West Yorkshire and Harrogate
Health and Care Partnership

West Yorkshire & Harrogate
Joint Committee of Clinical Commissioning Groups

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<tr><td>Report title:</td><td colspan="3">Urgent and emergency care Provider collaboration review - CQC West Yorkshire and Harrogate ICS</td></tr>
<tr><td>Joint Committee sponsor:</td><td colspan="3">Jo Webster</td></tr>
<tr><td>Clinical Lead:</td><td colspan="3">Dave Tatham, GP and Clinical Lead Bradford CCGs / UEC Programme</td></tr>
<tr><td>Author:</td><td colspan="3">CQC / Louise McKelvey, Programme Manager, UEC Programme</td></tr>
<tr><td>Presenter:</td><td colspan="3">Louise McKelvey</td></tr>
<tr><td colspan="4">Purpose of report: (why is this being brought to the Committee?)</td></tr>
<tr><td>Decision</td><td></td><td>Comment</td><td>✓</td></tr>
<tr><td>Assurance</td><td>✓</td><td></td><td></td></tr>
<tr><td colspan="4">Executive summary</td></tr>
<tr><td colspan="4">The Care Quality Commission conducted a provider collaboration review in to Urgent and Emergency Care during October 2020. Provider collaboration reviews (PCRs) look at how health and social care providers are working together in local areas. They aim to help providers learn from each other's experience of responding to coronavirus (COVID-19). WY&H was one of eight ICSs chosen to take part in this particular review.

Deep dive reviews were conducted in Kirklees and Harrogate due to the size of the overall patch and the time the team had to conduct the review. Kirklees and Harrogate were chosen to give a contrasting picture due to the differences in their demography and geography. However the pathway itself was reviewed across all places in WY&H.

The first set of slides (Annex 1) were authored by CQC and outline the findings of the review and highlight areas of good practice and areas for future focus. The second set of slides (Annex 2) is the high level feedback to the review findings, facilitated by the UEC Programme Board. However, further work will need to be undertaken with place, providers and across other ICS programmes to embed any findings that require substantial change.

The final CQC report will be published in January 2021 (date TBC).

In conclusion the CQC final findings reflected:
• Overall the system appeared to work well together.
• There were well established partnerships which had mature partnerships allowing effective collaboration.
• Covid broke down hurdles to achieving shared objectives across the ICS and within individual sectors.</td></tr>
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Recommendations and next steps	
The Joint Committee of Clinical Commissioning Groups is asked to note the attached slides and areas of best practice and areas for future focus.	
Delivering outcomes: describe how the report supports the delivery of outcomes (Health and wellbeing, care and quality, finance and efficiency)	
The findings of the review and identification of areas for future focus will enable high quality personalised care for patients across the Urgent and Emergency Care system. Positive changes that have improved patient journeys will be reviewed and used to inform decisions and future planning, both across the ICS and within the Urgent and Emergency Care Programme. The findings align with the direction of travel for the Urgent and Emergency Care Programme, where health inequalities, workforce and digital solutions will form key workstreams for 21/22.	
Impact assessment (please provide a brief description, or refer to the main body of the report)	
Clinical outcomes:	The CQC findings concluded the overall the system appeared to work well together, there were well established partnerships which had mature partnerships allowing effective collaboration and covid broke down hurdles to achieving shared objectives across the ICS and within individual sectors. These factors contribute positively to clinical outcomes across WY&H.
Public involvement:	CQC consulted with Healthwatch to ensure there was public involvement in the Provider Collaboration Review. The findings include feedback from the public around a number of issues relating to the covid-19 pandemic.
Finance:	None
Risk:	The CQC did not escalate any specific risks but have outlined in their areas of future focus, particular findings that may carry risk if not addressed.
Conflicts of interest:	None

Annex 1

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Provider Collaboration Review

West Yorkshire and Harrogate Integrated Care System (ICS) Urgent and Emergency Care PCR

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Provider Collaboration Reviews

How have providers worked collaboratively in a system in response to the COVID -19 pandemic?

The Scope

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- The journey for people using **urgent and emergency care** with/without COVID-19 across health and social care providers

- The objective is to **support providers** across systems by sharing learning on the COVID 19 period and on how providers are re-establishing services and pathways in local areas.

The outputs

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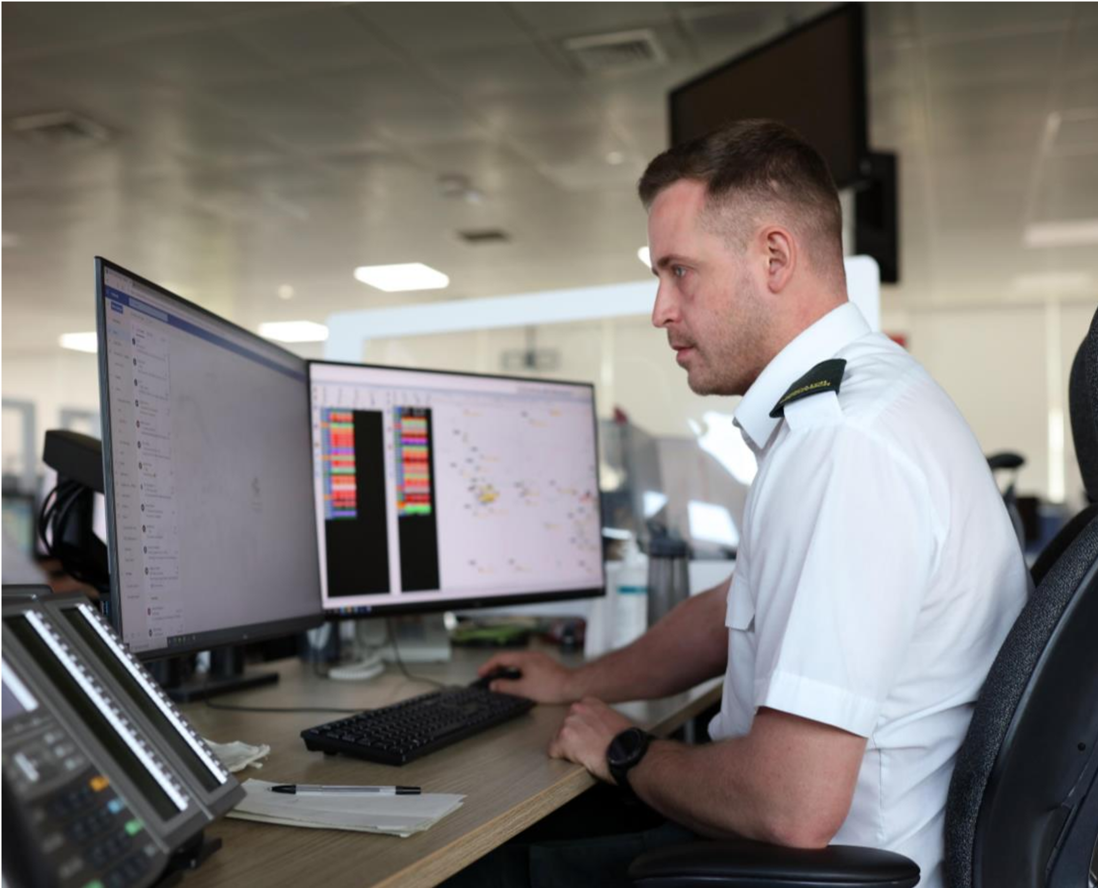

- Feedback for each local system
- Insight report: December 2020
- Final report: in-depth report in January 2020.

