Leeds Health & Care Partnership

NHS West Yorkshire Integrated Care Board

Leeds Committee of the
West Yorkshire Integrated Care Board (WY ICB)

Wednesday 11th September 2024, 13:15 – 16:30
(Private pre-meet for members 13:00, public meeting 13:15)
St George's Centre, 60 Great George Street, Leeds, LS1 3DL
AGENDA

No.	Item	Lead	Page	Time
LC 22/24	**Welcome, Introductions**	**Rebecca Charlwood** Independent Chair	-	13:15
LC 23/24	**Apologies and Declarations of Interest** - To note and record any apologies - A register of interests of members can be found at mydeclarations.co.uk. Once redirected to the portal, please select 'filter', and in the 'All decision making groups' field, select 'Leeds Committee of the WYICB' from the drop down box.	**Rebecca Charlwood** Independent Chair	-	-
LC 24/24	**Minutes of the Previous Meeting** - To approve the minutes of the meeting held 22nd May 2024	**Rebecca Charlwood** Independent Chair	4	-
LC 25/24	**Matters Arising** - To consider any outstanding matter arising from the minutes that is not covered elsewhere on the agenda	**Rebecca Charlwood** Independent Chair	-	-
LC 26/24	**Action Tracker** - To review the outstanding actions on the action tracker	**Rebecca Charlwood** Independent Chair	13	-
LC 27/24	**People's Voice** - To receive the 'How does it feel for me?' summary report for Mercy's story	**Hannah Davies** Healthwatch Leeds	-	13:20
LC 28/24	**Questions from Members of the Public** - To receive questions from members of the public in relation to items on the agenda	**Rebecca Charlwood** Independent Chair	-	13:40
LC 29/24	**Place Lead Update** - To receive a report from the Place Lead	**Tim Ryley** Place Lead	14	13:50
LC 30/24	**Marmot City Update** - To receive an update on the Marmot City programme of work	**Victoria Eaton** Director of Public Health Leeds City Council	28	14:10
LC 31/24	**Director of Public Health Annual Report** - To receive the annual report and identify any actions to be taken in response to the recommendations	**Victoria Eaton** Director of Public Health Leeds City Council	40	14:30
BREAK 14:55 – 15:05				
ROUTINE REPORTS				
LC 32/24	**Quality & People's Experience Sub-Committee Update** - To receive an assurance report from the Chair of the sub-committee	**Rebecca Charlwood** Independent Chair & Chair of the Quality and People's Experience Sub-Committee	59	15:05

No.	Item	Lead	Page	Time
LC 33/24	**Finance & Best Value Sub-Committee Update** - To receive an assurance report from the Chair of the sub-committee	**Cheryl Hobson** Independent Member & Chair of Finance & Best Value Sub-Committee	61	15:10
FINANCE				
LC 34/24	**Financial Update at Month 4** - To receive an update on the financial position	**Alex Crickmar** Director of Operational Finance	63	15:15
ITEMS FOR DECISION / ASSURANCE / STRATEGIC UPDATES				
LC 35/24	**Assurance and update on our plan for financial sustainability in 24/25** - To receive an update on the process for understanding the impacts of finanical decisions	**Tim Ryley** Place Lead	82	15:25
LC 36/24	**Joint Working Agreement (JWA) for Maintenance And Reliever Therapy (MART) Phase 2** - To approve the JWA	**Dr Jason Broch** Medical Director	98	15:50
GOVERNANCE / RISK MANAGEMENT				
LC 37/24	**Risk Management and Board Assurance Framework Report** - To receive and consider the risk management information provided	**Tim Ryley** Place Lead	109	16:00
LC 38/24	**Urgent Decision: Procurement Route Approval for Social Prescribing Service** - To ratify the decision taken on 17 July 2024 by the Chair and the Place Lead	**Rebecca Charlwood** Independent Chair	132	16:10
FORWARD PLANNING				
LC 39/24	**Items for the Attention of the ICB Board** - To identify items to which the ICB Board needs to be alerted, which it needs to be assured, which it needs to action and positive items to note	**Rebecca Charlwood** Independent Chair	-	16:15
LC 40/24	**Forward Work Plan** - To consider the forward work plan	**Rebecca Charlwood** Independent Chair	142	-
LC 41/24	**Any Other Business** - To discuss any other business	**Rebecca Charlwood** Independent Chair	-	-
LC 42/24	**Date and Time of Next Meeting** The next meeting of the Leeds Committee of the WY ICB will be held on 27th November 2024 13:15 – 16:30 (private pre-meet for members 13:00, public meeting 13:15)	**Rebecca Charlwood** Independent Chair	-	-

The Leeds Committee of the WY ICB is recommended to make the following resolution:

"That the press and public be excluded from the meeting during the consideration of the following item as it contains confidential information as set out in the criteria published on the ICB's website, and the public interest in maintaining the confidentiality outweighs the public interest in disclosing the information."

No.	Item	Lead	Page	Time
43/24	**PRIVATE & CONFIDENTIAL** **External Investigation Report** - To discuss the report	**Tim Ryley** **Place Lead**	-	16:20

Draft Minutes

Leeds Committee of the West Yorkshire Integrated Care Board (WY ICB)

Wednesday 22 May 2024, 1.15pm – 4.30pm

HEART: Headingley Enterprise & Arts Centre, Bennett Rd, Headingley, Leeds, LS6 3HN

Members	Initials	Role	Present	Apologies
Rebecca Charlwood	**RC**	Independent Chair, Leeds Committee of the WY ICB	✓	
Caroline Baria	**CB**	Director of Adults & Health, Leeds City Council (LCC)	✓	
Victoria Eaton	**VE**	Director of Public Health, LCC	✓	
Dr Sarah Forbes	**SF**	Medical Director, ICB in Leeds	✓	
Pip Goff	**PG**	Volition Director, Forum Central	✓	
Jo Harding	**JH**	Director of Nursing and Quality, ICB in Leeds	✓	
Cheryl Hobson	**CH**	Independent Member – Finance and Governance		✓
Yasmin Khan	**YK**	Independent Member – Health Inequalities	✓	
Dr Sara Munro	**SM**	Chief Executive, Leeds and York Partnership Foundation Trust (LYPFT)	✓	
Visseh Pejhan-Sykes	**VPS**	Place Finance Lead, ICB in Leeds	✓	
Jane Mischenko	**JM**	Co- Chair, Healthwatch Leeds	✓	
Selina Douglas	**SD**	Chief Executive, Leeds Community Healthcare NHS Trust (LCH)		✓
Dr Ruth Burnett (deputy for SD)	**RB**	Executive Medical Director, LCH	✓	
Tim Ryley	**TR**	Place Lead, ICB in Leeds	✓	
Dr George Winder	**GW**	Chair, Leeds GP Confederation	✓	
Prof. Phil Wood	**PW**	Chief Executive, Leeds Teaching Hospital NHS Trust (LTHT)		✓
Additional Attendees				
Sam Ramsey	**SR**	Head of Corporate Governance & Risk, WYICB	✓	
Harriet Speight	**HS**	Corporate Governance Manager, WYICB	✓	
Tom Daniels (Item 08/24)	**TD**	Senior Pathway Lead – Cancer, ICB in Leeds	✓	
Dr Steve Bradley (Item 08/24)	**SB**	Chair of the Cancer Population Board	✓	

Members	Initials	Role	Present	Apologies
Prof. Pete Lodge (Item 08/24)	**PL**	Associate Clinical Director for Cancer, LTHT	✓	
Helen Lewis (Item 14/24)	**HL**	Director of System and Pathway Integration, ICB in Leeds	✓	

Members of public/staff observing – 2

No.	Agenda Item	Action
01/24	**Welcome and Introductions** The Chair opened the meeting of the Leeds Committee of the West Yorkshire Integrated Care Board (WY ICB) and welcomed all attendees to the meeting. The Chair welcomed Jane Mischenko (JM) to her first meeting of the Leeds Committee in her new role as Co-Chair of Healthwatch Leeds.	
02/24	**Apologies and Declarations of Interest** Apologies had been received from Cheryl Hobson, Selina Douglas and Professor Phil Wood. Dr Ruth Burnett was in attendance as deputy for Selina Douglas. Members were asked to declare any interests presenting an actual or potential conflict of interest arising from matters under discussion. The Chair noted that the report included at Item 14 - 'Procurement of new contract for integrated provider of Short-Term Community Beds' – sought approval to proceed with procurement, as opposed to awarding a contract. A direct conflict of interest for partners was therefore not presented at this stage in the process, and processes to manage conflicts of interest had been built into provider selection processes in line with the Procurement Policy. No further interests were declared.	
03/24	**Minutes of the Previous Meeting – 13 March 2024** The public minutes were approved as an accurate record. **<u>The Leeds Committee of the WY ICB:</u>** a) **Approved** the minutes of the previous meeting held on 13 March 2024.	
04/24	**Matters Arising** Referring to Item 80/23 (NHS Leeds Financial Plan 2024-2025), JM requested an update on the progress of the work undertaken to understand the impact of changes to service funding set out in the plan on service users. Tim Ryley (TR) advised that an extraordinary meeting of the Leeds Committee had been scheduled	

No.	Agenda Item	Action
	for Wednesday 26th June 2024 to consider a report providing an update on the Quality Equality Impact Assessment (QEIA) tool and assurance process undertaken, along with any final decisions requiring approval. *N.B. The extraordinary meeting scheduled for Wednesday 26th June 2024 was cancelled following the announcement of the general election on 4th July 2024 and the subsequent pre-election guidance. The item was rescheduled for the next meeting of the Leeds Committee on Wednesday 11th September 2024.*	
05/24	**Action Tracker** The committee noted the completed actions set out in the action tracker.	
06/24	**People's Voice** JM introduced a video from the 'how does it feel for me?' series with Mercy from Chapeltown, coordinated by Healthwatch Leeds. In the video, Mercy described her experiences of healthcare and community services whilst undergoing treatment for cataracts and dry macular degeneration. George Winder (GW) highlighted that Mercy's experiences showed a clear variation in communication of changes to the delivery of primary care services implemented to utilise other healthcare practitioners as opposed to just GPs, where appropriate, and the need for better coordinated communication campaigns around this. TR noted the limitations of wide-spread communication campaigns in terms of reach, and therefore the importance of communication at an individual practice level, and between patient and practitioner. GW also reflected on the barriers to improving the balance of types of practitioners in primary care services, including strict funding requirements for the Additional Roles Reimbursement Scheme (ARRS) and suggested that this could form part of a lobbying ask to NHS England. TR advised that WY had already held discussions with NHS England on this issue, along with other ICBs across the country, and would continue to lobby for changes to the funding requirements. Sara Munro (SM) noted that some of Mercy's reasonable adjustments had not been met and reflected how software systems used by providers often inhibit reasonable adjustments, such as the use of large font for visually impaired patients. The Chair noted that the WYICB Digital Strategy should support digital solutions for reasonable adjustments. Members highlighted the positive feedback around third sector services in Leeds, including BID Services and Feel-Good Factor, clearly showing the strength of the provision. Victoria Eaton (VE) noted that Mercy spoke about these services as her most valued experiences and that the challenges she had experienced were associated with statutory services, which evidenced an imbalance that required further attention.	

No.	Agenda Item	Action
	The Chair thanked Healthwatch Leeds for the work of their coordination of patient experiences through the 'how does it feel for me?' project, generating such rich discussions at each meeting of the sub-committees and the Leeds Committee.	
07/24	**Questions from Members of the Public** No questions were submitted on this occasion.	
08/24	**Population and Care Delivery Board Update** Tom Daniels (TD), Steve Bradley (SB) and Pete Lodge (PL) delivered a PowerPoint presentation, providing an overview of the Cancer Board's work streams. Highlights included improving access to chest x-ray for possible lung cancer, improving access to services via the migrant access programme (MAP), improving cervical screening uptake, and improving pathways by enabling referrals straight to MRIs for possible brain cancer and utilising the Faecal Immunochemical Test for possible colorectal cancer. TR thanked colleagues for their work, clearly evidencing the strong focus on health inequalities in Leeds. TR emphasised the importance of early identification and diagnosis of cancer, particularly for less served communities, which would be the focus of Goal 2 of the Healthy Leeds Plan. TR also recognised the clear role of third sector services in supporting the uptake of cervical cancer screening. Pip Goff (PG) added that further drive for better data would be required to support release of more resources, and that communication and coordination would be key to support uptake. Caroline Baria (CB) advised that utilising community hubs and family hubs across the city could support communication efforts to encourage uptake of screenings. The Chair asked representatives present whether they felt the Population and Care Delivery Board infrastructure had supported their work, in terms of integration and supporting flow of resources. Members were advised that the Cancer board infrastructure had provided legitimacy and coordination to partnership working that had been well established in previous arrangements, with all partners aligned in terms of values, particularly around inequalities, and members taking key messaging back to their respective organisations. Members agreed that embedding clear mechanisms to support allocation of resources to workstreams would be key to strengthening the role of the boards. **<u>The Leeds Committee of the WY ICB:</u>** a) **Received** the update. ***Sara Munro (SM) left the meeting between 14:05 and 14:25 during discussion of this item.***	

No.	Agenda Item	Action
09/24	**Place Lead Update** TR provided an overview of the report, setting out the national context, including the focus on NHS driven by the anticipated general election and an expectation that workforce numbers should decrease following significant increases in staffing numbers through the pandemic. TR also advised that following the last meeting, the Leeds NHS Financial Plan had been submitted, with a further iteration submitted on 2nd May 2024. The Chair thanked colleagues for their collective response to financial planning for 2024/25. Jo Harding (JH) provided an update following the recent Joint Targeted Area Inspection (JTAI) that focused on the effectiveness of the multi-agency response to children and young people at risk of or affected by serious youth violence and/or criminal exploitation. JH advised that the inspection found that most children in Leeds who are affected by serious youth violence and/or criminal exploitation benefit from an effective and well-coordinated multi-agency response. Members were also advised that a celebration event would take place following publication of the report. **ACTION –** To circulate the link to the recent Joint Targeted Area Inspection (JTAI) report. PG noted the focus on co-morbidities as set out within the Healthy Leeds Plan priorities for Goal 1, however raised the potential for missed opportunities to provide non-medical support services to support mental health with this model. TR highlighted that people with three health conditions and a serious mental illness (SMI) are far less likely to be able to live an independent life, and therefore the importance of inclusion within the Goal 1 priorities, however that further work was required to address early intervention systematically through the priorities. **The Leeds Committee of the WY ICB:** **a) Received** the update.	**HS**
10/24	**Quality and People's Experience Sub-Committee Update** The Committee received the AAA report on behalf of the Chair, Rebecca Charlwood. **The Leeds Committee of the WY ICB:** **a) Noted** the update.	
11/24	**Delivery Sub-Committee Update** The Committee received the AAA report on behalf of the Chair, Yasmin Khan (YK). **The Leeds Committee of the WY ICB:**	

