE and provides details of achievements and what has changed as a result of the investment.
16. **FOR INFORMATION: Hospital to Home Service:**

LB advised this service re-started two weeks ago and early indications are that it is doing brisk business and initial indications are positive, however there is nothing formal to report at this time though there are plans to do so as information is received. In addition conversations are to take place regarding the continuation of the project beyond April 2016.

17. **FOR INFORMATION: Local Section Agreements:**

MB advised the supporting paper closes off some agreements which have been ongoing for some time. AP observed there is a lot of money which changes between WCCG and WMDC and is controlled via a contract summary which still needs to be signed and page 4 of the supporting paper details a lot of historic agreements and suggested that a piece of work is undertaken to understand the value added associated with the agreements listed.

In discussion, AN advised some internal WMDC resource is trying to be obtained to review these agreements listed i.e. to get some background etc. In terms of things moving forward, AB would be keen to review some of the historical agreements and noted a number of those listed focus on third sector and preventative activity and felt there was an opportunity to tidy things up and be more coherent going forward. LB offered to assist in the review of these agreements.

18. **Any other Business:**

No items were raised.

19. **Date and Time of Next Meeting:**

Thursday 10 December, 9.00am to 11.00am in Seminar Room, White Rose House
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<th>Title of meeting:</th>
<th>Governing Body</th>
<th>Agenda Item:</th>
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<tr>
<td>Date of Meeting:</td>
<td>12 January 2016</td>
<td>Public/Private Section:</td>
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<tr>
<td>Paper Title:</td>
<td>Probity Committee: presentation of minutes and items for approval by Governing Body</td>
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<td>Purpose (this paper is for):</td>
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<td>Discussion</td>
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<td>Committee chair:</td>
<td>Rhod Mitchell – Lay Member</td>
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<td>Meeting minutes enclosed:</td>
<td>13 October 2015</td>
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It is recommended that the Governing Body receive and note the minutes of the Probity Committee held on 13 October 2015.

**Executive Summary:**

**Care Homes LES**
- models of care in place for the primary care elements for the care homes vanguard
- Aims to offer one GP practice to one care home model
- provide higher quality service to this vulnerable and medically complex population
- funding supported until March 2016, review to take place in September 2015
- Cost benefit analysis taken place which shows a 12.5% reduction in admissions to hospital. Approximately 2000 patients will benefit from this scheme.

**Network Development Framework approval of payments**
- Thirty eight practices have met or exceeded the KPI target for additional clinical activity in Q2. One practice has missed the target for Q2 but this was anticipated as part of the remediation plan and one practice has missed the target for Q2 and so failed to deliver its remediation plan.
- Practices have provided 33,800 additional patient contacts in Q2 and the total additional contacts provided by practices in the six quarters of the NDF to 30 September 2015 is 209,569.

**Terms of Reference Review and Report to Audit Committee meeting: progress against work plan**
- Proposed changes to the Probity Committee Terms of Reference presented in line with delegation agreement.
NHS Wakefield Clinical Commissioning Group

PROBITY COMMITTEE

Minutes of the Meeting held on 13 October 2015

Present: Rhod Mitchell (Chair) Lay Member
Sandra Cheseldine Lay Member
Andrew Pepper Chief Finance Officer
Jo Pollard Chief of Service Delivery & Quality
Stephen Hardy Lay Member
Hany Lotfallah Secondary Care Consultant

In Attendance: Lesley Carver Senior Project Manager
Nichola Esmond Healthwatch Representative
Mark Jenkins NHS England
Gemma Reed Minute Taker
Pat Keane Director of Strategy and Organisational Design
Cllr Pat Garbutt Health and Wellbeing Board Representative
Catherine Wormstone Programme Manager

15/38 Apologies

Apologies were received from Sharon Fox, Greg Connor, Jo Webster, Katherine Bryant and Kathryn Hilliam

15/39 Welcome and Introductions

Rhod Mitchell welcomed everyone to the meeting.

15/40 Declarations of Interest

No declarations were made.

15/41 Minutes from meeting held on 22 September 2015

The minutes from the meeting held on 22 September 2015 were agreed as an accurate record.

15/42 Actions from meeting held on 22 September 2015

All actions were noted.

Catherine Wormstone informed the committee that a breach notice issued at King Street and a meeting is scheduled with the practice to discuss staffing issues. It was noted that the CCG has been informally notified that another breach has occurred and formal notice of position is imminent.
Matters Arising

A Quality Impact Assessment is taking place regarding Orchard Croft branch closure. It is anticipated that there will be an increase in interest; therefore a communication brief is being developed. Further update to be provided at November meeting.