Key Lines of Enquiry

- How have providers **collaborated** to ensure that **people** moving through health and care services have been seen safely in the right place, at the right time, by the right person?
- Was there a **shared plan** and system wide governance and **leadership** during the COVID -19 period?
- Was there a plan for ensuring the **safety of staff**, and sufficient health and care skills across the health and care interface during the COVID -19 period?
- What impact have **digital solutions** and technology had on providers and services during the COVID -19 period?

How we carried out this Review

- We carried out this review in the weeks 5 and 12 October 2020.
- We spoke with a range of health and social care staff, senior managers and executive leaders.
- We carried out 24 interviews with groups of people from such services as social care, primary care, mental health, A&E, Out of Hours (OOHs), staff from local A&E Boards and the ICS.
- This review covered the geographical footprint of West Yorkshire and Harrogate integrated care system (ICS). Because of the size/complexity of ICS, the focus was primarily on Kirklees and Harrogate areas.
- The review did not assess the role that commissioning plays within the system as we do not have the legal powers to comment on the commissioning of services.

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Provider Collaboration Review

Analytical Data
West Yorkshire and Harrogate ICS.

West Yorkshire and Harrogate ICS in context 1/2

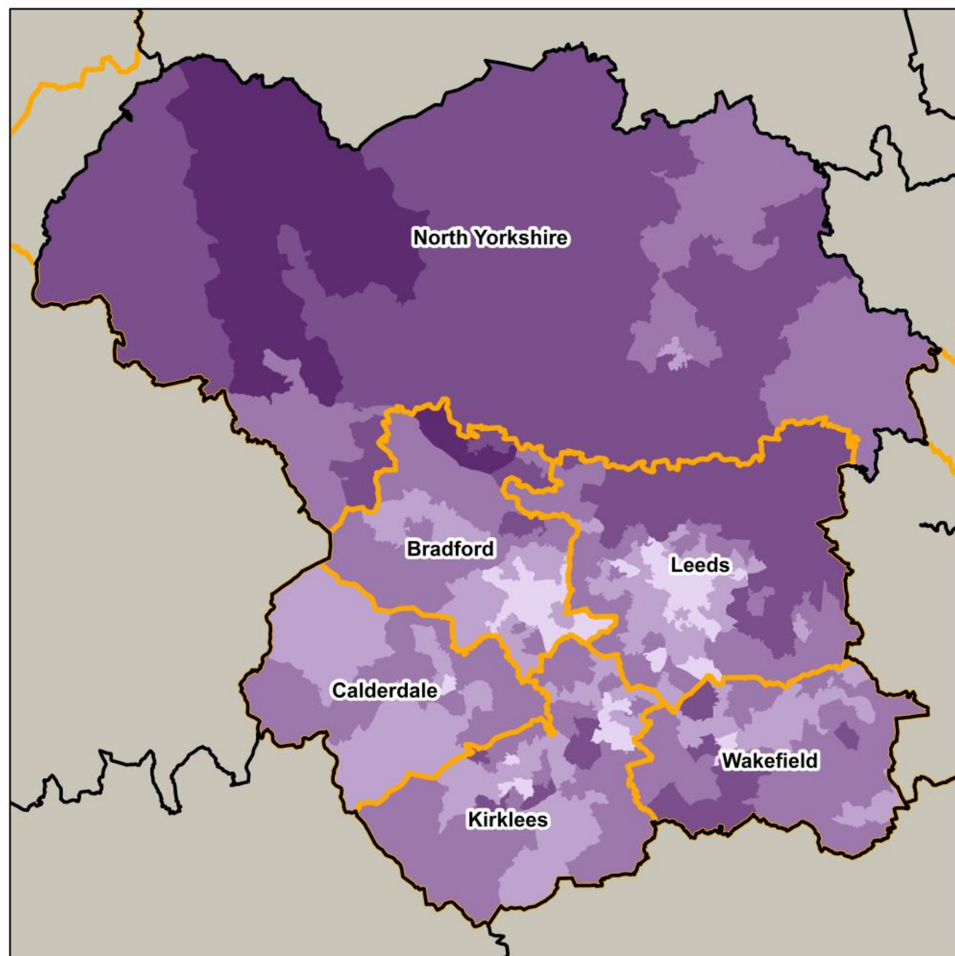
The following organisations are part of West Yorkshire and Harrogate ICS:

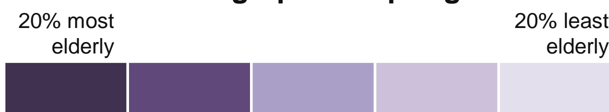
- **Clinical Commissioning Groups (CCGs)**: Bradford District and Craven; Calderdale; Greater Huddersfield; Harrogate and Rural District; Leeds; North Kirklees; Wakefield.
- **Councils/Local Authorities (LAs):** Bradford; Calderdale; Craven District; Harrogate Borough; Kirklees; Leeds; North Yorkshire; Wakefield.
- **NHS trusts and foundation trusts (hospitals)**: Airedale; Bradford; Calderdale and Huddersfield (C&HFT); Harrogate and District; Leeds; Mid Yorkshire.
- **NHS trusts and foundation trusts (mental health (MH) and community):** South West Yorkshire Partnership (SWYPT); Leeds and York Partnership; Bradford District Care; Leeds Community Healthcare.
- **Others:** GP Federations/primary care networks (PCNs); Yorkshire Ambulance Service (YAS); Local Care Direct; Locala; voluntary and community partners; Public Health England; Health Education England; Healthwatch; NHS England; NHS Improvement.

West Yorkshire and Harrogate ICS in context 2/2

- **Proportion of older people:** The age of the population varies quite a lot across the system. Harrogate has an older population than the other LAs in the system, while Bradford and Leeds have younger populations, especially centred around the cities.
- **Deprivation:** There is a lot of variation in deprivation levels across most of the system. Harrogate is generally less deprived, while in each of the other LAs there are large areas of high deprivation.
- **BAME populations:** Bradford and Kirklees have comparatively high percentages of the population from BAME communities, followed by Leeds and Calderdale. Wakefield and North Yorkshire have lower percentages of people from BAME communities.