No.	Agenda Item	Action
	a) **Noted** the update.	
12/24	**Finance and Best Value Sub-Committee Update** The Committee received the AAA report on behalf of the Chair, Cheryl Hobson (CH). **<u>The Leeds Committee of the WY ICB:</u>** a) **Noted** the update. ***The meeting adjourned for a comfort break at 2.45 p.m. until 2.55 p.m.***	
13/24	**2024-25 Financial Plan Update and Month 1 Progress on Efficiency Plan** Visseh Pejhan-Sykes (VPS) introduced the report and further to TR's update at Item 09/24, advised that NHS England had indicated that there would be no further iterations of planning submissions and that systems must now focus on delivery, with the expectation that systems would focus on closing their financial gap by year end as part of their delivery efforts. VPS advised that at month 1, the Leeds system had reported a financial gap of £8.3m collectively, after excluding some technical adjustments around the treatment of Private Finance Schemes (PFI) at LTHT and LYPFT that had been highlighted to NHSE as anomalies arising from changes to accounting policies nationally. **<u>The Leeds Committee of the WY ICB:</u>** **a)** **Reviewed** and **noted** the final 2024-25 financial plan submission. **b)** **Reviewed** and **noted** the QIPP delivery for 24-25 at month 1.	
14/24	**Procurement of new contract for integrated provider of Short-Term Community Beds** The Chair reiterated that the role of the Leeds Committee was to approve the Provider Selection Regime route for the procurement, as opposed to awarding a contract, and that processes to manage conflicts of interest had been built into provider selection processes in line with the Procurement Policy. Helen Lewis (HL) introduced the report, advising that the item had been considered in advance by the Finance and Best Value Sub-Committee and subsequently further information had been considered by the Chair and Place Lead. HL set out the recommendation in the report to proceed to procurement with a competitive process. PG noted that the information in the report was not easy to understand from a lay person's perspective. HL advised that this was the first decision of this nature to	

No.	Agenda Item	Action
	come through to the Leeds Committee and recognised that the detail in the report was mostly technical, however this was the necessary level of information required at this stage. SM commented that the lead coordinator model as set out in the report would be appropriate, however queried whether the risk level would sit with the lead commissioner and whether funding additional to the required level would be a separate budget. HL confirmed that the lead role would be expected to manage both parts, but the financial allocation would be separate. HL added that the risks and costs associated with replacing capacity would sit with the coordinator. In response to a query regarding the length on contract as set out in the report, HL advised that the contract would be for 10 years and 3 months to build stability and embed partnership working, and that inclusion of a break clause would be explored. HL also confirmed that the contract would receive the standard NHS uplift over the contract period. **The Leeds Committee of the WY ICB:** a) **Approved** the Provider Selection Regime (PSR) route for the Short-term Community Bed service as: Competitive Process	
15/24	**Shakespeare Medical Practice - Alternative Provider Medical Services Contract** HL presented the report, advising the committee that following the approval of the Preferred Bidder Outcome Report in October 2023 by the Leeds Committee, notification had been received of the change of ownership of the provider to Chilvers & McCrea Limited, and mobilisation of the service had since commenced. HL confirmed that assurance was obtained following legal advice that the change of ownership occurred prior to award on contract and therefore the award process was valid. HL added that there were no changes to the services provided for patients and no concerns had been raised by service users regarding the change. **The Leeds Committee of the WY ICB:** **a) Noted** the change of control.	
16/24	**Sub-Committee Annual Reports and Terms of Reference** Sam Ramsey (SR) introduced the report, advising that the three sub-committees of the Leeds Committee (Delivery, Quality and People's Experiences, Finance and Best Value) had undertaken their annual governance reviews at their recent meetings and therefore their annual reports and terms of reference had been submitted to the Leeds Committee for approval. SR advised that the Delivery Sub-Committee had agreed to hold a further development workshop to focus on further clarity around its purpose and membership and therefore the terms of reference would be submitted for approval	

No.	Agenda Item	Action
	to a future meeting. YK added that the sub-committee had made good progress throughout the year, however there was still room for improvement and that the development workshop would support this. SR advised that the Finance and Best Value Sub-Committee had reported improved collective understanding of system finance, including clinical impact, and in terms of membership, had requested partners to explore further representation from Non-Executive Directors. SR advised that the Quality and People's Experience Sub-Committee had reported the learning and adapting culture amongst members as a key strength, with some suggestions for development around further focus on primary care and changes to membership to support this. The Chair added that partners had progressed significantly in owning joint system quality issues. PG highlighted feedback from the recent Leeds Committee Development Session to further develop coproduction of the Population and Care Delivery Board reporting to the sub-committees, to ensure that the boards have real ownership of the reports. SR confirmed that further engagement with each of the boards had been arranged and taken place to support this. **The Leeds Committee of the WY ICB:** a) **Received** the annual reports. b) **Approved** the amends to the terms of reference.	
17/24	**Risk Management Report** TR provided an overview of the report and advised that some challenge had been received through a recent internal audit to ensure that Place risk registers reflect the strategic risks set out within the Board Assurance Framework (BAF) to provide assurance to the WYICB. Members discussed the need for risks included on the risk register to have a more person-centred focus, for example for risk no. 2414 (Leeds City Council financial position) to include the implications to people as a result of service changes. It was agreed that the Leeds Place risk register should be reviewed to ensure that risks are person-centred and adequately reflect strategic risks set out within the BAF. **ACTION** – To review the articulation of risks included on the Leeds Place risk register to ensure that descriptions and mitigations are person-centred and reflect strategic risks set out within the BAF. **The Leeds Committee of the WY ICB:** a) **Received** and **noted** the High-Scoring Risk Report (scoring 15+) as a true reflection of the ICB's risk position in Leeds, following any recommendations from the relevant committees; b) **Received** and **noted** the risks directly aligned to the Leeds Committee of the ICB scoring 12 and above; and	**TR/SR**

No.	Agenda Item	Action
	c) **Noted** in respect of the effective management of the risks aligned to the Committee and the controls and assurances in place.	
18/24	**Items for the Attention of the ICB Board** The Chair outlined that the Committee would submit a report to the West Yorkshire ICB on items to be alerted on, assured on, action to be taken and any positive items to note. The key areas to highlight were set out as follows: - An alert to the impact of considerable financial challenge on people's experiences and specifically health inequalities. Linked to this, the action to review the Leeds Place Risk Register to ensure that descriptions and mitigations are person-centred and reflect strategic risks set out within the BAF. - Escalation of the issue raised around the Additional Roles Reimbursement Scheme (ARRS), to promote and lobby for more balance and flexibility. - The need to shape a genuinely transformative system to allow for more focus on prevention and early intervention, and support comorbidity in the most holistic way. - Assurance around great work coordinated by the Cancer Population Board. - The positive experiences of third sector services, including BID Services and Feel-Good Factor, highlighted by Mercy's 'how does it feel for me?' series of videos.	
19/24	**Forward Work Plan** The forward work plan was presented for review and comment, noting that it continued to develop and would be an iterative document. Members of the Committee were invited to consider and add agenda items. It was suggested that either the Leeds Committee or its sub-committees undertake deep dives into the highest scoring risks, following the review requested at Item 17/24.	
20/24	**Any Other Business** The Chair noted her thanks to VPS for all of her work over the year in Leeds over the years in challenging financial circumstances and wished her good luck in her new role at West Yorkshire. The Chair also noted that the draft Leeds Committee Annual Report and draft Terms of Reference would be circulated via email to members for comment ahead of being submitted to the next WYICB meeting on 25th June 2024 for approval.	
21/24	**Date and Time of Next Meeting** The next meeting of the Leeds Committee of the WY ICB to be held at 1.15 pm on Wednesday 11th September 2024.	

Action Tracker

Leeds Committee of the WY ICB

Action No.	Meeting Date	Item Title	Actions agreed	Lead(s)	Accountable body / board / committee	Status	Update
Completed Actions							
09/24	**22 May 2024**	**Place Lead Update**	To circulate the link to the recent Joint Targeted Area Inspection (JTAI) report.	**HS**	**LCICB**		Circulated 17/06/2024
17/24	**22 May 2024**	**Risk Management Report**	To review the articulation of risks included on the Leeds Place risk register to ensure that descriptions and mitigations are person-centred and reflect strategic risks set out within the BAF.	**SR/TR**	**LCICB**		Update provided in Risk Management Report (11/09/2024)

Meeting name:	Leeds Committee of the West Yorkshire Integrated Care Board
Agenda item no.	29/24
Meeting date:	11 September 2024
Report title:	Place Lead Update
Report presented by:	Tim Ryley, Place Lead, ICB in Leeds
Report approved by:	N/A
Report prepared by:	Tim Ryley, Place Lead, ICB in Leeds

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

Previous considerations:

This is a regular item, considered at each meeting of the Leeds Committee of the West Yorkshire ICB.

Executive summary and points for discussion:

The report covers a number of topics to provide the Leeds Committee of the ICB with an overview of the work over the last three months and to point to any national or local emerging issues. These issues include the implications of our new government, finance and performance.

Which purpose(s) of an Integrated Care System does this report align with?

☒ Improve healthcare outcomes for residents in their system

☒ Tackle inequalities in access, experience and outcomes

☒ Enhance productivity and value for money

☒ Support broader social and economic development

Recommendation(s)

The Leeds Committee of the West Yorkshire Integrated Care Board is asked to:

1. Note and discuss the report.

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

N/A

Appendices

1. Alert, Advise, Assure (AAA) Report – Leeds Committee – 22nd May 2024

Acronyms and Abbreviations explained

1. ICB – Integrated Care Board
2. LTHT – Leeds Teaching Hospitals NHS Trust
3. LCH - Leeds Community Healthcare
4. LTCs – Long Term Conditions
5. BMA – British Medical Association

What are the implications for?

Residents and Communities	The report highlights the impact of specific issues on the residents and communities of Leeds throughout.
Quality and Safety	The report highlights several workstreams that aim to drive the improvement of quality and safety across the Leeds system.
Equality, Diversity and Inclusion	The report highlights implications for equality, diversity, and inclusion throughout.
Finances and Use of Resources	The report highlights several workstreams that aim to improve system flow and make best use of resources.
Regulation and Legal Requirements	None identified.
Conflicts of Interest	None identified.
Data Protection	None identified.
Transformation and Innovation	Challenges and opportunities for transformation and innovation are highlighted throughout the report.
Environmental and Climate Change	None identified.
Future Decisions and Policy Making	The national and regional developments detailed are likely to have future implications for decision and policy making.
Citizen and Stakeholder Engagement	The report highlights where stakeholder engagement has taken place.

1. Introduction

1.1. The report covers a number of topics to provide the Leeds Committee of the ICB with an overview of the work over the last three months and to point to any national or local emerging issues. A number of items are covered in more detail elsewhere, finance and performance in particular.

1.2. We welcome Alex Crickmar to Committee as the ICB Director of Operational Finance for the Leeds place and note that Dawn Hanwell (LYPFT) is acting as the Place Director of Finance since the retirement of Simon Worthington (LTHT) in July.

2. New Government

2.1. Since our last meeting in May the United Kingdom has elected a new Labour government and we have a new Secretary of State, Wes Streeting. Along with the wider NHS and with Social Care we look forward to working with the new SoS and his team.

2.2. Analysis of the Labour manifesto and early policy statements provides us with an understanding of the opportunities and risks associated with the changes. There has been no indication of any desire to change NHS organisational structures which is to be welcomed.

2.3. There are a number of strengths and opportunities within existing announcements that can be identified. These include a commitment to a model which has a stronger focus on preventative approaches; a welcome focus on determinants of health and reducing gap in healthy life expectancy, a commitment to neighbourhood model of health and care which aligns well with the priorities of Leeds and Local Care Partnerships. From a Leeds Health & Care Partnership point of view these are to be welcomed and are reflective of overall ambition and approach.

2.4. There are clearly also areas where there may be some risks and concerns. There is to date no detail on levels of investment for initiatives against a backdrop of significant financial pressures on NHS and local government finances. We will also want to see a cross-governmental approach to addressing determinants of health and healthy life expectancy gap. The initial focus on pressing NHS delivery issues in elective care and urgent care could distract from the medium-term preventative neighbourhood approach.

2.5. Leeds is well positioned to continue to influence national policy through previous and existing leadership and national recognition in areas such as Health Tech and Innovation, and HomeFirst. Wes Streeting visited Leeds in August and as well as meeting NHS Chief Executives from across the wider

region, visited LTHT. We also have the Leeds Health & Social Care Hub working directly with civil servants in the DHSC. It will be important that Leeds continues to utilise and build on these opportunities.

3. Recent Unrest

3.1. All members will have been deeply distressed by recent Islamophobic, racist and anti-refugee/asylum seeker unrest and the sentiment that this has exposed in parts of our community. Many of our communities and our colleagues in Leeds have been left extremely fearful and anxious both by what has taken place and by what it has revealed.

3.2. Whilst we are thankful the unrest has quietened down fairly quickly, no one is under any illusion that the consequences and issues will take much longer to address and need constant attention. Whilst Islamophobia was a particular focus recently, the wider racism including antisemitism, will require us as organisations and colleagues to remain vigilant.

3.3. Individual organisations in the Leeds Health & Care Partnership including the ICB at West Yorkshire level have worked with their colleagues and staff networks to offer opportunities to discuss the issues facing them, address immediate safety concerns and promote a strong anti-racist and anti-Islamophobic message. Leeds City Council with other partners has led wider civic messages.

3.4. Health and Care organisations in Leeds are working together to consider how best to collectively address the wider issues, supporting both staff and patients, over the longer period. We will bring back further information on our medium-term approach to the next committee in November.

4. Performance

4.1. Mental Health Out of Area Placements were incredibly high at the start of the financial year (c40plus at any given time). A significant and focussed piece of work led by colleagues at LYPFT with support of system partners has reduced this to c15 which is ahead of the planned trajectory of 19 in August. There remain challenges in sustaining this and continuing to reduce to meet the submitted end of year goal of close to zero, but the good progress should be acknowledged. This is good news for patients and families, and it is also an important contribution to Leeds system and LYPFT financial sustainability.

4.2. NHS England has a particular focus on aspects of hospital performance. All Trusts are expected to deliver a minimum of 78% of people seen within 4 hours by March 2025. LTHT is ahead of planned trajectory at 76% (July) and is on

plan in terms of bed occupancy. There still remain some significant challenges in eliminating 65 week waits in LTHT by the end of September with 681 people on the list (July). There has been progress made on improving access 62-day cancer performance and 28-day faster diagnosis standard though the latter is still marginally behind plan (May).

4.3. Leeds General Practice continues to meet the national access standard trajectories. There are some remaining data issues which may be suppressing the Leeds figures a little which are being worked through. Across Q1 there were 1,232K GP appointments, slightly above our plans of 1,174k. Latest available position of June, we reported 86.3% of GP appointments were within 2 weeks. In the latest GP patient survey, patients report above national levels of satisfaction and despite the incredibly challenging context a small improvement in satisfaction levels on almost all indicators.

5. Financial Position

5.1. The NHS financial position within Leeds and across West Yorkshire remains incredibly difficult. There are also extreme and ongoing challenges in the local authority sector including in Leeds. The challenges in the statutory sector also continue to impact on the voluntary sector along with other funding streams.