Care Homes LES

Lesley Carver briefed members regarding the models of care in place for the primary care elements for the care homes vanguard which aims to offer one GP practice to one care home model, therefore aligning practices to care homes in the future. It was noted that larger homes of more than 40 beds can be shared by one GP practice.

The aim is to facilitate primary care practitioners to take a proactive, patient-centered approach to caring for people registered with their practice living in care homes. This would be by using a multi-disciplinary approach to provide higher quality service to this vulnerable and medically complex population.

Discussion took place regarding the financial resources available to support this scheme. The CCG is awaiting the outcome of whether additional funding to support the vanguards is available; this is expected in November 2015. However in the interim it was agreed that funding was supported until March 2016, with a review to take place in September 2016.

A cost benefit analysis has taken place which shows a 12.5% reduction in admissions to hospital. Approximately 2000 patients will benefit from this scheme. However work is needed with care home residents to promote this scheme.

Work has taken place to map the number of residents against each practice across each network. Discussions have been held with the LMC regarding the service specification and it was agreed that no care homes should not have access to a GP.

The model is aimed to be wider than a medical model and the CCG is working with stakeholder such as Age UK for holistic assessment tools within care homes. This scheme will ensure that there is greater access to additional staff, system one, nhs mail, training will be available for all staff in care homes, family and friends, community anchors to improve the quality of care for individuals in care homes.

It was RESOLVED that the:

(i) Probity Committee approved the enhanced service for primary care, care home vanguard model.

Network Development Framework approval of payments
Pat Keane presented this paper informing the committee that a detailed review of NDF framework for Q2 has taken place. Thirty eight practices have met or exceeded the KPI target for additional clinical activity in Q2. One practice has missed the target for Q2 but this was anticipated as part of the remediation plan and one practice has missed the target for Q2 and so failed to deliver its remediation plan.

Overall practices have provided 33,800 additional patient contacts in Q2 and the total additional contacts provided by practices in the six quarters of the NDF to 30 September 2015 is 209,569. The Governing Body are to be made aware of the excellent work that has taken place in achieving this.

It was RESOLVED that the:

(i) Probity Committee approves the report of the NDF Scrutiny Panel including the proposals for payments to practices.

15/46 Terms of Reference Review and Report to Audit Committee meeting: progress against work plan.

Gemma Reed presented this paper which highlighted changes to the Probity Committee Terms of Reference in line with the delegation agreement as part of the programme for annual review of the terms of reference of all Governing Body Committees.

The committee asked that a definition be included which clarifies local incentive schemes and local enhanced services.

It was noted that primary care complaints will be included in the primary care quality dashboard once this available. The governance structure in relation to the primary care vanguard is agreed at Board level and this is though a single committee.

It was RESOLVED that the:

(i) Probity Committee delegated authority to the Chair of the Probity Committee to approve the updated terms of reference
(ii) Probity Committee notes the mid year progress report presented to Audit Committee.

15/47 Any Other Business

Nothing further discussed.

it was RESOLVED that:

(i) 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)
Date and Time of Next Meeting

Tuesday 24 November, 2.30 to 4.30 pm, White Rose House.
HEALTH AND WELLBEING BOARD

Thursday, 17 September 2015

Present: The Chair Councillor Mrs Garbutt
The Deputy Chair Dr P Earnshaw
Councillor Ayre WMDC
Councillor Forster WMDC
Ms J Roney OBE Chief Executive, WMDC
Mr A Balchin Corporate Director, WMDC
Mr J Wilson Corporate Director, WMDC
Dr A Furber Director of Public Health
Ms J Webster Accountable Officer CCG
Mr P Keane Director Strategy and Organisational Design, CCG
Dr A Carroll CCG Representative
Mr S Hardy Non-Executive Member of CCG
Mr S Eames Mid Yorkshire NHS Trust
Mr K Dodd Wakefield and District Housing
Mr S Whitehead West Yorkshire Police
Ms P Bee Voluntary Sector Representative

25. ACCEPTANCE OF APOLOGIES FOR ABSENCE
Apologies for absence submitted prior to the meeting were accepted on behalf of Mr J Webb, Mr P Loosemore, Mr S Michael OBE and Ms L Harris.

26. MINUTES - 30 JULY 2015
Resolved – That the Minutes of the meeting of the Health and Wellbeing Board held on 30 July 2015 be approved as a correct record.

27. CHAIR’S ANNOUNCEMENTS
The outcome of the Mid Yorkshire NHS Trust CQC inspection carried out in June was expected in October 2015. Early feedback had been positive.