West Yorkshire and Harrogate ICS in context – age profile



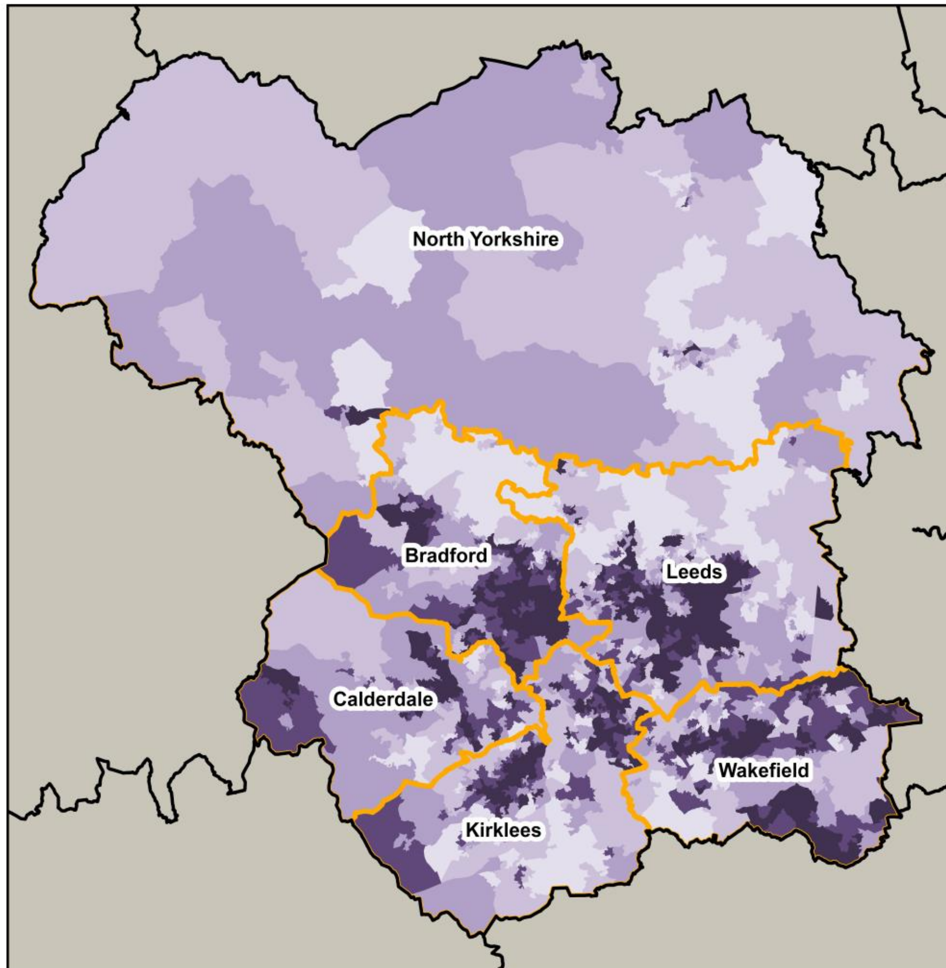


Darker purple areas show where a higher percentage of the population are aged 65+. Orange lines refer to the Local Authority boundaries. The LAs that overlap with the system are labelled.

The age of the population varies quite a lot across the system. The part of North Yorkshire that sits within the system has an older population than the other LAs in the system, while Bradford and Leeds have younger populations, especially centred around the cities.

Source: ONS- 2011

West Yorkshire and Harrogate ICS in context – deprivation



Darker purple areas show where a higher percentage of the population are deprived based on the 2019 Indices of Multiple Deprivation. Orange lines refer to the Local Authority boundaries. The LAs that overlap with the system are labelled.

There is a lot of variation in deprivation levels across most of the system. However, compared to other LAs in the system North Yorkshire is generally less deprived, while in each of the other LAs there are large areas of high deprivation.

Source: IMD - 2019

West Yorkshire and Harrogate ICS in context – ethnicity

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Demographic map- Ethnicity

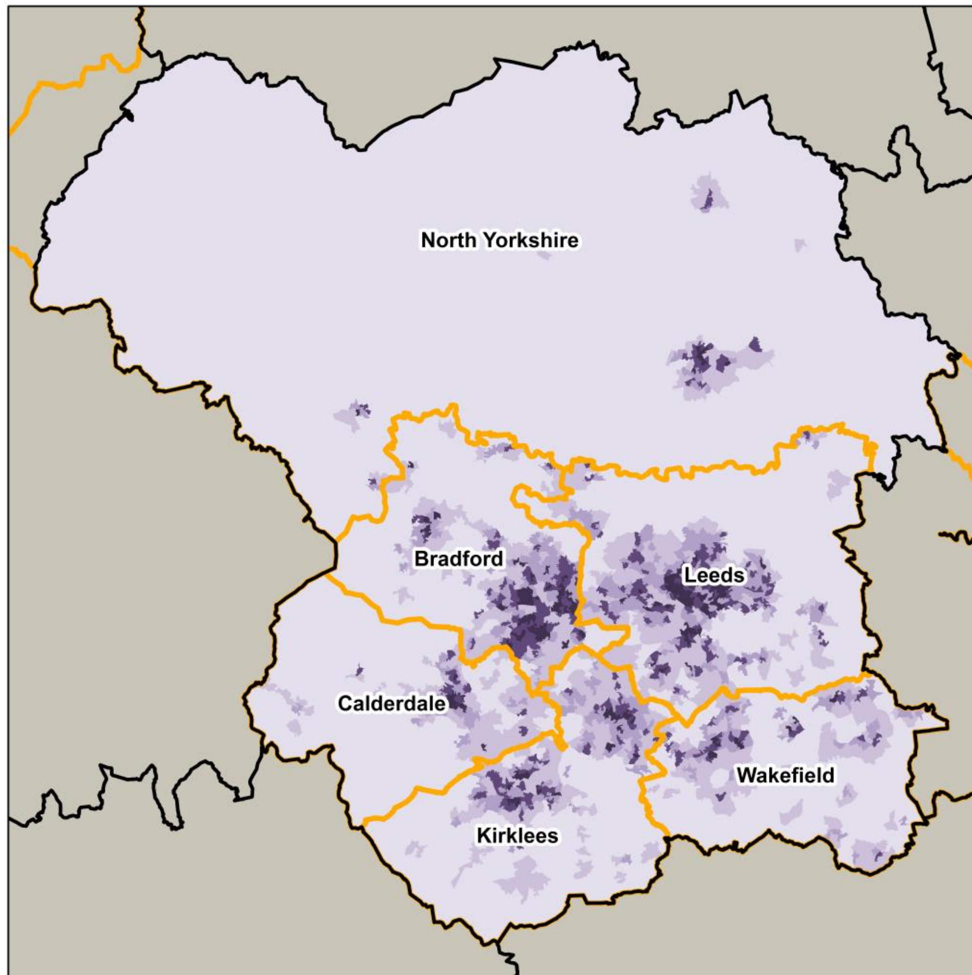
Darker purple areas show where a higher percentage of the population are BAME. Orange lines refer to the Local Authority boundaries. The LAs that overlap with the system are labelled.