5.2. The West Yorkshire ICB position at month 4 is £12m worse than the £50m deficit plan. More detail is set out in the finance report. However, this has meant West Yorkshire as a whole has moved from Level 2 to Level 3 with greater NHS intervention. We have therefore decided collectively to extend work undertaken by PWC with our acute trusts to all parts of the NHS system. This work is being undertaken this month and will focus both on financial processes and controls, and areas of opportunity.

6. Medium Term Financial Plan and Planning

6.1. The draft medium-term plan for the NHS will be brought to the Leeds Committee of the ICB at its November meeting. We are working not only in Leeds but also with West Yorkshire ICB colleagues and alignment of timeframes will be important. With a new government and a budget statement announcement for October it is prudent that we take these into account in local planning. We are anticipating a one-year settlement in 2025-26, followed by a longer-term settlement announced next year for 2026 onwards. We will also want to build in findings from PWC.

6.2. Finance colleagues are currently working to develop a robust and consistent understanding of what the scale of the financial challenge facing the NHS will be and identifying what efficiency and productivity opportunities are already in plans and where known service gaps are, for example ADHD. With support of Leeds colleagues West Yorkshire are also reflecting demographic changes.

Collectively this will set out the scale of the work partners need to undertake to prevent demand and understand the strategic choices needed to live within the resources available.

6.3. Clearly it will be important to link this with colleagues across the partnership. Work has started between the ICB and Leeds City Council to ensure planning for 2025-2026 and in the medium term is aligned. A set of bi-monthly meetings with a programme of work is now in place through the auspices of Integrated commissioning executive (ICE). The council will require there plans to be ready for consultation before the NHS will normally receive planning guidance. Therefore, the importance of medium-term planning is really important.

7. Healthy Leeds Plan

7.1. The Healthy Leeds Plan currently sets out six priority programmes of joint activity. Among these are Home First and Community Mental Health Transformation. There are four other areas of focus: Three or more Long-Term Conditions and SMI, Falls and fractures, respiratory in both children and at end of Life. Work continues on all of these areas though at different stages. Home First and Community Mental Health Transformation are in implementation, the others in diagnosis and planning phases. Partnership Leaders will be reviewing progress on Respiratory at End Of Life at its September meeting.

7.2. We have also undertaken a detailed analysis of what diseases is contributing to health inequality with a focus on early identification and intervention. This piece of work will also be reporting in September.

7.3. Importantly the focus in all of this is addressing inequality.

7.4. The revised partnership governance (Section 13) and the completion of the ICB Operating Model work (Section 15)should help us pick-up the pace of transformation.

8. Third Sector Position Statement

8.1. The Third Sector in Leeds plays an important role in supporting and improving health across the city. With the LHCP Healthy Leeds Plan focus on a socio-medical preventative approach and the emerging national approach to developing a neighbourhood health model and strengthening preventative approaches this strength is likely to be even more significant.

8.2. To support the ongoing strengthening and development of the working relationship between the ICB and the Third Sector the ICB is in the process of producing an annual position statement. This will set out priorities as agreed through the Healthy Leeds Plan and other strategies and 12 commitments on

how we will work in order to support colleagues in the sector to plan with greater confidence, seize new opportunities and to secure a strong and purposeful relationship.

8.3. A number of conversations took place during May and June culminating in a workshop with 25 or so Third Sector leaders in early July co-created with Forum Central. A first draft is now out for comments from third sector and other colleagues, with the ambition to publish this by the end of September and refresh each year. We will meet with Third Sector partners each Winter to plan for the year ahead and then in summer to review progress together.

8.4. One of our commitments will be to work with other partners across the city (council and NHS) to further simplify and align our approach as a city over the next year.

9. Winter Planning

9.1. As part of our continuous planning cycle, the LHCP reviewed the past winter at a workshop in April. The review identified that we had improved on our approach to communication and early escalation, and that overall, our planning and improvements had enabled a better winter. The embedded use of data dashboards and the discipline of regular review meant we were able to be more proactive in identifying queues that were building and developing solutions. These solutions including the ICB commissioning a home care service to provide short term home care, which helped mitigate some temporary reductions in the reablement service. This improved use of home care meant we were also less reliant on care home beds than we have been in previous winters.

9.2. The System Partners have held two further workshops in June and in August. These workshops have shared intelligence from public health colleagues which suggest, based on the Southern Hemisphere data, that the flu and COVID position may be similar to last year. We are therefore reviewing our demand assumptions for the likely surge in demand over the relevant months based on last year's evidence.

9.3. Each provider is reviewing the expected seasonal profiles for demand and their key actions to maximise surge capacity, by early September. We will then meet and test this collectively, and also refresh the 'decision management' tools that each organisation uses in partnership when triggers are reached. We expect there to be significant additional scrutiny this year on long waits and the use of inappropriate settings for care, and our ambition is to continue to improve the experience we provide for patients.

9.4. There will be a WY Assurance process during September and October with ICB Sign off in October, following a stress test/scenario planning workshop. Alongside our internal reviews, we continue to focus on the UEC

recovery actions which relate to maximising capacity in all settings (we are focused on maximising and maintaining the volumes of throughput); improving productivity in all settings and maximising diversion and use of community alternatives wherever possible.

10. HomeFirst and Procurement

10.1. Compared to last year, there have been further gains in bed productivity (further reduction in lost bed days in LTHT and improved throughput in community beds); more reablement capacity; better transfer of care processes on the wards; and better developed virtual ward offers from LTHT and improved productivity in LCH virtual ward offers. We have also increased our SDEC pathways and our ongoing work with YAS in using the Primary Care Access Line or diverting to community services as an alternative to conveyance.

10.2. At the last meeting in May the ICB Committee approved the procurement mechanism by which we would undertake the procurement of an integrated provider of community care beds in the city based on the work coming out of the HomeFirst programme. This procurement is underway and once the outcome and other legal processes are concluded we will inform the committee members.

11. Neurodiversity Services

11.1. In line with other parts of the Country and West Yorkshire, the Leeds Place demand for Neuro Diversity assessment and treatment in both adults and children has significantly outstripped the available capacity in recent years. Individuals have a right to choose, but we are aware that not only NHS providers, but independent providers also have long waits. The issue is primarily one of qualified staffing capacity.

11.2. The waiting time for Neurodiversity assessments for school age children is over 4 years and increasing. We know that some schools are already asking GPs to refer directly to Right to Choose, rather than waiting for assessment in the LCH service. The LHCP is now writing to families to update them on the wait and providing a signposting/right to choose discussion offer. We are doing this rather than referring back to GPs, to minimise work for general practice, but also to ensure families understand the support available them through schools without a diagnosis, and the gaps in medication initiation from many of the independent sector providers.

11.3 The letters have gone out first to the oldest children and to those already identified with the most complex needs/other risk factors. The safety of individuals is a major consideration in taking this action.

11.4. The LHCP has already identified £400k for the provider to work closely with a subcontractor to focus on those believed to be most at risk and these are

already being contacted. We cannot know the full financial risk, as the market is very capacity constrained, and the costs will depend on the capacity/activity for Leeds patients rather than the overall demand.

11.5. The Leeds NHS service offer is through the LYPFT Adult ADHD service. The assessment capacity is in the order of 16 per month, with the demand at around 170 compared to around 20 when it was established in 2011. There are around 4,400 people on the waiting list. Following an audit, we believe around 80% of them will still need to be seen. As of May, patients being seen had been referred in February 2021, but the wait is obviously longer for people being referred in now because of the increasing backlog. There is also a waiting list for medication initiation.

11.6. Work is currently being undertaken and will be finalised during September to consider how to address this in a way that mitigates the existing clinical safety concerns. We will keep the Committee sighted of the outcome of this planning in the next few weeks.

11.7. Whilst these plans will seek to address short-term risks they come with significant potential financial risks as well as ongoing clinical concerns. As part of our medium term planning we are intending to ensure we set out a clear city strategy and shape national thinking where we can.

12. Pay Awards, Industrial and Collective Action

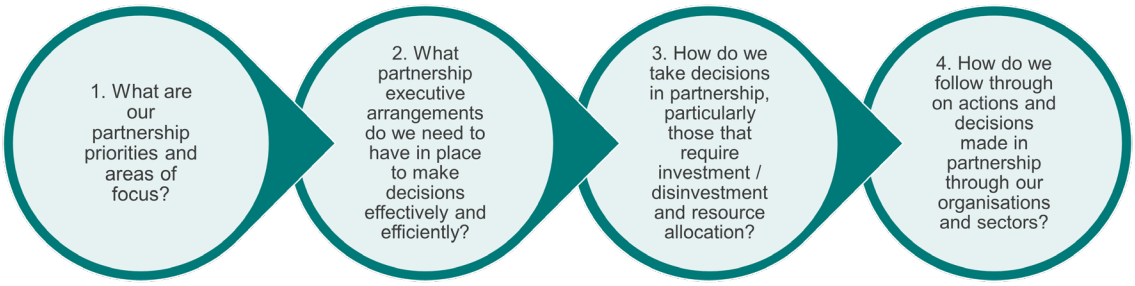
12.1. Since the last meeting of the Committee in May the new government have agreed with the BMA a revised pay over which has been put to the junior doctors. The referendum on whether to accept is due to close on the 15th of September. The government have also accepted the recommendations of the Pay Review bodies for other NHS staff of 5.5%.

12.2 General Practitioners agreed to collective action in a number of areas at the end of July. It is up to each practice to decide to what extent it participates. Colleagues in the ICB team have been working with other partners and the LMC (Local Medical Committee) to understand the situation and address the risks. The government and the BMA are in active talks and the government have improved on the original 2% uplift offer in agreeing that doctors in general practice will also get the 6% offer to doctors. The details of this and other issues are still part of ongoing conversations.

12.3. The ending of industrial action by junior doctors is important in addressing waiting list performance among many other reasons. It is yet to be fully understood what the impact of the GP collective action on general practice and also wider city performance will be.

13. Partnership Development

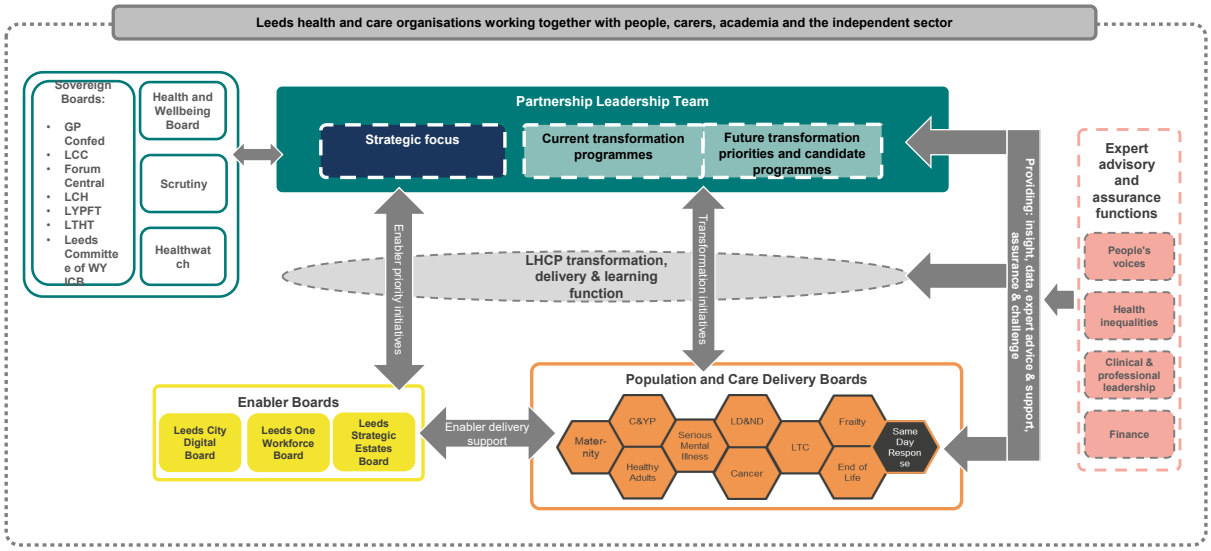
13.1. The Leeds Health & Care Partnership has been doing work to review and further strengthen our partnership architecture and working practices. We set ourselves a challenge to address 4 issues as set out in the diagram below.



13.2. The Healthy Leeds plan with its 6 priority programmes agreed is our response to Question 1. Further work on processes to ensure continual prioritisation and review are coming to Partnership Leadership Team (PLT formerly PEG) in September.

13.3. We have revised our partnership executive arrangements and agreed to rebranding and a creating an approach more focussed on delivery of shared plans through creating the Partnership Leadership Team.

13.4. Work is just drawing to a close on addressing question 4 with a set of proposals coming to PLT in September on how we better work through our existing structures to both build and take decisions, and what the underlying support to our joint programmes will be. In addressing questions 2 and 4 we have started to also address question 3 and to give the population boards a much clearer purpose. The diagram below describes the revised joint executive leadership structure in Leeds.



13.5. We will continue to keep the ICB Committee and other statutory Boards and Organisations along with partners abreast of the main programmes of work steered strategically by the Health & Wellbeing Strategy and Healthy Leeds plan Priorities. From an ICB perspective this work will strengthen the delegation to place which remains among ICS's across the country an unusual, but respected model.

14. ICB Committee Arrangements

14.1 We have undertaken a process to gather feedback from members on how the committee and sub-committees are working after nearly two years. At the same time there is the work underway across the city as set out above to look at wider Leeds Health & Care Partnership governance, and work across West Yorkshire looking at the ends of the terms of office of all non-executive director/lay members. Therefore, it seems an appropriate time to consider the number, remit and scope of the various sub-committees and non-executive members. Conversations are underway and we anticipate bringing back proposals to the January Committee ahead of next year.

15. ICB Operating Model

15.1. The West Yorkshire ICB has now completed the implementation of the structural and staffing changes that arose from the review of its Operating Model last year driven by a 30% reduction in "running cost" allocations. In Leeds in particular this has required some fairly fundamental changes resulting from a 20% reduction in workforce establishment.

15.2. Work continues on organisational development and working with the new teams both in Leeds and at West Yorkshire and in the interface between them now that the new structures themselves are bedding in. After a period of

considerable disruption, it is important that colleagues across the ICB are being supported to adapt to new ways of working within the organisation and in their role to support population planning, transformation, co-ordination and partnership development.

16. Summary and Conclusion

16.1. The Leeds Health & Care System continues to develop and remains strong in what is a challenging environment. It will be important over the next year we continue to retain our influence on national policy, seizing opportunities to deliver performance and financial sustainability and use our partnership to deliver transformational change for the people of the city.