It was noted that National Hate Crime Awareness Week would take place from 10 – 17 October 2015. The purpose of the week was to tackle Hate Crime issues by raising awareness of what Hate Crime is and how to respond to it, encourage reporting, and promote local support services and resources. Work was also underway throughout the District to identify and prevent cases of Female Genital Mutilation.

An email had been received from the CQC advising that Wakefield had been chosen as one of eight areas that would participate in a review of Integrated Care for Older People, which would take place between October – December 2015. The Board would be informed when further information was available.

28. MEMBERS DECLARATIONS OF INTEREST
No declarations of interest were made.

29. PUBLIC QUESTIONS
No questions had been submitted by members of the public.

30. WEST YORKSHIRE URGENT EMERGENCY CARE NETWORK VANGUARD
The Board was provided with a presentation on the Urgent and Emergency Care Vanguard. The Vanguard was tasked with developing new approaches to improve the
coordination of urgent and emergency care services and reduce pressure on A&E departments. It presented an opportunity to accelerate national change, building on the progress already made at a local level in transforming primary, community and acute care services. The West Yorkshire Urgent Emergency Care Network had been established in 2014 and its membership included CCGs and NHS Trusts from Leeds, Bradford, Calderdale, Kirklees, Wakefield and Harrogate.

Members were provided with an overview of the work undertaken by the Network so far and what work would be undertaken as part of the Vanguard commitment. Future challenges included strengthening the system-wide leadership and adding value to the role of paramedics and ambulance technicians so that the Yorkshire Ambulance Service was recognised as a mobile treatment service rather than simply a means of transport to hospital.

The NHS England Vanguard Team would carry out a site visit in late October 2015 to ensure that the Network was on track and the West Yorkshire Urgent Emergency Care Vanguard Value Proposition would be submitted in late November 2015. Regular updates would be provided to the Board.

Resolved – That the report be noted.

31. CRISIS CARE CONCORDAT - ACTION PLAN
Consideration was given to a report detailing progress against the Crisis Care Concordat Action Plan, which outlined a range of initiatives that were designed to ensure that all key partners in Wakefield were able to work collaboratively to support people in mental health crisis.

Key successes for the period March – August 2015 included the pilot of a new data collection tool that aimed to ensure consistency in information gathered with regard to S136 detentions through usage of a standard template. In addition, Wakefield CCG had been successful in securing Children and Young Peoples IAPT status, which aimed to improve existing community Child and Adolescent Mental Health Services.

A draft suicide prevention action plan was in the process of being developed using the findings of a recent suicide audit and it was suggested that it would be beneficial for the Board to have sight of the action plan once it was complete.

Planned tasks for the next period included more detailed consideration of a letter sent by the Minister of State for Community and Social Care, which had asked CCGs to give thought to a number of issues including patient experience of crisis care.

Resolved – That the progress report be noted.

32. FUTURE IN MIND PROPOSAL
Board Members were provided with a presentation on Future in Mind, a national programme aimed at transforming children and young people’s mental health and wellbeing services. A Children and Young People’s Health and Wellbeing Taskforce had been established in 2014 and had issued a report in March 2015 that set out key proposals to transform the design and delivery of a local offer of services for children and young people with mental health needs. The report had identified the following key themes:

- Promoting resilience, prevention and early intervention
HEALTH AND WELLBEING BOARD - THURSDAY, 17 SEPTEMBER 2015

- Improving access to effective support
- Care for the most vulnerable
- Accountability and transparency
- Developing the workforce

A local Transformation Plan would be developed in response to the Taskforce report and a project group made up of key stakeholders had been established to lead on the Plan’s development. Clear guidance on the structure and content of the Plan was available and governance arrangements and reporting routes would be in place to manage its development and implementation and monitor improvements. Subject to approval of the Plan, funding would be available to support its implementation and delivery.

The Transformation Plan would be submitted to NHS England and the Department of Health for feedback and approval before its publication. Ongoing commitment to the five-year Plan was required from all partners to ensure that changes were embedded by 2020.

Resolved – 1) That the report be noted.

2) That the Transformation Plan be approved.

33. 24/7 WORKING IN PRIMARY CARE
Consideration was given to a presentation detailing proposals to improve access to primary health care. It was reported that 90% of NHS contacts were within primary care, which included services such as dentistry and optometry as well as GP practices. Access to appointments remained a key issue for patients within the Wakefield District and one of the CCG’s priorities was to make it easier for patients to get appointments at local practices and improve access to ‘urgent’ care. The contract for the King Street walk-in centre was due to expire and, following consultation around primary care access, consideration would be given to the District’s walk-in provision. Examples of work that was already being carried out were provided, which included additional routine and urgent appointments (8am to 8pm, 7 days a week) in West Wakefield and nurse-led triage.