While most of the system has very little ethnic diversity, there are some areas Calderdale, Kirklees, Leeds and Bradford in particular where a comparatively high percentage of the population is from BAME communities.

Compared to the other LAs in the system, Wakefield and North Yorkshire have a lower percentage of people from BAME communities.

Source: NOMIS - 2015

West Yorkshire and Harrogate ICS in context – population density



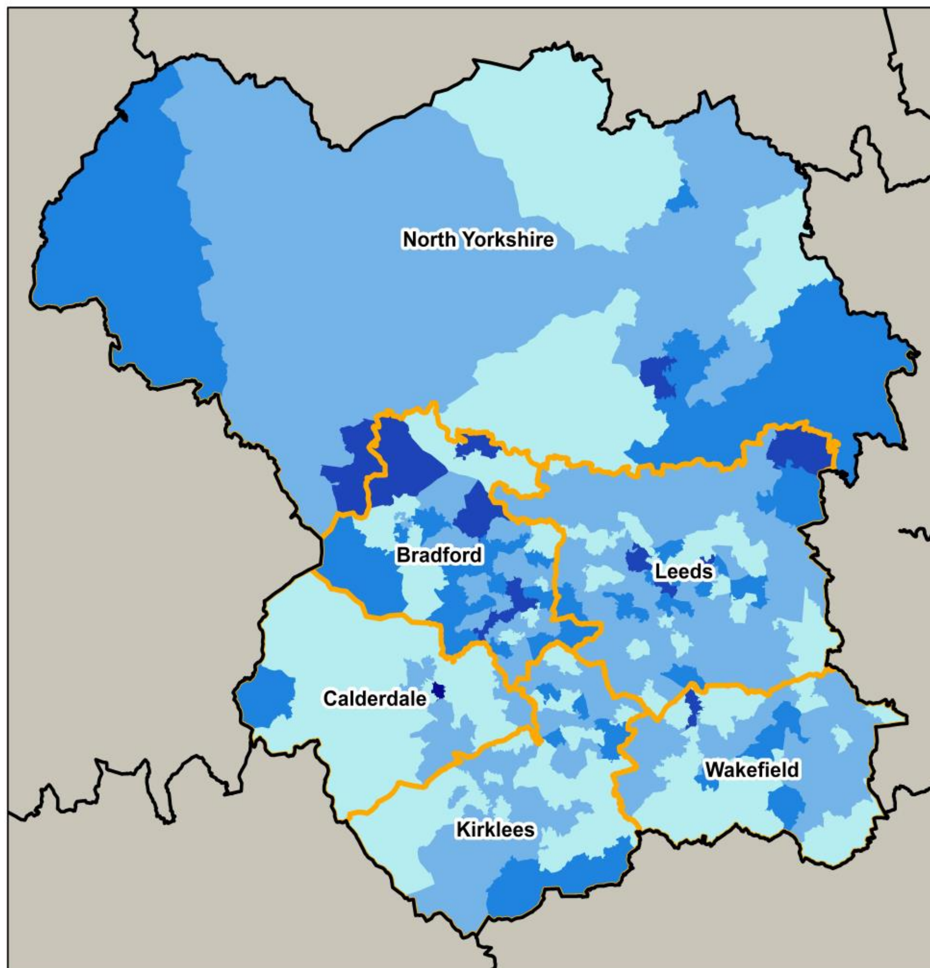
This map shows the population density of the ICS/STP as the number of people per square kilometre. The darker the shaded area, the more densely populated it is. Orange lines refer to the Local Authority boundaries. The LAs that overlap with the system are labelled.

Population density is low across North Yorkshire.

Bradford, Leeds and Kirklees have areas which are much more densely populated than other parts of the system, but also still have areas which are more rural.

Source: ONS mid-2018

West Yorkshire and Harrogate ICS in context – COVID-19 vulnerability



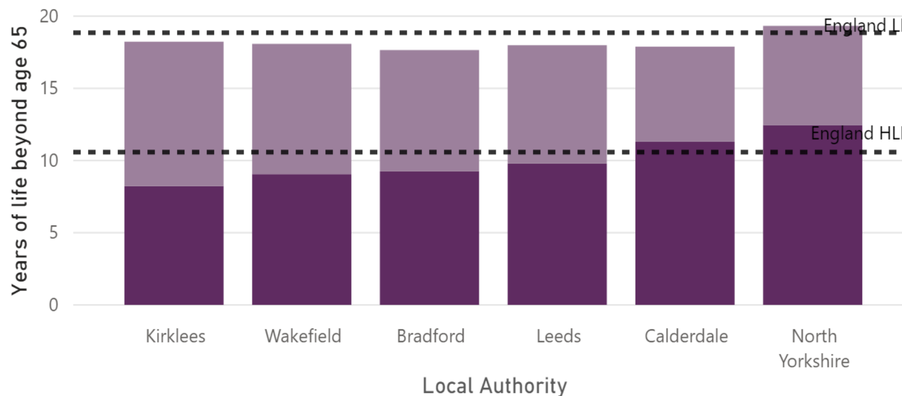
Darker blue areas show where an area has a higher SAVI (Small Area Vulnerability Index) score. The SAVI is an empirically informed measure of COVID-19 vulnerability. The SAVI investigates the association between each predictor (proportion of BAME, care home residents, overcrowded housing and chronic health condition admission) and COVID-19 mortality.
This essentially provides a measure for each area that indicates the relative increase in COVID-19 mortality risk that results from the level of each of the four vulnerability measures for each area.

Across the ICS there is a lot of variability in the population's vulnerability to COVID-19, with pockets of high vulnerability in each LA.

The largest pocket of high vulnerability to COVID-19 is across the rural areas around the Bradford/North Yorkshire border. Calderdale has the lowest levels of vulnerability generally.