17. Recommendations

The Leeds Committee of the West Yorkshire Integrated Care Board is asked to:

1. Note and discuss the report.

Committee Escalation and Assurance Report – Alert, Advise, Assure

Report from: Leeds Committee of the WY ICB

Date of meeting: 22 May 2024

Report to: West Yorkshire Integrated Care Board (WY ICB) on 25 June 2024

Report completed by: Harriet Speight, Corporate Governance Manager, ICB in Leeds on behalf of Rebecca Charlwood, Independent Chair, Leeds Committee of the WY ICB

Key escalation and discussion points from the meeting
Alert:
Financial Pressures – The Impact on People The Committee wished to alert the WYICB to the continued impact of considerable financial challenge on people's access to and experiences of services, and the risk of widening health inequalities. Linked to this, during discussion of the risk management report, members discussed the need for risks included on the risk register to focus on the implications on service users, particularly the risks associated with financial pressures. It was agreed that a review of the risks held on the Leeds Place Risk Register would be undertaken to ensure that descriptions and mitigations are person-centred and consider the strategic risks set out within the Board Assurance Framework (BAF). **Additional Roles Reimbursement Scheme (ARRS)** During the meeting, barriers to improving the balance of types of practitioners in primary care services were discussed, including strict funding requirements for ARRS. The Committee wished to escalate this as a key issue impacting recruitment to primary care settings and request that the WYICB continue to lobby NHS England for changes to the funding requirements to promote more flexibility and balance.
Advise:
Healthy Leeds Plan – Goal 1 Priorities The Committee received the Place Lead Update which included an update on the six priorities identified for Goal 1 of the Healthy Leeds Plan - Respiratory Disease in Children and at End of Life, Home First (Intermediate Tier), Frailty and Cancer Injury and Fracture, Community Mental Health Transformation, and people living with multi co-morbidities. It was noted that work to progress this agenda would be focused on shaping a genuinely transformative system to allow for more focus on prevention

and early intervention, to improve outcomes and reduce inequality in a sustainable way.

Assure:

Cancer Population Board

The Committee received a presentation from the Cancer Population Board providing an overview of the Board's work streams. Highlights included several schemes focused on improving pathways to diagnosis including direct referrals to MRI scans and utilising the Faecal Immunochemical Test for possible colorectal cancer, improving overall access to services via the migrant access programme (MAP), and a programme of work to increase cervical screening uptake. Members welcomed the work undertaken, the clear focus on health inequalities, and the key role of the third sector in delivering this work.

People's Voice – Third Sector Services

The Committee watched a video from Mercy's 'how does it feel for me?' series of videos coordinated by Healthwatch Leeds. In the video, Mercy described her experiences of healthcare and community services whilst undergoing treatment for cataracts and dry macular degeneration. As part of the interview, Mercy was asked which service she valued most and she responded by detailing her positive experiences of two third sector services in Leeds, BID Services and Feel-Good Factor. The Committee wished to note the valuable work of third sector services in Leeds.

Meeting name:	Leeds Committee of the West Yorkshire Integrated Care Board
Agenda item no.	30/24
Meeting date:	11th September 2024
Report title:	Fairer Healthier Leeds – a Marmot City
Report presented by:	Tim Fielding - Deputy Director of Public Health
Report approved by:	Victoria Eaton - Director of Public Health
Report prepared by:	Sarah Erskine – Head of Public Health (Health Inequalities)

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

Previous considerations:

N/A

Executive summary and points for discussion:

In January 2023, Leeds Health and Wellbeing Board made a commitment for Leeds to become a 'Marmot place'. In April 2023, a formal two-year partnership began with the Institute of Health Equity (IHE) – led by Professor Sir Michael Marmot.

In the first year, the aim of the Marmot or 'Fairer, Healthier Leeds' programme has been to enable the city to better understand how to maximise opportunities to address health inequalities. This is important, given the changing population in Leeds (namely, an increase in the number of people living in the most deprived neighbourhoods) and concerning trends in health outcomes associated with the impact of austerity, COVID-19 and the cost-of-living crisis.

This report provides an update on Fairer, Healthier Leeds. The programme has been delivered to date via three interconnected workstreams: *whole system review*, *collective action* and *cross-cutting priorities*. Progress in each of these areas is described below along with next steps.

In particular, the Leeds Committee of the WY ICB is asked to note the findings and recommendations of the whole-system review; these are set out in a recently published report from the IHE: 'Fairer, Healthier Leeds - Reducing Health Inequalities'.

The Executive Summary is attached as an appendix to this report. The full suite of documents will be available on the IHE website (https://www.instituteofhealthequity.org) from 9th September 2024.

Which purpose(s) of an Integrated Care System does this report align with?

☒ Improve healthcare outcomes for residents in their system

☒ Tackle inequalities in access, experience and outcomes

☒ Enhance productivity and value for money ☒ Support broader social and economic development
Recommendation(s)
The Leeds Committee of the West Yorkshire Integrated Care Board is asked to: 1. Note progress of the Fairer, Healthier Leeds programme. 2. Consider the findings in the 'Fairer, Healthier Leeds – Reducing Health Inequalities' and commit to supporting delivery of the IHE recommendations.
Does the report provide assurance or mitigate any of the strategic threats or significant risks on the Corporate Risk Register or Board Assurance Framework? If yes, please detail which:
N/A
Appendices
1. Fairer, Healthier Leeds: Reducing Health Inequalities Executive Summary
Acronyms and Abbreviations explained
1. N/A

What are the implications for?

Residents and Communities	Improved population health and reduced health inequalities
Quality and Safety	N/A
Equality, Diversity and Inclusion	Improved population health and reduced health inequalities
Finances and Use of Resources	Consideration of proportionate universalist principles in resource allocation
Regulation and Legal Requirements	N/A
Conflicts of Interest	N/A
Data Protection	N/A
Transformation and Innovation	Consideration of proportionate universalist principles in resource allocation Strengthening 'social determinants of health' approaches' in healthcare.
Environmental and Climate Change	Alignment between health equity policies and climate goals
Future Decisions and Policy Making	Consideration of proportionate universalist principles in resource allocation Strengthening 'social determinants of health' approaches in healthcare.

Citizen and Stakeholder Engagement	Ongoing connection with key ‘Community voice and Power’ workstreams

Main report detail

1 Purpose of this report

This report provides an update on Fairer, Healthier Leeds. The programme has been delivered to date via three interconnected workstreams: *whole system review*, *collective action* and *cross-cutting priorities*. Progress in each of these areas is described below along with next steps.

The Leeds Committee of the WY ICS is asked to note the findings and recommendations of the whole-system review; these are set out in a recently published report from the IHE: 'Fairer, Healthier Leeds - Reducing Health Inequalities'.

The Executive Summary of this report is attached as an appendix. The full suite of documents will be available on the IHE website (https://www.instituteofhealthequity.org) from 4th September 2024.

2 Background information

2.1 Leeds Health and Wellbeing Board made a commitment for Leeds to become a 'Marmot place' in January 2023. In April 2023, a formal two-year partnership began with the Institute of Health Equity (IHE) – led by Professor Sir Michael Marmot. The programme was formally launched in June 2023.

2.2 A recent paper published by the IHE defined a 'Marmot place' in the following way: "*Based on the eight principles, Marmot Places develop and deliver interventions and policies to improve health equity; embed health equity approaches in local systems and take a long-term, whole-system approach to improving health equity".*

2.3 The aim of the Leeds programme in the first year has been to enable the city to better understand how to maximise opportunities to address health inequalities. This is important given the city's changing population (namely, an increase in the number of people living in the most deprived neighbourhoods) and concerning trends in health outcomes associated with the impact of austerity, COVID-19 and the cost-of-living crisis.

2.4 Since the decision was made to work with the IHE, the pressure on Local Authority and NHS budgets has increased. Understanding how to improve health, reduce health inequalities and make the best use of resources within this context is therefore vital.

2.5 The Fairer, Healthier Leeds programme is being led on behalf of the city by Public Health with political support from the Executive Board Member for Equality, Health and Wellbeing.

2.6 The development of the programme has been co-ordinated through the Marmot Strategic Delivery Partnership (formerly the Marmot City Working Group) – a strategic partnership with membership drawn from across the Local Authority, NHS, Third Sector and academia.

2.7 Along with the '*whole-system review'*, early discussions in the city identified two key priority areas: Housing and Best Start. In consultation with partners, the focus of Best Start has been expanded to '0-5 years' and this priority and Housing constitute the '*collective action* 'workstream described above.

2.8 In rolling out the programme, three further priority areas or cross-cutting themes have also been incorporated.

2.9 *Community Voice* seeks to ensure that, along with data and policy analysis - 'what people in Leeds say is important to them' - is included in the recommendations developed by the IHE and is at the heart of the development of the Fairer, Healthier Leeds work.

2.10 '*Addressing racism and discrimination and their outcomes'* is included in the Marmot eight principles. This was added as cross-cutting priority area to ensure that all work, including the identification of 'Marmot indicators' considered the impact of racism and discrimination on health.

2.11 Finally, '*Inclusive economies'* has been included as employment, the cost-of-living crisis and poverty have been key issues that have intersected with all the work delivered during 2023-24 both at a strategic level and in engagement with partners.

2.12 Further detail about each workstream is set out below.

3 Main issues

Whole System Review

3.1 The whole system review carried out by the IHE has included:

- Analysis of health outcomes and data covering the social determinants of health (e.g. housing, education)
- A 'health equity' assessment of strategies, policies and programmes
- Interviews and workshops with key stakeholders.
- Mapping of community insight aligned to the 8 Marmot principles.
- Identification of key health equity indicators to measure Leeds progress over the next 5 – 10 years.

3.2 The data compiled as part of this workstream has informed the city's Joint Strategic Assessment.

Summary of Findings from 'Fairer, Healthier Leeds: Reducing Health Inequalities'

3.3 *In line with many other cities in the UK, there are significant and persistent inequalities across a range of outcomes in Leeds. Inequalities are evident in health outcomes (e.g. life expectancy, low birthweight babies) but also in the social determinants of health (e.g. earning a Living Wage, educational attainment). Compared to other core cities, Leeds compares unfavourably across several measures.*

3.4 *Within the city, there are stark inequalities between the richest and poorest neighbourhoods, but these inequalities also occur on a gradient – with increasing wealth associated with better health. Leeds has a population that is becoming younger and more ethnically diverse and an increasing number of people living in the poorest neighbourhoods. Life expectancy in Leeds was 'levelling off' before Covid for both men and women and in most recent figures is showing a decrease.*

3.5 *The Leeds system has 'improving the health of the poorest the fastest' at its centre and has well-established strategic approaches and partnerships in place to support achieving this aim. However, the context is challenging, and as described above, many inequalities are stubborn, and some are worsening.*

3.6 *There is good work to build upon, however the system could go further in making equity a core component of all decision-making in the city and having named leaders accountable for ensuring this happens. Having more explicit health equity goals in partnerships and expanding these so that a broader set of stakeholders in Leeds play their part would support the development of a health equity system. Leeds partners may also benefit from having further conversations about where there are opportunities to 'join up' across and within sectors, scale up what is working well and be bolder in addressing inequities.*

3.7 *Having a core set of Marmot indicators that are disaggregated by ward or decile will enable system leaders to understand and have a clear line of sight on progress to drive forward effective action.*

3.8 The report contains 15 system level recommendations that address: leadership and accountability, effective partnerships and research and monitoring (Appendix 1)

Draft Marmot Indicators

3.9 A set of high-level indicators (with life expectancy as an additional over-arching measure) have been identified to monitor changes in health equity in line with the eight Marmot principles.

3.10 The indicators meet the following criteria: they are amenable to change; are already measured via the Health and Wellbeing Strategy, Social Progress Index or Public Health performance report, and can (in most cases) be disaggregated by ward or IMD decile.

3.11 The indicators will be presented annually to the Health and Wellbeing Board alongside the Health and Wellbeing Strategy (HWS). They have also been adopted by the Best City Ambition scorecard, ensuing that analysis of and accountability for health equity is embedded at a city-wide strategic level.

Collective Action

3.12 During 2022/23 local partners identified both housing and 0-5 years (Best Start) as priorities for the Marmot place work. These areas continue to be of significant concern both nationally and in Leeds.

3.13 In developing this workstream the process carried out as part of the whole-system review has been replicated: analysis of outcomes/data and insight; assessment of strategies, policies and programmes, and interviews and workshops with key stakeholders.

3.14 However, there has also been a commitment from the outset to 'add value' to existing work, connect the system better to itself, embed learning from elsewhere and for the 'health equity' or Marmot lens to act as a catalyst for action.

3.15 Two short reports (along with recommendations) of the priorities will be published in Autumn 2024.

Housing

3.16 Housing affects our health through a range of pathways that can be summarised into four domains: quality of housing, e.g. damp and mould, hazards; affordability of housing, e.g. rent, heating; security and homelessness, e.g. security of tenure, having a home and the local area, e.g. transport links, green space.

3.17 In Leeds, the 'Housing and Health breakthrough group' is co-ordinating action in the city to support better joint working between sectors.

3.18 IHE evidence along with local mapping supported identification of priorities for the group which include training for health and housing staff; 'out of hospital' workers in acute sectors and development of a children's asthma/housing pathway.

3.19 The IHE identified the selective licensing scheme in Leeds as an area of good practice. A qualitative evaluation of 'stakeholder perceptions of the impact of Leeds existing selective licensing scheme' has been completed and is supporting the development of a business case to be submitted to Leeds City Council Executive Board regarding the possibility of a new scheme.

3.20 This evaluation also suggested a framework that could be adopted if LCC were to extend selective licensing. An evaluation of this type would be of national significance given the lack of robust evidence around selective licensing.

3.21 An operational health and selective licensing group has been established to co-ordinate better immediate relationships on the ground. Actions include sharing information about selective listening with relevant Primary Care networks and supporting better relationships between health staff and housing workers. Public Health are also working in partnership with housing colleagues to embed questions about health and health inequalities into the selective licensing survey (completed by housing workers).

3.22 Data alignment work is bringing together housing data held by West Yorkshire Combined Authority and local health data to support targeting of funding for housing and health.

0-5 years

3.23 Recent national and local analysis of maternal and child health indicates that there are concerning trends across a range of health outcomes.

3.24 The IHE facilitated a collaborative workshop on 16th January 2024. This involved sense checking IHE findings from stakeholder interviews and policy analysis and planning next steps.

3.25 Key issues that have emerged from the IHE scoping phase include: the need to clarify the offer for children and families aged 0-5 years; the complex governance arrangements for babies and children and poor outcomes for young children from minority ethnic backgrounds.

3.26 The findings from the event, along with further scoping work described above are being used to inform the IHE short report on 0-5 years.

Cross-cutting priorities

Community Voice

3.27 Early consultation with stakeholders in Leeds led to the Fairer, Healthier Leeds programme adopting ‘Community Voice’ as a key priority – ensuring that ‘’what people in Leeds said was important to them’ was combined with data and policy analysis carried out by the IHE. A key principle of this work was to make full use of existing consultation and insight in the city rather than asking communities who may feel ‘over-consulted’.

3.28 Local insight, mapped against the eight Marmot principles, has informed recommendations made by the IHE.

3.29 In the longer term, the mapping work will also help to identify where there may be further opportunities to involve community voices in improving the social determinants of health.

Racism and Discrimination

3.30 There is a continued commitment to ensure that analysis of health outcomes (including the Marmot indicator set) is disaggregated by ethnicity so that action can be supported across the system to address inequalities – recognising that some of the poorest outcomes may be experienced by communities who do not ‘appear’ in health or social care data.