A query was raised as to whether a record was kept of abandoned calls to GP surgeries as this would provide a true picture of demand. It was acknowledged that some surgeries did have the technology needed and that the information collated could be used more intelligently to inform decision-making.

The importance of extensive public engagement was emphasised to ensure that clear and consistent messages regarding the future shape of services were being given. It was suggested that the Board should have sight of an overall plan, which would bring together all ongoing and proposed projects and schemes, together with details of public engagement strategies.

Resolved – That the report be noted.

34. PHYSICAL ACTIVITY - DRAFT STRATEGY
At the Board meeting held on 30 July 2015, Members had received a presentation on the Physical Activity Strategy and Action Plan. Consideration was now given to further information regarding existing assets and resources throughout the District that would facilitate the delivery of the Strategy. ‘Get Wakefield Moving’ - a free guide to facilities
HEALTH AND WELLBEING BOARD - THURSDAY, 17 SEPTEMBER 2015

and activities that were on offer had been published and work was also being undertaken to explore ways to maximise the potential of existing assets, for example through social media marketing.

A Workplace Charter was in the process of development and it was hoped that each organisation would nominate a representative to attend the related network meetings.

It was reported that the Yorkshire and Humber Academic Health Science Network was delivering a Workplace Wellness programme in partnership with Sheffield Hallam University. The programme offered individualised health checks, lifestyle management advice, one-to-one coaching and educational workshops to raise awareness on topics including exercise, healthy eating, mental wellbeing and resilience. It was suggested that a representative from the Network be invited to attend a Board meeting to present information on the pilots and schemes on offer in relation to the retention of a healthy workforce.

Resolved – (1) That the report be noted.

(2) That further information relating to the Academic Health Science Network’s Workplace Wellness programme would be shared at a future meeting.

35. CHALLENGES FOR THE HEALTH OF WAKEFIELD - UPDATE
Consideration was given to a report updating the Board on discussions that had taken place with regard to Health and Wellbeing priorities for 2016/17 onwards, together with details of current priorities and future challenges. A number of issues had been identified as particular challenges as they cut across Wakefield’s current partnership arrangements. However, the Chairs and co-ordinators of Wakefield’s partnerships would meet regularly to oversee how these cross-cutting issues were being dealt with. It was felt that a clear narrative on how priorities and performance were being managed was needed and that, given the scale of the issue, a dedicated substantive agenda item was required.

Resolved – (1) That the report be noted.

(2) That a substantive item to specifically consider matters relating to performance review and management be included on future agendas.

36. DISTRICT OUTCOMES FRAMEWORK - DELIVERY PLANS
An update on the Delivery Plans would be circulated to Board Members following the meeting and the matter would be considered in greater detail at the next Board meeting.

Resolved – That the District Outcomes Framework Delivery Plans be considered at the November 2015 meeting of the Health and Wellbeing Board.

37. CONNECTING CARE EXECUTIVE
A report detailing some of the highlights of the recent Connecting Care Executive meetings had been circulated for information.

Resolved – That the report be noted.

38. CARE HOME AND MSCP VANGUARD GOVERNANCE ARRANGEMENTS
At the June 2015 Board meeting, Members had been informed that the Wakefield District had been successful in a bid to lead two national vanguards to develop new
HEALTH AND WELLBEING BOARD - THURSDAY, 17 SEPTEMBER 2015

Models of Care for both a Multi-Speciality Community Provider and Enhanced Care Homes. It was reported that both vanguard programmes had now submitted business cases for their delivery models and approval was awaited. The Board’s approval was sought for the governance arrangements for both vanguard programmes. This would involve the establishment of a Connecting Care Executive sub-group, which would provide the vanguards with the appropriate governance arrangements.

Resolved – That the updated Connecting Care Executive Terms of Reference, the proposed vanguard governance arrangements and the Terms of Reference for the Wakefield Vanguard Commissioning Group, as detailed within the report be approved.

39. BETTER CARE FUND - QUARTERLY REPORT
Consideration was given to a report detailing what had been achieved to date with regard to the Better Care Plan. As the Health and Wellbeing Board was responsible for the performance review and oversight of the Better Care Fund, further progress reports would continue to be submitted on a regular basis. It was suggested that future reports included data on the outcomes of those people who had not attended A+E.

Resolved – (1) That the Better Care Fund key performance data be noted.

40. DATE AND TIME OF NEXT MEETING
Resolved – That the next meeting of the Health and Wellbeing Board be held on Thursday 26 November 2015, at 12.30pm, in the Old Restaurant, Town Hall, Wakefield.