Source: PLDR - Daras and Barr, University of Liverpool July 2020-
https://pldr.org/dataset/e6kl0/small-area-vulnerability-index-savi

West Yorkshire and Harrogate ICS in context – life expectancy at age 65



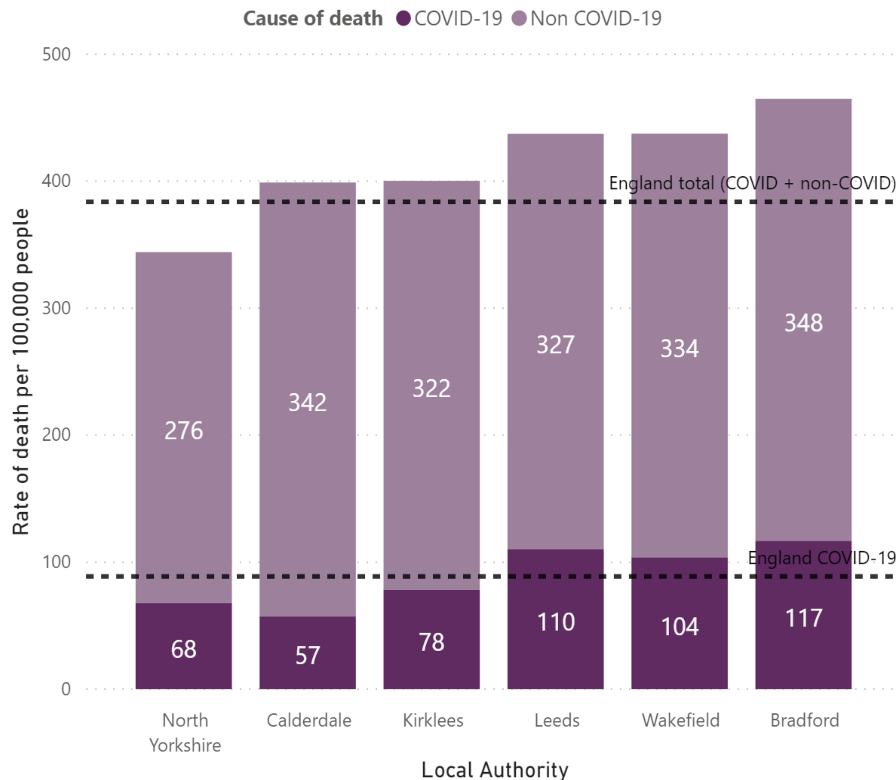
These charts show the total life expectancy beyond age 65 for females and males respectively across the main local authority areas within the system compared to England. The proportion of these years that people are expected to live in good health is shaded boldly.

Across most of the system, life expectancy at age 65 is below the England average. Only in North Yorkshire are older people expected to live longer than the national average, they also live the longest in good health compared to the other areas in the system.

Healthy life expectancy at age 65 is below the national average in Kirklees, Wakefield, Bradford and Leeds. Whilst total life expectancy of older people in Calderdale is below the England average, the number of years they are expected to live in good health is above the England average.

Source: Public Health England 2016-18

West Yorkshire and Harrogate ICS in context – mortality rates



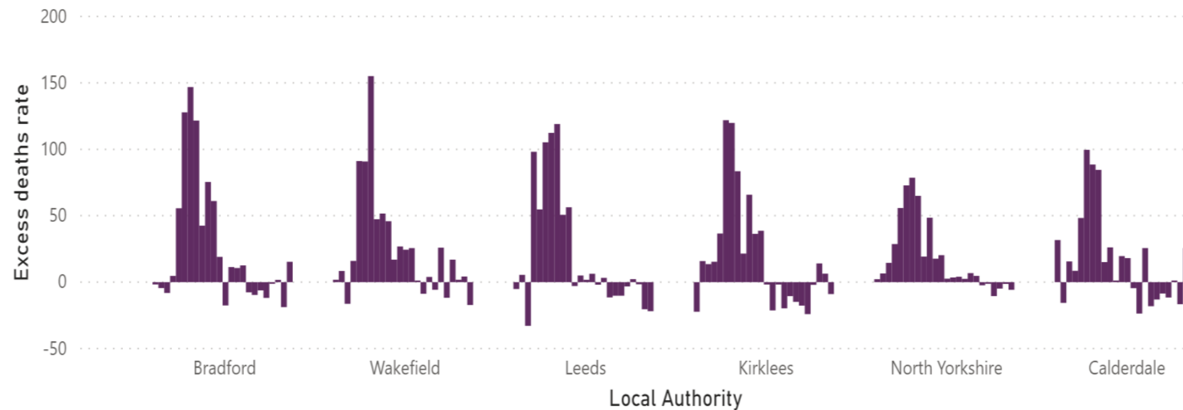
This chart shows Covid and non-Covid mortality rates between March and June across the system's local authorities. These mortality figures are rates per 100,000 population and have been standardised for age to enable fairer comparison of areas with different age structures.

COVID-19 mortality rates in the system were higher than the England average in Leeds, Wakefield and Bradford.

Non-COVID-19 mortality rates in the system were also higher than the England rate (296) in every local authority except North Yorkshire.

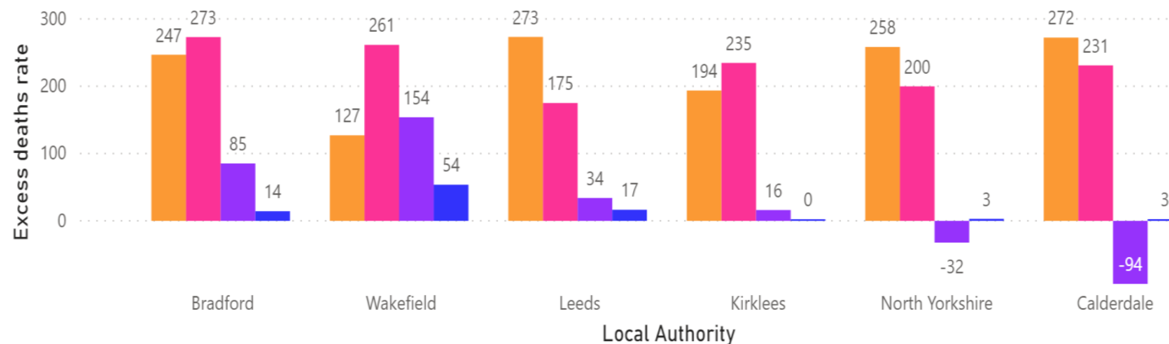
Source: ONS Deaths registrations by local area and cause

West Yorkshire and Harrogate ICS in context – excess deaths



This slide shows the rate of excess deaths in each Local Authority. The rate is the difference between the average weekly deaths in 2015-2019 against the 2020 numbers as a rate per 100,000 population aged 65+.

Data is from Week 10 (early-March) to Week 34 (mid-August).



Every local authority in the system experienced high rates of excess mortality between mid-March and early-June, after which it fluctuated around the average differently for each area.

Across the system, care homes, hospices and people's homes experienced the highest rates of excess mortality. Hospitals experienced comparably few excess deaths – in North Yorkshire and Calderdale, it was lower than in previous years.