3.31 In Year 2 of Fairer, Healthier Leeds ‘Addressing racism, discrimination and their outcomes’ has been added to the programme as a discrete workstream. It will build on national IHE analysis and existing successful approaches in the city (e.g. Synergi-Leeds) to enable system leaders to have conversations about ethnicity, racism and discrimination and health in new ways. This re-framing will support effective and sustainable responses to inequalities in health experienced by people from diverse communities.

Inclusive Economies

3.32 The influence that the local and national economy has on people’s heath is significant and intersects with the full breadth of the Marmot eight principles.

3.33 There are established programmes of work in the city to mitigate against poverty (the cost-of-living group) and support employment and improve the local economy (Anchor’s network, Inclusive Growth Strategy).

3.34 The Public Heath Health Inequalities team continue to support the ‘Good Jobs Better Health Fairer Futures’ project (funded by the Health Foundation and led by LCC Economic Development) and through this work develop improved understanding across health and economic led approaches.

Embedding Equity

3.35 As noted, the aim of the Fairer, Healthier Leeds programme is to support a broad set of stakeholders in the city to take action on the social determinants of health and to make

decisions about interventions and resources based on principles of fairness and health equity.

3.36 Examples above highlight where and how action is being taken on the social determinants of health in Leeds - including on housing and employment.

3.37 The programme has also acted as a catalyst for wider developments. For example, a local GP has developed a template' for use in Primary Care based on the eight Marmot principles. This will enable practitioners to actively review people's social and economic circumstances and provide easy referrals to key services including those addressing fuel poverty and benefits advice.

3.38 The Asset Management and Regeneration directorate are also planning to embed consideration of the eight Marmot principles and health equity more robustly into new developments in the city.

Communications – Building a Social Movement for Health Equity

3.39 The national IHE Health Equity Network aims to build a 'social movement for health equity'.

3.40 This involves communicating the significant role that the social determinants or 'building blocks' of health' play in causing or mitigating against health inequalities and setting out the role that a range of agencies and sectors have in improving health.

3.41 Within the Leeds programme the @fairerleeds | Linktree site hosts digital and printed content about local approaches and activity. This will be further developed in

4. Next Steps

The 15 whole-system recommendations in ‘Fairer, Healthier Leeds: Addressing Health Inequalities’ provide a framework for action in the city – identifying where and how strategic partners can embed health equity in the system and ‘join up, scale up and be bold’ in action to address health inequalities.

The 15 recommendations will be used to inform an agile action plan – setting out short, medium and long term activity. This will be led by the Marmot Strategic Delivery Partnership.

The action plan will be developed during September and October 2024.

5. Recommendations

The Leeds Committee of the West Yorkshire Integrated Care Board is asked to:

The Leeds Committee of the West Yorkshire Integrated Care Board is asked to:

a) Note progress of the Marmot - Fairer Leeds programme in Year 1.

b) Consider the findings in the ‘Fairer, Healthier Leeds – Reducing Health Inequalities’ and commit to supporting delivery of the IHE recommendations.

6. Appendices

1. Fairer, Healthier Leeds: Reducing Health Inequalities Executive Summary

FAIRER, HEALTHIER LEEDS
MARMOT RECOMMENDATIONS

In line with many other cities in the UK, there are significant and persistent health inequalities in Leeds. Inequalities are evident in health outcomes (e.g. life expectancy, low birthweight babies) but also in the social determinants of health (e.g. earning a living wage, educational attainment). Within the city there are stark inequalities between the richest and poorest neighbourhoods, but inequalities also occur on a gradient – with increasing wealth associated with better health.

Leeds's population is becoming more ethnically diverse and the proportion of people living in its poorest neighbourhoods is increasing. Life expectancy for all populations in Leeds was stagnating before COVID for both men and women. Women living in Leeds's most deprived neighbourhoods live, on average, nine years less than women living in the least deprived neighbourhoods; for men, the difference is 10 years.

The Leeds system has committed to **'improving the health of the poorest the fastest'** and has well-established strategic approaches and partnerships in place to achieve this aim. However, the context is difficult, and as described above, many inequalities are entrenched and some are worsening.

The Institute of Health Equity's recommendations for Leeds challenge the city to take stronger action on the social determinants of health. They are the building blocks for building a healthier and more equitable society.

LEADERSHIP AND ACCOUNTABILITY FOR HEALTH EQUITY

AIM: Increase accountability, ensure actions take place and measure impact

1. Identify named senior leaders who are accountable for health equity in Leeds.
2. Commit to closing the gap in health outcomes as measured by the Fairer, Healthier Leeds Marmot indicators over a five to ten-year period and set out implementation plans to do this.
3. Leaders, organisations and partnerships to adopt a health equity in all policies approach to identify, test and embed processes that deliver health equity across the system.
4. Continue to allocate senior capacity and resource in public health to lead the Leeds health equity approach and maximise the expertise of the wider public health team in planning and delivery.
5. Continue to deliver the inclusive growth agenda with a focus on IMD 1 and 2 neighbourhoods. Leeds City Council to convene partners and anchor organisations to maximise the impact of their work in these areas. Scale up employment and skills training that meets the needs of communities and residents in IMD 1 and 2 neighbourhoods.
6. Leeds health and care partnership to continue to build on Core 20PLUS5 to reduce inequalities in health ensuring action is scaled up to meet the needs of communities in IMD 1 and 2 neighbourhoods.
7. Continue to enable the Third Sector to play a lead strategic role in addressing heath equity and, through fairer funding agreements, to deliver sustainable action on the social determinants of health.
8. Ensure the needs of ethnic minority populations in Leeds are addressed in all citywide strategies to reduce inequalities.

There are opportunities for the Leeds system to go further by, clarifying the Leeds approach to addressing health inequalities, making equity a core component of all decision-making in the city and supporting all parts of the system to act on the social determinants of health.

Accountability for health equity needs to be strengthened and workforces across different organisations could be better supported to have greater capacity to act on the social determinants.

Action should be taken to ensure that health equity and the social determinants of health receive greater focus within the healthcare system. Leeds NHS Boards should strengthen the strategic focus on social determinants, extending activity

beyond anchor approaches. Primary care and Local Care Partnerships could better support actions to reduce inequalities by building on work to improve local living and working conditions, being a strong advocate and working with individual patients to improve the social determinants of health.

Businesses affect the health of their workforce and are a major factor in health and health inequalities. The Leeds anchor networks could take more proactive approaches to supporting greater equity and reducing deprivation in local areas.

The population of Leeds is becoming increasingly diverse and ethnic inequalities across a range of measures are persistent. The city should review current strategic and operational approaches to better address the health needs of its diverse communities.

EFFECTIVE PARTNERSHIPS FOR HEALTH EQUITY

AIM: Existing and future partnerships prioritise greater health equity in Leeds

9. Adopt more ambitious health equity goals in existing strategic partnerships.

10. For each Marmot principle, ensure that membership of relevant networks and/or partnerships is broad enough to facilitate actions on the social determinants of health.

11. Working with the Third Sector, involve communities in identifying drivers of poor health and in the design, implementation and evaluation of actions to reduce them.

12. Clarify community approaches to addressing the social determinants of health in IMD 1 and 2 neighbourhoods, including joining up programmes, reducing duplication and scaling up what works.

These recommendations challenge Leeds to reset its partnership approach and place equity at its heart, with clear decision-making and governance structures that support health equity.

Having more explicit health equity goals in partnerships and expanding membership to include a broader set of stakeholders would contribute to a more effective health equity system in Leeds. Partners may also benefit from having further conversations about where there are opportunities to 'join up' across and within sectors, 'scale up' what is working well and 'be bolder' in addressing health inequalities.

Leeds has an opportunity to build on and simplify existing work and develop its own approach to working with communities that centres community power and enables community-centred solutions to health inequalities.

RESEARCH AND MONITORING FOR HEALTH EQUITY

AIM: Drive more effective interventions and evaluations and implement the Fairer, Healthier Leeds Marmot indicators

13. Leeds Academic Health Partnership to continue to have 'reducing health inequalities' as its central focus and to increase activities to facilitate closer working and better understanding of the social determinants of health within the Leeds academic community.

14. Develop the Fairer, Healthier Leeds Marmot indicators and collect data and communicate progress against them.

15. Ensure that the Fairer, Healthier Leeds Marmot indicators findings influence strategic approaches (e.g. Joint Strategic Assessment and Best City Ambition) and delivery of programmes (e.g. Early Years, planning).

Leeds has delivered a number of projects and programmes over many years to address health inequalities, but more could be done to develop a 'learning system' in the city that builds on what works locally.

Two existing partnerships have the capacity to accelerate evidence-based actions in the city to improve health equity and the social determinants of health. The Leeds Academic Health Partnership brings together the NHS, Leeds City Council, Leeds Beckett University, University of Leeds and Leeds Trinity University with the aim of reducing health inequalities in the city. The Leeds Inclusive Anchors Network brings together Leeds's largest public sector employers and again, the three universities participate in this network.

Meeting name:	Leeds Committee of the West Yorkshire ICB
Agenda item no.	31/24
Meeting date:	11th September 2024
Report title:	Director of Public Health Annual Report 2023 - Ageing Well: Our Lives in Leeds
Report presented by:	Victoria Eaton – Director of Public Health (Leeds)
Report approved by:	Victoria Eaton – Director of Public Health (Leeds)
Report prepared by:	Helen Laird and Tim Fielding

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

Previous considerations:

The Director of Public Health Annual Report 2022 was brought to the Leeds Committee of the West Yorkshire ICB to consider the key findings and recommendations.

In addition to sharing the key findings and recommendations for the 2023 Director of Public Health Annual Report, this report provides a progress update on the priorities outlined in Annual Report 2022 (contained within the full version of the DPHAR 2023 report - Appendix 1).

Executive summary and points for discussion:

The Director of Public Health (DPH) has a statutory duty to publish a report annually describing the health of the population and make recommendations to improve health. The Director of Public Health Annual Report 2023 is called 'Ageing Well: Our Lives in Leeds'.

The report provides the Leeds Committee of the West Yorkshire ICB with:

- An update on the Director of Public Health Annual Report 2023.
- An overview of the experiences of ageing well in Leeds, bringing together lived experiences alongside a review of data and evidence relating to ageing well.
- An outline of the many things we are doing to support ageing well in Leeds.
- Key findings and recommendations contained within the Director of Public Health Annual Report 2023, focussed on actions to create the conditions for healthy ageing and increase the number of years spent in good health.
- A progress update on the priorities as outlined in the Director of Public Health Annual Report 2022 (contained within the full version of the report).

Which purpose(s) of an Integrated Care System does this report align with?

☒ Improve healthcare outcomes for residents in their system

☒ Tackle inequalities in access, experience and outcomes ☒ Enhance productivity and value for money ☒ Support broader social and economic development
Recommendation(s)
The Leeds Committee of the West Yorkshire Integrated Care Board is asked to: 1. Note the findings and recommendations of the of the 2023 Director of Public Health Annual Report. 2. Note and support the recommendations identified for Leeds Health & Care Partnership and Leeds NHS organisations.
Does the report provide assurance or mitigate any of the strategic threats or significant risks on the Corporate Risk Register or Board Assurance Framework? If yes, please detail which:
N/A
Appendices
1. Director of Public Health Annual Report 2023 - Ageing Well: Our Lives in Leeds (link) 2. Executive Summary
Acronyms and Abbreviations explained
N/A

What are the implications for?

Residents and Communities	Implementing recommendations would increase the number of years spent in good health in Leeds.
Quality and Safety	N/A
Equality, Diversity and Inclusion	The report uses data and the voices of people in later life to shine a light on inequalities in the experiences of ageing well e.g. for people living in the most deprived areas of Leeds, different age ranges, ethnically diverse communities, men and women and disability/long term conditions. Findings identified differences in ageing well outcomes for particular communities and recommendations in order to address these.
Finances and Use of Resources	There is a strong economic case for supporting ageing well. Implementing recommendations will increase the number of years spent in good health, which is key to sustaining the level of services that we provide in the city through reducing the risk/need for health and care support. In addition, creating age friendly employment practices will ensure health and care organisations are supporting more people to age well in work will support job satisfaction and retention.

Regulation and Legal Requirements	NA
Conflicts of Interest	NA
Data Protection	NA
Transformation and Innovation	A number of the recommendations within the report are directed at Leeds Health & Care Partnership and NHS organisations. Leeds Committee of the West Yorkshire ICB to consider how these are considered in relation to transformation and innovation of existing services and future decisions and policy making.
Environmental and Climate Change	Interlinks between ageing well, climate change, environmental determinants of health are considered within the report.
Future Decisions and Policy Making	A number of the recommendations within the report are directed at Leeds Health & Care Partnership and NHS organisations. Leeds Committee of the West Yorkshire ICB to consider how these are considered in future decisions and policy making.
Citizen and Stakeholder Engagement	Large scale engagement was conducted in producing the report and in order to understand what supports people to stay happy, healthy and strong as they age. To build on this, the report contains a recommendation for 'Leeds City Council and Leeds NHS organisations to ensure the voices of people in later life are central to all ageing well work'.

1. Main Report Detail

Key Findings

The following outlines the key findings in the Director of Public Health Annual Report 2023 - Ageing Well: Our Lives in Leeds:

1.1 **Our ageing population is changing and becoming more diverse.**

As well as an expected increase in the 70+ age groups, population trends show that the older population (50+) is growing in the most deprived areas and becoming more diverse. We need to support people to age well in an inclusive and equitable way that considers the needs of different communities.

1.2 **The number of years that people spend in good health in later life is unequal between different communities.**

People living in more deprived communities on average spend more years in poorer health and this starts in their early 50s. Poor health isn't an inevitable part of ageing. There is much more we can do to reduce the time people spend in poorer health in later life.

1.3 **Inequalities exist in later life.**

The experiences and outcomes of ageing well (e.g. employment and travel) are not equal for people living in deprived areas of Leeds, and for particular communities. Key to addressing this will be creating healthy places, communities and opportunities that enable people to live a healthy and long life.

1.4 **Later life is an opportunity to help citizens keep active and stay healthy.**

People saw later life (50+) as an opportunity to keep active and stay healthy. Data also identified that there were opportunities to reduce inequality in healthy living between communities.

1.5 **Identifying health problems and risk factors earlier would help to delay the amount of time that people spend in poor health.**

This would also help support people in poorer health to continue to lead connected, fulfilling, and independent lives. Increasing the uptake of preventative support and services is key to this.

1.6 **Having strong, positive, social connections is an important factor in ageing well.**

Being socially active (e.g. through work, volunteering, family and community networks) is a strong protective factor for the physical and mental health and wellbeing of people of all ages, including older adults. People recognise this as an important part of ageing well. Social isolation and loneliness have a serious negative impact on physical and mental health, comparable to other well established risk factors, such as smoking, obesity and physical activity. Reducing isolation and increasing social connectedness are both central to improving healthy ageing across the city.

1.7 **People in later life experience negative sterotypes, ageism and discrimination.**

Experiences of people in later life, their health and wellbeing outcomes and access to services or support are impacted by stereotypes, ageism and discrimination. Tackling these will be key to ensuring that people in later life are valued and receive the support they need.

Recommendations

There are many things we are doing and lots more we can all do to support ageing well in Leeds. The following outlines the report's recommendations focussed on actions to increasing the number of years spent in good health:

1.8 Leeds City Council, Leeds Health and Care Partnership, Anchor Organisations, third sector and local businesses to work collaboratively to further develop Leeds as an Age Friendly City. This should include actively engaging with Age Friendly Leeds (through Age Friendly Board and Partnership, Action Plan and becoming Age Friendly

Businesses/Organisations) and embedding ageing well into all policies and services.

1.9 Leeds City Council to review and further develop ways for citizens to keep active and stay healthy (primary prevention) throughout their later lives, with a particular focus on supporting people to age well in more deprived areas (i.e. IMD* 1 and 2) and ethnically diverse communities.

1.10 Leeds City Council, Leeds Health and Care Partnership, third sector partners and Leeds Age Friendly Board to work together to review and increase opportunities for people to be socially connected, and ensure reducing social isolation in later life is central to all policies and services.

1.11 Leeds NHS organisations to increase early identification and management of risk factors and long term conditions to reduce preventable poor health in later life (secondary prevention). This should take a targeted approach working with communities with historically reduced access to and low uptake of prevention services, screening and vaccination.

1.12 Leeds City Council and Leeds NHS organisations to ensure the voices of people in later life are central to all ageing well work, taking into account insight developed through this report, State of Ageing in Leeds and people's voices from voluntary and community sector organisations.

1.13 All partners, individuals and communities to challenge negative stereotypes relating to ageing, including loss of value, discrimination and ageism.

1.14 Anchor institutions, businesses and employment and skills organisations to review and further develop positive practices to support more people in later life to age well in work.

1.15 West Yorkshire Combined Authority and Leeds City Council to work together to increase accessible and safe travel for people in later life to support independence and healthy ageing.

1.16 Academic partners to support citywide work to strengthen local research, evidence and evaluation in relation to ageing well, with a focus on local implementation and delivery.

Next Steps

1.17 Academic partners to support citywide work to strengthen local research, evidence and evaluation in relation to ageing. The report has been shared with a range of partners and will be presented at a number of strategic and partnership groups.

1.18 Delivery of the recommendations will commence and run throughout the financial year 2024-2025 and beyond. System wide partners have a role in taking account of and putting in place actions that address the recommendations in the report and the Director of Public Health is responsible for reporting progress on actions across the system.

2. Recommendations

The Leeds Committee of the West Yorkshire Integrated Care Board is asked to:

1. Note the findings and recommendations of the of the 2023 Director of Public Health Annual Report.
2. Note and support the recommendations identified for Leeds Health & Care Partnership and Leeds NHS organisations.

Appendices

1. Director of Public Health Annual Report 2023 - Ageing Well: Our Lives in Leeds (link)
2. Executive Summary

Leeds CITY COUNCIL

Executive Summary

Director of Public Health Annual Report 2023

Ageing Well: Our Lives In Leeds

Age Friendly Leeds

Ageing Well:
Our Lives
In Leeds

Watch the film

Read the full report

Welcome to the Executive Summary of 2023 Director of Public Health Annual Report for Leeds. I'm delighted to share this summary with you.

The focus of the report is ageing well in Leeds. It explores how healthy people, places, and communities all contribute to living and ageing well in Leeds.

Leeds is a wonderful place to age well. Our many strengths include:

- a longstanding commitment to be Age Friendly; with Leeds being recognised nationally as an example of good practice for this work and one of three places to hold a strategic partnership with the Centre for Ageing Better to further test and apply 'what works' to make Leeds a better place to age;
- an increasingly diverse ageing population;
- places and spaces that enable people to live healthy, fulfilling and independent lives;
- a thriving voluntary sector and communities which support social interaction;
- some fantastic activities and services to help people to stay healthy;
- support for people to manage long term health conditions and stay connected and independent in later life.

Yet not everyone in later life has the same experiences of ageing well. Some communities spend a greater number of years in later life in poorer health.

For example, people aged 50+ experience poorer outcomes across a range of issues. We see inequalities in later life for people living in deprived areas of Leeds, and for some ethnically diverse communities. We also see differences between men and women.

Like many large cities in the UK, we have a relatively young population. However, a third of the population are aged 50+ and the size of the 70-80+ population in particular is going to increase significantly in the coming years. Population trends also show that the older population (50+) is growing in the most deprived areas and becoming more ethnically diverse. With this in mind, we need to ensure that people in later life continue to feel that Leeds is a place that they can and will age well.

The report uses data and the voices of people in later life to shine a light on the experiences of ageing well in Leeds across a range of topics. This broadly covers the health and wellbeing experiences of 'people' in later life. Also, how 'places' and 'communities' support ageing well in Leeds, all with a focus on groups who experience poorer outcomes.

The good news is there is lots we can all do to support people, and ourselves, to stay healthy in later life and to reduce the time spent in poorer health.

I am grateful to everyone who has taken time to share their stories and experiences. Thanks also to colleagues and partners who have contributed data and shared examples of how we are supporting people in Leeds to age well.

Victoria Eaton
Director of Public Health
Leeds City Council

Ageing Well: Our Lives In Leeds

Introduction

Whenever we talk about ageing well, there's often a question about who do we mean? When does older age start? There are different ways of looking at this:

- **our actual age:** is the number of years since we were born. This is something we can't do anything about;
- **our biological age**: is about changes that take place in our bodies through our lives. This is influenced by many factors. For some people it means that they spend more years in later life in poor health;
- for the purpose of this report we are broadly referring to people aged 50+.

The places we live, work and socialise in, and our communities and services in Leeds play an important role in enabling people to live healthy, fulfilling and independent lives. Ageing well is everyone's business, we can all benefit and play our part - from individuals to communities and organisations. There is lots we can all do to support ageing well and increase the number of years that people in Leeds spend in good health. That is the focus of the report.

What is ageing well about?

Everybody's wellbeing! Everyone can experience ageing well:

- the amount of time people spend in poor health towards later life is largely preventable, and;
- people that are in poorer health can continue to lead healthy, connected, fulfilling and independent lives.

How do we support people to age well?

Things we can do to increase the amount of time that people spend in good health towards later life in Leeds include:

- creating places, communities and opportunities that enable people to live a healthy and long life. This can include things such as good quality work, financial security, safe and secure housing and social connections;
- pr evention and support programmes which can shorten the time that people spend in poorer health and support people to continue to lead connected, fulfilling and independent lives.

Ageing Well: Our Lives in Leeds

Living a healthy and long life is something that many of us will wish for. Whilst we know that places, communities and services help to support ageing well in Leeds, for many this is not a reality. The experiences and outcomes of ageing well are not equal across Leeds.

Our ageing population is changing and becoming more diverse (e.g. ethnically diverse and LGBTQ+) with growing numbers of people aged 50+ living in the most deprived areas. So, we need to think about how we support people to age well in an inclusive and equitable way that considers the needs of different communities.

In the report we use data and the voices of people in later life to shine a light on the experiences of ageing well in Leeds. Including:

- healthy people, covering the conditions that support healthy living focussed on topics that help people in Leeds to increase the number of years spent in good health. This includes topics such as physical activity, stopping smoking and limiting alcohol intake and long-term conditions;
- healthy places and the role that the environment in which people live supports people in Leeds to live healthy, connected and independent later lives. This includes topics such as travel, housing and public spaces;
- healthy communities and the role that our social circumstances play in supporting people to have active and fulfilling later lives. This includes topics such as community and social connections, digital inclusion and employment;
- cross cutting issues such as social connection and inequalities in the experiences of different groups. This includes differences for people living in the most deprived areas of Leeds and ethnically diverse communities, men and women;
- how people in Leeds are supported to age well across the range of topics.

There are many things we are doing and lots more we can all do to support ageing well in Leeds. In this report we will make recommendations around actions focussed on increasing the number of years spent in good health.

Further reading

- Chief Medical Officer's Annual Report 2023 – Health in an Ageing Society
- WHO: Healthy ageing and functional ability
- A consensus on healthy ageing

Key findings

In the report we explored data and heard from people in later life to shine a light on the rich and diverse experiences of ageing well in Leeds. Our key findings are summarised below. The details of what we found are included throughout the report. Overall we found:

Our ageing population is changing and becoming more diverse.

As well as an expected increase in the 70+ age groups, population trends show that the older population (50+) is growing in the most deprived areas and becoming more diverse. We need to support people to age well in an inclusive and equitable way that considers the needs of different communities.

The number of years that people spend in good health in later life is unequal between different communities.

People living in more deprived communities on average spend more years in poorer health and this starts in their early 50s. Poor health isn't an inevitable part of ageing. There is much more we can do to reduce the time people spend in poorer health in later life.

Inequalities exist in later life.

The experiences and outcomes of ageing well (e.g. employment and travel) are not equal for people living in deprived areas of Leeds, and for particular communities. Key to addressing this will be creating healthy places, communities and opportunities that enable people to live a healthy and long life.

Later life is an opportunity to help citizens keep active and stay healthy.

People saw later life (50+) as an opportunity to keep active and stay healthy. Data also identified that there were opportunities to reduce inequality in healthy living between communities.

Identifying health problems and risk factors earlier would help to delay the amount of time that people spend in poor health.

This would also help support people in poorer health to continue to lead connected, fulfilling, and independent lives. Increasing the uptake of preventative support and services is key to this.

Having strong, positive, social connections is an important factor in ageing well.

Being socially active (e.g. through work, volunteering, family and community networks) is a strong protective factor for the physical and mental health and wellbeing of people of all ages, including older adults. People recognise this as an important part of ageing well. Social isolation and loneliness have a serious negative impact on physical and mental health, comparable to other well established risk factors, such as smoking, obesity and physical activity. Reducing isolation and increasing social connectedness are both central to improving healthy ageing across the city.

People in later life experience negative stereotypes, ageism and discrimination.

Experiences of people in later life, their health and wellbeing outcomes and access to services or support are impacted by stereotypes, ageism and discrimination. Tackling these will be key to ensuring that people in later life are valued and receive the support they need.

Ageing Well:
Our Lives
In Leeds

What local people and professionals told us

In this section we share the key findings from the voices of people in later life and professionals, along with key bits of complimentary data. People told us that the following were important to helping them to stay happy and healthy in later life

1. Healthy living

such as keeping active and eating a balanced diet, not smoking and drinking less or no alcohol. Later life was mentioned as being a time and opportunity to be more active. Healthy living was also the second most important thing that people wanted to change to help them age well. Our data also identified opportunities to help people to keep active and stay healthy, support management of long-term conditions and reduce inequalities for people aged 50+ and between certain communities.

2. Being socially connected

with family, friends, neighbours, the wider community and community groups.
Later life was mentioned as being a time and opportunity to be more socially connected. This was also the third most important thing that people wanted to change to help them age well. Data identified that people in later life (55+) are more likely to have ‘never felt lonely’ than been lonely some, most or all of the time.

3. Public & civic spaces

including access to safe green spaces and culture, such as theatres and libraries are important for a happy and healthy later life.

4. Employment

that was flexible and enables people to have a good work-life balance was also something that people wanted to change to help them age well. Data identified that many people are working in later life, however some groups will experience greater barriers to being in or staying in employment.

5. Travel & road safety

including good frequency and coverage of buses, access to bus passes, feeling safe, accessibility of taxis and age friendly paths and routes both enabled and stopped people from ageing well. This was also the most important thing that people wanted to change to help them to age well. Data identified that driving and walking are the most popular ways to move around, and buses are popular. However, transport provision isn’t equal around Leeds.

Professionals also identified a number of priorities for ageing well, with the top three mirroring those identified by people in later life (though not in the same order):

1. being socially connected;
2. healthy living;
3. travel and road safety;
4. mental health and wellbeing;
5. financial wellbeing.

There were some differences between the priorities from people in later life and professionals. This highlights the importance of ensuring that the voices and priorities of people in later life and also wider evidence feed into planning and delivery of services and support:

- employment and learning were less prominent as a priority for professionals than people in later life. Although some did talk about retirement and redundancy, flexible/suitable work and caring responsibilities;
- public and civic spaces was less prominent as a priority for professionals than people in later life. Although the importance of accessible and age friendly parks and green spaces were mentioned;
- financial wellbeing was mentioned less often as a priority by people in later life than for professionals.

Despite the clear evidence about housing and its impact on health in later life, housing wasn’t frequently identified as a priority by both people in later life and professionals:

This may reflect the fact that when asked people tend to focus more on issues such as healthy living rather than the role that the environment plays in supporting them to keep healthy. However, some did talk about the importance of appropriate and secure housing, affordability and housing quality to being independent and ageing well. Our wider data also identified the importance of housing to ageing well. Many people in later life want to remain in their own home, with extra support as needed, however national data suggests that half of the homes in Leeds with health hazards may be occupied by people aged 60+.

Ageing Well: Our Lives In Leeds

What we did

The first stage in creating the report was to conduct a rapid literature review. We reviewed over 400 papers and reports on the things that support people to age well, as well as barriers. This informed the scope and evidence base for the report.

We conducted an in-depth data analysis for the report, including inequalities for different demographic groups. This helped us develop new insights into health, wellbeing, social and environmental factors of ageing well for Leeds' people.

We then published an online survey aimed at people aged 50+ in Leeds. We wanted to understand what supports people to stay happy, healthy and strong as they age. The survey received 909 responses from people covering a range of groups across Leeds. We processed, coded and analysed the data for key themes. These are explored within the report.

In addition, we conducted an online survey aimed at professionals working with people aged 50+ in Leeds. We promoted this directly with partners. The survey reached at least 100 people by email and many more by social media and staff newsletters, with 53 completed responses across health, care, wider partners and the voluntary and community sector.

We analysed the responses to identify recurring themes. These are explored within the report.

We then conducted focus groups with people aged 50+ in Leeds. We approached organisations and community groups across Leeds, to reach and engage audiences from a broad range of different backgrounds, demographics, and life experiences. The focus groups took place at:

- Hamara Healthy Living Centre - 'Recycled Teenagers' Group;
- Burmantofts Community Friends - Lunch Club;
- Armley Helping Hands;
- SAGE Men's Space hosted at Yorkshire MESMAC.

We asked people to:

- tell us what impacts their ability to age well;
- share the positives and negatives of ageing;
- contribute to group and one-to-one discussions about the topic of ageing well.

We then processed, coded and analysed the data for key themes and trends.

We identified key themes, across the three areas of:

- healthy people: healthy living, long term illness, mental health and wellbeing;
- healthy places: travel and road safety, housing, public and civic spaces, health protection and climate change;
- healthy communities: community connections, digital inclusion, employment and learning, financial wellbeing.

We also developed a short film highlighting the individual stories of people aged 50+ in Leeds and infographics of key population health data

The report will discuss each key theme in turn. It will summarise the experiences of people aged 50+ in Leeds. Each theme is supported by contributions from people of Leeds.