Source: ONS Deaths

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Provider Collaboration Review

Key Line of Enquiry Findings

1. How have providers collaborated to ensure that people moving through health and care services have been seen safely in the right place, at the right time, by the right person? 1/2

What we heard went well:

- Acute trusts **changed flow through A&E to enable more senior decision-making at the front door**, e.g. C&HFT and Harrogate – both enabled quicker access via streaming to specialist services and consultants. A&E staff at C&H were given access to SystmOne to book phone appointments with patients' own GPs.
- Out of Hours (OOHs) service worked with YAS and took ownership of booking the appointment slots which improved control of physical environment, IPC (Infection, prevention and control) and safety.
- The **PCNs worked with MH teams** to ensure that there were virtual practitioners that patients could access (alongside social prescribers). GP hot sites were also established so shielded patients could access services.
- **Acute home visiting service (Kirklees)**, provided GP practices with an Advanced Nurse Practitioner for home visits during the day. This allowed patients to have more timely home visits rather than waiting for the GP to visit after surgery.
- **Community provision to prevent hospital admissions**, e.g. Leeds Community Healthcare enhanced a virtual frailty ward with AHP and nursing staff to keep people at home and facilitate early discharge. QUEST at C&HFT and Locala provided nursing home support, such as giving IV fluids to prevent patients attending ED. The trust was looking to enhance this provision further.

1. How have providers collaborated to ensure that people moving through health and care services have been seen safely in the right place, at the right time, by the right person? 2/2

What we heard went well:

- **Cohort Visiting Service**: Established by a Kirklees federation and four PCNs for housebound patients with Covid symptoms.
- **Redirecting patients from A&E that needed an OOHs primary care response**. Local Care Direct (OOHs provision) worked with Leeds Trust to provide telephone/video or face to face consultations from July 2020.
- Primary care: understanding that some people had difficulties with tele- consultations and put alternatives in place.
- **Improved access to primary care in care homes**: weekly ‘ward rounds’, appointment either face to face or video-conferenced.
- **Mental health crisis pathway pressures reviewed** through ICS collaborative. Crisis line support increased to 24hr. Police used street triage service to decrease use of s136 (L&Y Partnership). The PCNs worked with MH teams to ensure that there were virtual practitioners that patients could access (alongside social prescribers).
- Identification of specific care homes for discharge of Covid +ve patients.
- Strong awareness of increases in specific safeguarding referrals. Support and training stepped up, escalating and alerting strengthened across providers.
- Community pharmacies extended services and opening hours to meet demand.

1. How have providers collaborated to ensure that people moving through health and care services have been seen safely in the right place, at the right time, by the right person?

Areas for future focus:

- Accessibility of testing for DCA clients and staff.
- Management of patients referred to secondary care – role of primary care.
- Third sector support provision reduced significantly – need to look at ways to re-provide this, especially for vulnerable groups.
- Primary care improving communication with patients: Perception was many GP practices closed their doors (provision was there, but different levels of understanding) and people expected to travel if they want a face-to-face appointment. It caused some issues especially in the Bradford area (Healthwatch). To counter this, GP practices communicated on websites and social media about the services being offered.
- GPs would benefit from more communication regarding 111 First.
- Continue to focus on identifying and protecting children from abuse.

Health inequalities findings – focusing on the Black, Asian and Minority Ethnic population

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What we heard went well:

- **YAS had focussed on vulnerable groups** (including BAME population and people with learning disabilities), sharing work around risk assessments, and patient targeting. They developed supporting materials to help them do this and partnered with other organisations.
- 111 service commissioned **health impact assessment** – across ICS and other Yorkshire ICS's.
- **Messaging communications with immigrant populations** re, accessing U&EC services.
- Primary care – **in-house multilingual BAME staff** were able to communicate and promote services with some local communities.
- **Testing was prioritised locally for certain g**roups such as those living in extra care housing and refugees (Harrogate area).

Areas for future focus:

- We were told some people (South Asian community especially) were scared to go to hospital as they did not think they would get out again. Further work to **dispel** this **myth** is required.
- Improve **access for the deaf community** as this was a challenge.
- Availability of data that includes **protected characteristics** to improve planning and monitoring of access/outcomes.
- Consider how to address the **backlog of community d**entistry that is disproportionately affecting the vulnerable and extending dental health inequalities.

2. Was there a shared plan and system wide governance and leadership during the COVID -19 period? 1/2

What we heard went well:

- Clear understanding of **roles and accountability** between the ICS and Place.
- Positive feedback re **leadership of ICS** working together on difficult issues, such as stroke pathways. ICS lead on: “wicked issues”; at scale changes; and sharing best practice. The new 111 First service affects whole ICS so coordination held at that level. The operational emphasis for U&EC was at Place.
- ICS agenda was balanced and included inequalities, children and care sector alongside more acute healthcare.
- **Harrogate and Rural Alliance** (HARA, delivered through a S75 agreement): brought together community health and social care services linked to local Primary Care practices, with community nurses, therapists and social care practitioners, they worked together to respond to people’s needs.
- **Well established mature partnerships** which enabled effective collaboration, e.g. PCNs worked together across Kirklees; MH, LD and Autism ICS Collaborative; and WYAT (West Yorkshire Acute trusts), community pharmacy CEO on U&EC board.
- Gold/silver command structures – all reported that these worked well.

2. Was there a shared plan and system wide governance and leadership during the COVID -19 period? 2/2

What we heard went well:

- **MH providers worked well together**: board to board and joint executive meetings were well established. Discussions about Covid pathways took place at these; clear plans were agreed in terms of safe transfer and handover of patients. Clear command structure in place which had been mapped across the districts and into the ICS so they know who to link with.
- **Discharge packages** – LA, CCGs and social care providers put in place "quarantine" beds for residents or the ability to cohort residents within care homes to improve discharge flow from hospitals. A command structure was in place to manage discharges; daily calls, weekly system calls including housing.
- Harrogate area - **ASC services** (domiciliary care agencies and care homes) **felt supported by the local authority,** their voice was heard at the independent care group, and through webinars/direct contact with senior local authority staff.
- Trusts worked with the **independent sector** to provide low risk beds for elective and non-elective patients who required recovery/rehab prior to discharge which helped flow through the hospitals.
- Nightingale Yorkshire and Humber - Illustrated how well the local NHS trusts and wider worked together to create the facility and to put the governance and executive board in place. This came from wider engagement and the PCR.

2. Was there a shared plan and system wide governance and leadership during the COVID -19 period?

Areas for future focus:

- **Communication with care homes** to ensure up to date regarding key messages. Feedback was mixed, Harrogate complimentary of local authority messaging less so national.
- Further develop the **role of Overview and Scrutiny Committee** (OSC) in scrutinising Place/ICS plans, strategy and governance.
- **Primary care voice could be strengthened** at strategic level; this is starting to happen with PCN leaders.