Setting the scene

1 in 3
people living in Leeds are aged 50+

19,300
more people aged 60+ estimated in 2033

More people 50+ moved out of Leeds (4000) than moved into Leeds (3000) in 2020[1]

1346
Approximately 1346 people aged 50+ are living with a learning disability[4]

2 in 10
people that identify as LGBTQ+ are aged 45+

Around 1 in 2 who 'prefer not to say' are 45+.[3]

2 in 10
people aged 50+ are living in the most deprived areas of Leeds

Over 1 in 2
of unpaid carers are aged 50+

By 2030, adults aged 70+ with a learning disability will more than double

37%
of people aged 50+ from ethnically diverse communities are living in the most deprived areas

Over 95
main languages spoken by Leeds residents[2]

77.6
Male Life expectancy
Most deprived 73 years
Least deprived 82.3 years

81.4
Female life Expectancy
Most deprived 77.3 years
Least deprived 86.1 years

Over 1 in 2
People aged 50+ are living with 2+ long-term conditions.[2]

13%
people aged 50+ are from ethnically diverse backgrounds

25%
of the 30-49 age groups are from ethnically diverse backgrounds

1. Internal UK migration data from ONS for June 2020.
2. Census 2021 where language count was minimum 50 people.
3. There are likely to be more LGBTQ+ people age 50+ that are not showing in the data. Note that age is 45+ as per ONS data release for this topic
4. Regestered on GP learning disability registers.

Setting the scene: ageing well and diversity in Leeds

Life Expectancy in Leeds

People in Leeds are generally living longer than they were 20 years ago. However, in recent years (between 2011-13 to 2019-21) there has been:

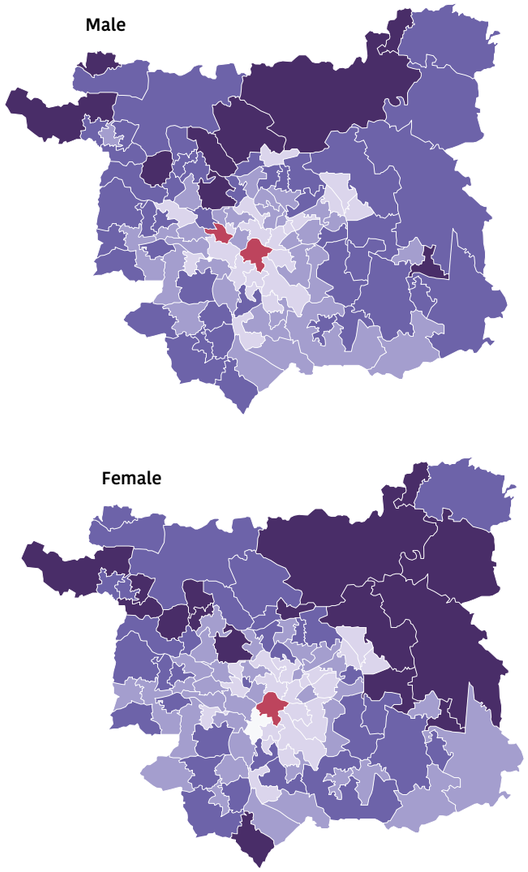
- a slight decline in the life expectancy of women (from 81.9 to 81.4 years);
- a decline in the most deprived areas (from 78.5 years to 77.3 years);
- no significant change in the least deprived areas (86.1 years in 2019-21).

Time spent in poor health in Leeds

The maps show how this plays out across Leeds. We know that behind this are real differences in how healthy people are as they age:

- the number of years that people spend in good health in later life varies in different communities;
- people living in our deprived areas spend a larger number of years in poor health in later life and this starts in their early 50's;
- this is particularly relevant for us, as in Leeds we have 1 in 4 of our total population living and ageing in the most deprived areas.

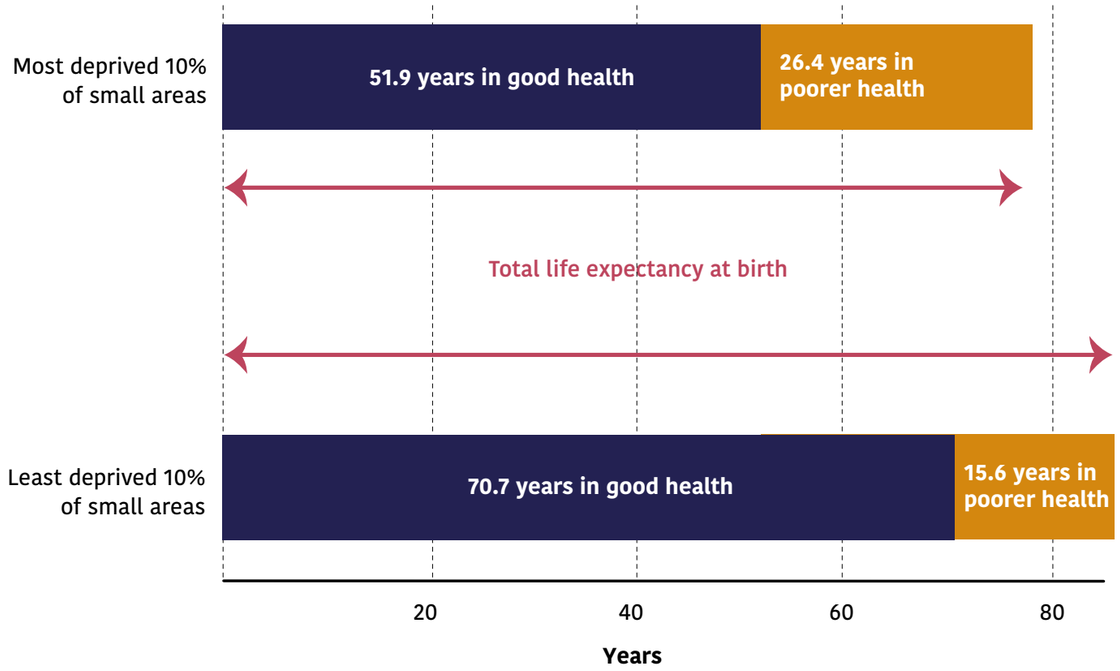
Life Expectancy at birth



Pink on map denotes areas that have no life expectancy data, which is a side effect of the calculation process. If there is a zero population in a five year age band (in an MSOA) it is not possible to calculate life expectancy.

69-74 years
74-78 years
78-82 years
82-86 years
86-90 years
No value

Inequality in life expectancy and healthy life expectancy at birth for females in the most and least deprived areas in England, 2018 to 2020



Source: Chief Medical Officer's annual report 2023: health in an ageing society

Ageing & diversity in Leeds

Using data, we can look at trends and projected changes in population size for different groups. We need to use this to think about how we can support people to age well in the future. For example:

- looking to 2033 we can see a reduction in 50-59 age group, and growth in the 70+ age groups (and very significant growth in the 80+ age group).
- many people that live in Leeds do stay until and throughout later life with 1 in 3 residents being aged 50+. So, whilst Leeds is a young city, we increasingly need to ensure that people in later life continue to feel that Leeds is a place that they can age well.
- 19% people aged 50+ are living in the most deprived areas. This increases to around 24% in people across all ages. People are ageing in our deprived areas and this will continue to grow.
- around 1 in 10 people aged 50+ in Leeds are from ethnically diverse communities (13%). This increases to more than 2 in 10 for people aged 30-49. This means our 50+ population will become more ethnically diverse;
- almost 2 in 10 people that are that identify as LGBTQ+ are aged 45+. The LGBTQ+ population in the 35-44 age group is more than two times higher than the 45+ age group. However, nearly half of people who 'prefer not to say' are aged 45+, so there may be more LGBTQ+ people age 50+ that are not showing in the data.

This suggests that the 50+ population will become more diverse (e.g. ethnically diverse and LGBTQ+) with growing numbers of people aged 50+ living in the most deprived areas. So, we need to think about how we support people to age well in an inclusive and equitable way that considers the needs of different communities.

Snapshot of ageing well in Leeds

34%
of people aged 55+ 'never' felt lonely, but 4% 'often/always' felt lonely; 12% felt lonely 'some of the time'

23%
of people aged 50+ are active

5 in 10
people from 'Asian' backgrounds reported being 'inactive'[2]

2 in 3
people aged 50+ are overweight

1 in 20
people aged 50+ underweight

Most people aged 50+ have good mental health

Common Mental Health Illness:
1 in 3 people aged 50+
1 in 4 people aged 18-49

18.1
Women spend **18.1 years** in poorer health in later life

16.8
men spend **16.8 years** in poorer health in later life[1]

3%
Only around 3% of the 65+ age group are living in a nursing or care home

There are an estimated 51,000 homes in Leeds with health hazards. Half of these homes will be occupied by someone aged 60+[5]

1 in 3
people aged 50+ in Leeds have successfully quit smoking

80%
of people eligible have claimed their bus pass. But only 60% in some inner-city areas

16%
people aged 60+ experience income deprivation

12x
People aged 65+ are 12x more likely to be non-digital users

2 in 3
people aged 50-64 years are in employment

40,000
people aged 50-64 are economically inactive. 6,600 not in work due to health reasons; 11,900 long term illness[4]

4x
Men aged 50+ are 4 times more likely to drink at higher risk levels compared to women aged 50+

3x
People 50+ are 3 times more likely to drink at higher risk levels[3]

27%
of people aged 50+ do not drink alcohol

Access/equity of access to services in 50+:

Smoking equal to need	=
Sexual health lower than need	▼
Mental health lower than need	▼
Alcohol lower than need	▼
Home adaptations equal to/higher than need	▲

Over 1 in 2
People aged 50+ are living with 2 or more long-term conditions. More than 4 out of 5 people aged 80+ are living with a long-term condition

1.5x
The risk of heart disease, or stroke, is 1.5x higher in the most deprived parts of Leeds

1. Difference between life expectancy at birth and healthy life expectancy. 2. Self-reported from GP data. 3. Compared to people aged under 50. 4. Not working due to caring responsibilities, health conditions, retirement or because they do not think there is suitable work available for them (Census 2021). 5. National Data.

Snapshot - What local people and professionals told us

Key

- Healthy people
- Healthy places
- Healthy communities

78%
of people said that healthy living helped them stay happy and healthy

21%
of professionals talked about mental health and wellbeing as being a priority for ageing well. Including addressing social isolation, equitable access to services, and community provision

40%
of people said that healthy living was a priority. Increasing opportunities to be active and addressing barriers to this were important

Later life for some people means being able to do the things they didn't get time to do when they were younger

56%
of people said public spaces are important to being happy and healthy

Later life can be an opportunity to be more active

Being physically active helps people to feel younger

People value going at a slower pace as they age. It can be less stressful, with more time, compared to working life

Public and civic spaces were mentioned less by professionals as being a priority for ageing well – some did talk about the importance of accessible and age friendly parks and green spaces with free parking

People value access to green spaces and enjoy using them – these are a positive feature of Leeds that enables people to age well

Theatres and libraries are important for staying happy and healthy

21%
of people said the frequency and coverage of buses, feeling safe, accessibility of taxis and age friendly paths and routes stop them from doing things

44%
of people said walking helps to keep them happy and healthy

Transport is a barrier to people attending health appointments in different parts of Leeds

36%
of professionals talked about travel as being a priority for ageing well

55%
of people talked about being socially connected with family, friends, neighbours, their wider community and community groups

Some people were looking forward to reducing hours or retirement so they could do more things to age well

12%
of people reported that improved financial wellbeing would help them stay happy and healthy as they age

Despite clear evidence, housing wasn't frequently identified as a priority by both people in later life and professionals

Later life is a time and opportunity to be more socially connected

66%
of professionals mentioned the importance of people being socially connected to support ageing well

For many people, community groups allows people to get out, be more sociable, and access additional resources and support

38%
of people talked about the importance of employment and learning

Employment and learning were mentioned less by professionals as being a priority for ageing well

Work and work-life balance enabled social interaction and allowed people to do things to age well

Some people are nervous of technology; some people accessed tech clubs in the community, but others were less interested in this

20%
of professionals mentioned financial wellbeing including cost of living, the cost of ageing well activities, or the transport to get to them as a priority for ageing well

Ageing Well:
Our Lives
In Leeds

Recommendations

1. **Leeds City Council, Leeds Health and Care Partnership, Anchor Organisations, third sector and local businesses to work collaboratively to further develop Leeds as an Age Friendly City. This should include actively engaging with Age Friendly Leeds (through Age Friendly Board and Partnership, Action Plan and becoming Age Friendly Businesses/Organisations) and embedding ageing well into all policies and services.**

2. Leeds City Council to review and further develop ways for citizens to keep active and stay healthy (primary prevention) throughout their later lives, with a particular focus on supporting people to age well in more deprived areas (i.e. IMD* 1 and 2) and ethnically diverse communities.

3. **Leeds City Council, Leeds Health and Care Partnership, third sector partners and Leeds Age Friendly Board to work together to review and increase opportunities for people to be socially connected, and ensure reducing social isolation in later life is central to all policies and services.**

4. Leeds NHS organisations to increase early identification and management of risk factors and long term conditions to reduce preventable poor health in later life (secondary prevention). This should take a targeted approach working with communities with historically reduced access to and low uptake of prevention services, screening and vaccination.

5. **Leeds City Council and Leeds NHS organisations to ensure the voices of people in later life are central to all ageing well work, taking into account insight developed through this report, State of Ageing in Leeds and people's voices from voluntary and community sector organisations.**

6. All partners, individuals and communities to challenge negative stereotypes relating to ageing, including loss of value, discrimination and ageism.

7. **Anchor institutions, businesses and employment and skills organisations to review and further develop positive practices to support more people in later life to age well in work.**

8. West Yorkshire Combined Authority and Leeds City Council to work together to increase accessible and safe travel for people in later life to support independence and healthy ageing.

9. **Academic partners to support citywide work to strengthen local research, evidence and evaluation in relation to ageing well, with a focus on local implementation and delivery.**

*Further information on the Indices of Multiple Deprivation

"[Ageing well] means still being active, having good health, being able to contribute and play my part, and being financially able to do that, and being respected and not ruled out as I age"

Hannah, 50
Roundhay

Ageing Well: Our Lives In Leeds

If you need information from this executive summary in a different format, please email: publichealth@leeds.gov.uk

Please tell us the web address (URL) of the content, your name and email address and the format you need. For example: audio, braille, BSL or large print.