3. Was there a strategy for ensuring the safety of staff and sufficient health and care skills across the health and care interface? 1/2

What we heard went well:

- **Risk assessments were carried out fully,** BAME staff and other vulnerable staff were prioritised, and staff were supported to work from home where possible with digital arrangements in place. Whilst the approach to workforce was well coordinated at Place, the extent to which it was a strategic response across the ICS was mixed.
- **Practical safety of staff was a priority.** West Yorkshire had mutual aid agreements in place for PPE. Estate was reviewed to support social distancing.
- **Testing services were provided across the 'place'** in terms of staffing, facilities and support. IPC advice and support was shared across services.
- **Memorandum of Understanding/NHS Passport** – provided staff flexibility across services. This was seen across several providers (nursing staff from community working in care homes).
- **Workforce plans were in place at organisational and place** - organisations shared work plans for winter, Covid was an extension of this. E.g. The three MH trusts worked together across the ICS to review staffing and any top up training needs, such as management of aggression/use of restraint.

3. Was there a strategy for ensuring the safety of staff and sufficient health and care skills across the health and care interface? 2/2

What we heard went well:

- **HARA improved joint working**. First joint appointment to run the service. MDTs took place in GP practices with GPs, community nurses, therapists and social care practitioners reviewing patients together to ensure most effective care planning. Recruitment campaign across all organisations for B3 & 4 vacancies. The reablement service was over-established to enable it to meet service user needs.
- Kirklees Council **co-ordinated recruitment to care homes**.
- DCAs reported that they continued to recruit throughout. They always had enough staff as some service users had stopped services by choice (for example with social visits). They did some staff sharing with other DCAs.
- **PCNs reported working well together to protect and share** staff as required. PCNs Kirklees – set up Covid teams. This was to protect staff and wider GP practices. Team focussed on c/o pts with Covid.
- Several providers reported having put in place **psychological support for staff**. Bradford District Care Trust put in place a helpline for staff across Bradford, this including care home staff.

3. Was there a strategy for ensuring the safety of staff and sufficient health and care skills across the health and care interface?

Areas for future focus:

- Assurance that staff from **BAME backgrounds running community pharm**acies, had appropriate protection in place.
- Future staffing of the Nightingale Hospital, across all types of staff.

4. What impact have digital solutions and technology had on providers and services during the COVID -19 period? 1/2

What we heard went well:

- **eConsulting in health** - shift to virtual consultations which enabled patient access to continue, particularly using accuRx. Improved ability to send information directly to a patient (through texting or photographs) and access to real time information.
- **eConsulting in care ho**mes - The system run by Airedale trust was cited as being in place in some care homes, enabling online consultations.
- **Use of apps/digital records to monitor social care**. Especially beneficial for updating family around people's care with access to real time info re DCA staff visits. Electronic records enabled services to work more closely with staff and other services, e.g. uploading updates from GPs into medicine (MAR) charts.
- **Video consultations in primary care worked well to support children and expectant mothers**. Lots of contact with parents as fear around coughs and colds – empowering parents to make a decision by providing evidence-based information. Staff could see the child in their own environment – "you can quite easily look at the child and think I need to see you".
- **Improved communication**, especially via WhatsApp, with patients, staff groups and community leaders, e.g. To send messages within the community to address issues such as reluctance to attend hospital.

4. What impact have digital solutions and technology had on providers and services during the COVID -19 period? 2/2

What we heard went well:

- **Improved access to a single shared patient record**: SystmOne was cited by GPs across West Yorkshire and OOH services to have played a significant role in accessing a single shared patient record.
- **Medicines:** The speed of Electronic Prescribing Systems (EPS) implementation was widely reported across the system, with some providers trying to access this for years. Spreadsheet of critical medicines was created at Harrogate hospital, with alerts of potential shortages.
- Video conferencing **improved attendance at meetings** – saved on travel time.
- iPads helped families remain in contact with people using services.
- **Digital access for vulnerable people:** Homeless population were given phones that the organisation no longer used. Bradford District Care trust introduced a scheme for people where a volunteer would drop off a laptop to a service user for their appointment and collect it again after the appointment ended.
- Additional training for staff using e-consultations to help safeguard people such as safety netting questions. Toolkits developed and circulated among clinicians.
- Organisations starting to review/audit impact of digital technology, e.g. SWYPT produced a report on the impact of digital technology.

4. What impact have digital solutions and technology had on providers and services during the COVID -19 period?

Areas for future focus:

- Potential **governance concerns re handovers of care** between organisations.
- GDPR (General Data Protection Regulation) can be an issue in care homes.
- Review **accessibility and additional support for digitally challenged** and marginalised people.
- Review how staff ensure the **safety of people during tele/video calls**. How do you ensure that people are in a safe space for conversations? Providers had done some additional training.

Dental Findings

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- **Increase in dental emergencies/abscesses** in primary care/ED/OOHs as most dental services were closed. Minor treatments had escalated into more urgent treatments.
- **Very limited emergency access** across the ICS – initially only the Leeds dental hospital. There was a view that there was a delay in national guidance. Kirklees rapidly set up some dental hubs.
- There was a challenge in managing expectations around **what constituted urgent dental care**.
- Leeds Dental Hospital – had a dedicated microbiologist from the trust who they have been working with to help then ensure a covid secure environment. Had good access to PPE from the trust. Developed procedures and SoP for the hot site; robust infection control procedures implemented. Used telephone and video calls (attend anywhere system) to triage patients who may need emergency care or initial triage for urgent care such as paediatric dentistry and oral medicine. Brought down waiting lists during the pandemic. Access to an interpreter remotely via IT which meant they did not need to have a face-to-face interpreter on site.

Areas for future focus:

- Apparent **different levels of access between private/NHS**, with private being more available.
- **Improvement of guidance** available for dental facilities from PHE or any other organisations. This was especially evident with regards to secondary and tertiary care facilities.
- **Redeployment of staff** – many staff were not keen on the roles they were given, this increased staff sickness and lowered staff morale.
- Consider how to address the **backlog of community dentistry** that is disproportionately affecting the vulnerable and extending dental health inequalities.

Medicines Optimisation 1/2

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What we heard went well:

- **Pharmacy support realigned** to support admission/frailty beds, shared staffing to meet demands.
- **Support from Fire Service** for medicines deliveries with DBS checked staff to vulnerable patients.
- **Shared learning with primary & secondary care**, CCG and community pharmacies to support community provision to patients, e.g. controlled drugs, End of life care (EOLC) medications and anticoagulants.
- **Admission avoidance work** from Locala with addition of rapid response, intermediate beds and rapid IV pathways.
- Improvements in **access to electronic prescribing in some services**. Local Care Direct - West Yorkshire secured use of this within first 4 weeks of the pandemic. Community teams had access to hospital discharge information.
- **Improved access to records for pharmacists across the** ICS. Pharmacists had access to trust electronic records so they could trouble shoot without bothering staff. Able to view discharge system with full access at CHFT **but not yet at Mid Yorks**. Able to look at medication changes, last dose administered and clinical decisions, this was a positive addition.

Medicines Optimisation 2/2

CareQuality Commission

Areas for future focus

- **Management of increased demand** for community pharmacy services when GP surgeries “closed”, impact not considered and little collaboration.
- **Protection for staff**. Some solely BAME staff. PPE and perspex supplies were a challenge for independent pharmacies. Resilience of smaller providers re staffing.
- **Lack of initial consultation with community ph**armacies when “hot” sites were set up. E.g. Kirklees was set up with extended hours and one designated pharmacy and EPS wasn't available.
- **Flu Vaccine – increased demand was challenging**, in some areas, managing administration safely in the community during a second wave.
- **Wet signatures on prescriptions** are an infection risk for community pharmacies.

Children's services findings 1/2

CareQuality Commission

- Some providers reported a **significant increase** in the number of **non-accidental injuries** in non-mobile babies.
- Providers stated they had seen an **increase** in presentations of **eating disorders**.
- Providers saw an increase in paediatric **wards being used as a place of safety**.
- **Self-harm, mental ill health, risk taking behaviours**: Mixed attendance rates, some had seen a decrease in children and young people attending at the start of the pandemic. Others had seen an increase, reporting the young people who attended were more poorly than usual and had to stay in hospital for longer due to a lack of community services. One provider noticed an increase in children and young people from the local young-offenders institution attending with mental ill health.
- Some providers reported children and young people self-harming in order to be admitted to hospital to leave their home environment.
- All providers were concerned about the national **lack of CAMHS intensive care beds**. They spoke about distressing incidents involving restraining young people on paediatric wards.
- A wellbeing service provided by the voluntary sector saw **a threefold increase in calls for emotional support** at the same time the NHS providers saw a significant decrease in requests for support.

Children's services findings 2/2

Care Quality Commission

What we heard went well:

- **Safeguarding**: Some providers reported 16 & 17-year olds were admitted to their paediatric wards (rather than adult wards) in order to preserve adult bed capacity. Staff stated this had demonstrated the paediatric ward was a safer environment for 16 & 17-year olds as more safeguarding issues have been identified.
- **Safeguarding training and supervision** had been delivered over teams; was described as easier to access. One trust reported their best ever compliance rates for safeguarding online training.
- Virtual working had enabled **more effective joint working** and this was planned to continue.

Challenges/Areas for future focus:

- **Visiting policy for paediatric wards**; was a significant concern and caused distress.
- Concerns that virtual consultations may **hinder identification of safeguarding** issues.
- The **challenge of communication** with all patient groups whilst in PPE. Lack of PPE at the start of lockdown.
- Volume of changing information and guidance related to Covid-19.
- Staffing issues due to isolation and shielding.

Reflections

Care Quality Commission

- Overall the system appeared to work well together.
- There were well established partnerships which had mature partnerships allowing effective collaboration.
- Covid broke down hurdles to achieving shared objectives across the ICS and within individual sectors.

Your questions please

Care Quality Commission

Care Quality Commission

Provider Collaboration Review

Feedback from West Yorkshire and Harrogate ICS to local findings

West Yorkshire and Harrogate ICS feedback to local findings – Key line of enquiry 1 (People)

How do you respond to these local findings?

- The UEC Programme will work with other ICS Programmes (Harnessing the Power of Communities and Primary Care specifically) to address some of the feedback that has been raised in the findings.
- The management of patients referred in to secondary care from primary care is an integral aspect of the work being undertaken in the 24/7 primary care workstream. We are working to understand the processes used in each Place (e.g. PCAL – primary care advice lines) and how the patient moves through the system to enable a seamless journey. We will take in to account the role of primary care within this and a priority for 21/22 is around 'any to any' booking. This would ensure that the patient information is transferred in a consistent way across the region from any primary care service in to secondary care.
- The national 111 First comms have been scaled back and delayed, however we did provide GP Practices with a briefing for staff prior to the 'go live date' to outline what the expected impact of 111 First would be for them.

West Yorkshire and Harrogate ICS feedback to local findings – Key line of enquiry 2 (Shared plan and leadership)

CareQuality Commission

How do you respond to these local findings?

- The UEC Programme will work with other ICS Programmes and stakeholders (Primary Care specifically) to address some of the feedback that has been raised in the findings.
- PCNs currently vary in maturity, one size doesn't fit all in terms of their voice and inclusion in the system. Locally places are working together with primary care and some PCNs already input in to A&E Delivery Boards (Calderdale and Greater Huddersfield). The UEC Programme recognises that PCN inclusion at a strategic level should be place based rather than system wide to allow for the unique differences between places. The UEC Programme Board clinical lead is a GP in Bradford and the UEC Programme Board chair is a GP in Wakefield, so there is PCN inclusion on the Programme Board, which operates at a strategic level.

West Yorkshire and Harrogate ICS feedback to local findings – Key line of enquiry 3 (Workforce)

CareQuality Commission

How do you respond to these local findings?

- PPE issues have been resolved and Community Pharmacy West Yorkshire have access to the PPE portal.
- The UEC Programme will work with other ICS Programmes and stakeholders (WYAAT and workforce specifically) to address some of the feedback that has been raised in the findings.
- Developing a strong, resilient, effective integrated workforce is a key priority for the UEC Programme. There are several programmes of work underway around workforce, including the development of a UEC competency framework, the launch of a rotational UEC Trainee Nursing Associate programme with the University and the development of a common UEC workforce strategy and principles.

West Yorkshire and Harrogate ICS feedback to local findings – Key line of enquiry 4 (Digital)

CareQuality Commission

How do you respond to these local findings?

- The UEC Programme will work with other ICS Programmes and stakeholders (Digital and technology specifically) to address some of the feedback that has been raised in the findings.
- Appropriate data sharing agreements and data protection impact assessments (DPIAs) are in place across place and providers to ensure safe and effective governance of the handover of patient data. Specific examples of where you found this has not been the case can be shared and we can escalate via the appropriate governance channels.
- Digital solutions will continue to form a key aspect of the UEC Programme’s priorities. We will ensure that we utilise specialist subject matter experts to reduce and mitigate risks around data sharing.

West Yorkshire and Harrogate ICS feedback to local findings – Health Inequalities

How do you respond to these local findings?

- The UEC Programme will work with other ICS Programmes and stakeholders (NHSEI and primary care specifically) to address some of the feedback that has been raised in the findings.
- The issues around medicines optimisation have been addressed and the CEO of Community Pharmacy West Yorkshire will provide further feedback to these areas shortly.
- BAME and Health Inequalities priorities are interwoven with the programme priorities and across the ICS. Areas identified in the feedback and the EHIA that was undertaken in relation to 111 First will be utilised in further to shape future programme priority delivery.