Read the full report online at:
www.leeds.gov.uk/publichealthannualreport23

Further information on health statistics for Leeds and past reports are available online at: http://observatory.leeds.gov.uk

We welcome feedback about our annual report. If you have any comments, please email: publichealth.enquiries@leeds.gov.uk

Report Design: Brightsparks Agency

Leeds CITY COUNCIL

Age Friendly Leeds

Committee Escalation and Assurance Report – Alert, Advise, Assure

Report from: Leeds Quality & People's Experience Subcommittee (QPEC)

Date of meeting: 17 July 2024

Report to: Leeds Committee of the West Yorkshire Integrated Care Board (WY ICB)

Date of meeting reported to: 11 September 2024

Report completed by: Karen Lambe, Corporate Governance Officer on behalf of Rebecca Charlwood, Independent Chair, Leeds Quality & People's Experience Subcommittee (QPEC)

Key escalation and discussion points from the meeting
Alert:
Risk Management Report During discussion of the risk management report, concern was raised regarding an emerging risk in the system impacting access to equipment services. Members were informed that a whole system review of equipment services and budget pressures was currently being undertaken by the local authority. The subcommittee noted the risk of patient harm due to financial pressures on equipment service providers. The subcommittee also noted the financial risk in the system and its impact on the quality of services.
Advise:
West Yorkshire Quality Committee Update (WYQC) The QPEC Subcommittee was informed that the WYQC had received a paper which detailed the processes, governance and reporting in operation across WY ICB to monitor the quality and safety of the care home sector. QPEC members discussed the need to be ambitious about quality improvement in the care home sector, reflecting on the challenges it faced in recruitment and training of staff. A 'deep dive' report on care home quality would be brought to the QPEC meeting in October 2024. **People's Voice** The subcommittee was made aware of two concerns raised by service users. Firstly, recent changes in accessing mental health (MH) crisis services had required people to contact 111 and be transferred to a national call centre, thereby replacing the previous direct access line to the Leeds & York Partnership NHS Foundation Trust (LYPFT) Single Point of Access (SPA). Secondly, following a change in provider of hearing aid tests, a number of people had incorrectly been directed to Healthwatch Leeds for assistance. Concern was expressed that a lack of communication in both cases had exacerbated access challenges for vulnerable service users and a lack of coordination had resulted in healthcare records not being

updated. The subcommittee noted the importance of progressing the development of a single care record.

Quality Highlight Report
There was a discussion regarding Datix and the new national NHS service for the recording and analysis of patient safety events to support and improve learning - Learn from Patient Safety Events (LFPSE). A briefing paper was being prepared to consider the reporting mechanism of incidences for GP practices in order to meet national requirements.

Assure:

Population and Care Delivery Board Reports
The subcommittee was presented with the reports of the Mental Health (MH) Population Board and the Learning Disabilities and Neurodiversity (LDND) Board. Members noted the challenges for the MH Board included financial position, financial transparency and wider MH governance. Board activity focussed on Community Mental Health (CMH) and Adult Mental Health Crisis Transformation as areas of work relating to the priorities and needs identified in the Healthy Leeds Plan. Members were informed that data analysis had indicated an underrepresentation of racialised communities in certain MH services. Assurance was given that, following learning from Staten Island work, progress was being made in reaching out to the identified communities.

A number of workstreams were highlighted in the LDND Board report including the development of a dynamic support register for people with LD and/or autism, as well as ADHD and autism pre-diagnostic support via social prescribing. With regards to right to choose providers, the subcommittee noted that there were some concerns regarding referral costs and some quality issues.

Members were informed that the out of area position remained challenging following COVID-19, with Leeds as an outlier in West Yorkshire. Assurance was given that work with NHS England was addressing the issue. A progress report on out of area placements would be brought to the QPEC in October 2024.

Quality Highlight Report
With regards to Commissioning for Quality and Innovation (CQIN) schemes, members were informed that all Leeds's trusts had successfully completed 2023/24 submissions. The mandatory scheme for 2024/25 had been paused and would become optional and subject to local agreement between providers and commissioners.

Committee Escalation and Assurance Report – Alert, Advise, Assure

Report from: Leeds Finance and Best Value Sub-Committee

Date of meeting: 31 July 2024

Report to: Leeds Committee of the West Yorkshire Integrated Care Board

Date of meeting reported to: 11 September 2024

Report completed by: Karen Lambe, Corporate Governance Officer, WY ICB, on behalf of Cheryl Hobson, Independent Member and Chair of Finance and Best Value Sub-Committee

Key escalation and discussion points from the meeting
Alert:
Final Financial Plan 2024-25 The Finance and Best Value Subcommittee was made aware of risk relating to the agreed pay settlements for NHS staff of 5% and how this would be funded. Concern was expressed that the increase would widen the discrepancy between third sector and NHS staff salaries. Members noted the further risk associated with pressures on services which were not funded via NHS budgets. Members were informed that the West Yorkshire Integrated Care System (WY ICS) had submitted a £50m deficit plan with efficiency plans of £434m to NHS England (NHSE). Following agreement with NHSE, the WY ICS had been offered £50m in non-recurrent support spending. The plan included a £71.6m provider deficit position, partially offset by a surplus of £21.6m within the ICB, with the planned deficit lying in the acute sector, excluding Leeds Teaching Hospitals NHS Trust (LTHT). While Leeds Place had the lowest deficit position (0.5%) of all five Places within the ICS and a Quality, Innovation, Productivity and Prevention (QIPP) target of £38.6m, the subcommittee wished to highlight to the Leeds Committee the significant risk held at Leeds Place with a £8.3m planned deficit with small surplus positions being held by all three provider organisations and a £12.3m deficit at the ICB in Leeds. **Financial Position Update at Month 3** The subcommittee was informed that Leeds Place was reporting £1.4m ahead of plan, mainly due to the phasing of the LTHT plan position. The ICB in Leeds reported a £3.1m deficit at Month 3 in line with plan. Members noted a number of emerging risks, including the primary care ballot, and reported forecast slippage within the QIPP programme of £1.8m that could adversely impact the plan and recognised that mitigations would require prioritisation.
Advise:
Population and Care Delivery Board Reports

The subcommittee was presented with the reports of the Mental Health (MH) Population Board and the Learning Disabilities and Neurodiversity (LDND) Board. The subcommittee discussed concerns regarding the financial transparency of right to choose (RTC) referral costs for NHS trusts and the complexity of how costs were apportioned across services.

Members discussed the challenge of meeting statutory obligations for people with high cost care needs while achieving financial balance. There was a discussion regarding the interface between Population Boards and their cohorts. Members considered the differences in how value was measured across a number of subgroups. It was agreed that a wider discussion and further work was required to define best value principles across all of the groups.

Risk Management Report

The subcommittee discussed the tension between short term delivery of the financial plan and medium term planning. Members agreed there needed to be compromise to ensure sustainability and to reconsider priorities and whether they aligned to the Healthy Leeds Plan. A progress update on the medium-term financial plan would be brought to the next subcommittee meeting in October.

Assure:

Risk Management Report

Members received a report providing an update on the Risk Register and the risks aligned to the Finance and Best Value Subcommittee. There were eight high scoring open risks scoring 12 or above. No risks were closed and no new risks were added. Members welcomed the forthcoming review of the full risk register by the Directors Leadership Team in August 2024 and discussed the rearticulation of the risks and the mitigations in light of the financial position. The subcommittee was assured that Place Directors of Finance were working collaboratively to ensure consistent articulation of financial risks.

Population and Care Delivery Board Reports

Members noted the maturity of the MH Population Board and the challenges it faced regarding the current financial position, financial transparency and wider MH governance. Assurance was given that the Leeds Partner Leadership Team (PLT) had sight of the wider MH governance issue. MH Board members had recently participated in a development session on finances to address the challenge of efficiencies and QIPP.

Meeting name:	Leeds Committee of the West Yorkshire Integrated Care Board (WY ICB)
Agenda item no.	34/24
Meeting date:	Wednesday 11th September 2024
Report title:	2024-25 Financial Position at Month 4
Report presented by:	Alex Crickmar, Director of Operational Finance
Report approved by:	Alex Crickmar, Director of Operational Finance
Report prepared by:	Alex Crickmar and Matt Turner

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

Previous considerations:

This is a regular item, considered at each meeting of the Leeds Committee of the West Yorkshire ICB.

Executive summary and points for discussion:

This paper sets out the financial position of the Integrated Care Board (ICB) in Leeds and the wider Leeds System at the end of July (Month 4) 2024/25.

The ICB in Leeds financial plan for 2024/25 was a £12.3m deficit. The ICB is forecasting a balanced position at Month 4, with pressures in Mental Health budgets currently being offset by an under spend in Prescribing. The Month 4 position and available data is still limited so there remains significant risks and potential pressures which will need managing to stay in a balanced position. This includes delivery of a significant efficiency programme in 2024/25 which currently shows a £2.4m pressure that will need to be mitigated before the end of the financial year.

At Month 4 the Leeds Health and Care Partnership are reporting £2.6m behind plan.

Which purpose(s) of an Integrated Care System does this report align with?

☐ Improve healthcare outcomes for residents in their system

☐ Tackle inequalities in access, experience and outcomes

☒ Enhance productivity and value for money

☐ Support broader social and economic development

Recommendation(s)

The Leeds Committee of the West Yorkshire Integrated Care Board is asked to:

a. Review and Comment on the 2024/25 financial position at Month 4
b. Review and Comment on the QIPP position for 24/25 at Month 4

c. Note the national context and the extended WY review of finances building on from the WYAAT commissioned review of acute trusts. d. Discuss next steps across the Leeds System as we continue to focus on achieving a financially balanced position across the Leeds system and for the ICB in Leeds
Does the report provide assurance or mitigate any of the strategic threats or significant risks on the Corporate Risk Register or Board Assurance Framework? If yes, please detail which:
Assurance around financial grip and oversight by Leeds system leaders of the Leeds NHS system and specifically around the Leeds Place of the ICB's financial recovery plan
Appendices
1. Risk assessment of Efficiency Delivery 2. QIPP tracker
Acronyms and Abbreviations explained
1. WY ICB – West Yorkshire Integrated Care Board 2. QIPP – Quality, Innovation, Productivity and Prevention (Commissioner terminology for efficiencies) 3. CIP – Cost Improvement Programme (Provider terminology for efficiencies) 4. LTHT – Leeds Teaching Hospitals NHS Trust 5. LCH – Leeds Community Healthcare NHS Trust 6. LYPFT – Leeds and York Partnership Foundation NHS Trust 7. PFI – Private Finance Initiative (Capital for Buildings)

What are the implications for?

Residents and Communities	Restricted developments
Quality and Safety	
Equality, Diversity and Inclusion	
Finances and Use of Resources	Strict Financial Recovery Measures
Regulation and Legal Requirements	
Conflicts of Interest	
Data Protection	
Transformation and Innovation	
Environmental and Climate Change	
Future Decisions and Policy Making	Continued scrutiny on value for money
Citizen and Stakeholder Engagement	

1. Main Report Details

1.1 The purpose of this report is to provide an update on the ICB in Leeds financial position as at month 4 of 24/25, as well as an update on QIPP delivery for 24/25.

Context and Background information

1.2 For the WY system to meet its financial duties all Providers across WY as well as all Places across the WY ICB must collectively meet their planned financial position. There is room for offsets across the whole system, but each Place consisting of the Providers in that Place and the WY ICB budgets devolved to Place is performance managed against its planned position.

1.3 Under the proposed national NHSE oversight framework (currently in consultation NHS England » NHS Oversight Framework) each ICB and provider is assigned a segment between 1 and 4 indicating their respective level of delivery and support or intervention needs. However, there is now a revised approach to Investigation and Rapid Intervention that NHSE have implemented following the reporting of the in year financial position which looks at only finance metrics (whereas NOF ratings take account of other factors). West Yorkshire ICB was initially rated as 2 (1 being best 4 being worse) at month 3. However, for month 4 the West Yorkshire system is forecasting a £12m adverse variance to plan with the ICS now moving into segment 3 in the finance metric which will mean additional intervention. It is within this context and the challenging financial plan set across West Yorkshire, that the ICS is commissioning an independent review of its financial position building on from the work already commissioned by the West Yorkshire Association of Acute Trusts (WYAAT). This work is currently being scoped with all NHS partners across West Yorkshire and will involve the whole ICS. This work is expected to start in September.

1.4 In terms of national updates we have been informed:

- The Pay Award will be funded (clarity on running costs and non-NHS contracts pay award funding is outstanding)
- Impact of Junior Dr strikes in year will be funded, but no changes to ERF targets.
- Nationally the message is there will no more funding in year with the NHS expected to deliver the plans it has committed to.
- By autumn we should expect final settlement for 24/25 NHS budget and a one year 25/26 budget.
- The Darzi NHS review of the NHS will be completed in September 24
- Next spring we should expect multiyear NHS budget following the spending review.

1.5 The position reported at month 4 for the ICB in Leeds reflects a best-case scenario in terms of outturn for the current financial year. It is based on information available at Month 4. There are a number of risks which have already crystallised which are being supported by other areas where risks may develop later and are already giving cause for concern. Given the ICB in Leeds underlying deficit position and our lack of flexibilities to mitigate, our position is very exposed to risks as they emerge with no headroom for mitigation.

2 Key Points – Month 4 Financial Position Update

2.1 The Leeds wide position reported at **month 4** is shown in the table below.

	YEAR TO DATE - M04			FORECAST					
Organisation	I&E reported Month 04 24/25			I&E forecast			Scenarios - Org assessment		
	Plan £m	Surplus / (Deficit) £m	Reported Variance £m	FOT Plan £m	FOT Surplus / (Deficit) £m	FOT Variance £m	Best Case Variance £m	Likely Case Variance £m	Worse Case Variance £m
Leeds ICB	(4.1)	(4.1)	(0.0)	(12.3)	(12.3)	(0.0)	0.0	0.0	(18.0)
LYPFT	(1.4)	(1.2)	0.2	1.0	1.0	0.0	0.0	0.0	(5.6)
LCH	0.3	(0.1)	(0.4)	1.0	1.0	0.0	0.0	0.0	(4.7)
LTHT	(14.4)	(16.8)	(2.4)	2.1	2.1	0.0	0.0	0.0	(90.8)
Leeds Place Total	**(19.6)**	**(21.2)**	**(2.6)**	**(8.2)**	**(8.2)**	**(0.0)**	**-**	**-**	**(119.1)**

2.2 This shows that at Month 4 the Leeds Health and Care Partnership are reporting £2.6m behind plan.

- LTHT have undertaken an internal 'fundamental review' of its position and the actions needed to achieve its plan but are behind their YTD plan by £2.4m in part due to industrial action impact of £1.6m. Currently LTHT are still forecasting under a best-case scenario that they can achieve plan but are flagging significant risks with a worst case of £90.8m in the Month 4 return to the WY ICB.

- LCH whilst showing they are behind plan at Month 4 are reporting that there run rate position is improving and they are still forecasting achievement of plan. LCH worst case is currently assessed as £4.7m variance to plan which has increased by £0.8m since Month 3.

- LYPFT are now ahead of YTD plan by £0.2m having seen a significant improvement in monthly run rate driven by actions including improvement in OAPs. LYPFT are still forecasting £1m surplus, with key risks to delivering being OAPs deterioration (especially over the winter months) and slippage on efficiencies. LYPFT worst case is currently assessed as £5.6m variance to plan.

- Leeds City Council are reporting a c.£20m forecast year end deficit at Month 3. To get to this position Adult Social Care will need to deliver £16m and Children's Services £18m of identified action plans over the remainder of the financial year.

2.3 The ICB in Leeds is reporting a £4.1m deficit at Month 4 in line with plan. The reported position corresponds to the best-case scenarios across the system and reflects the limited data available at this point. The month 4 year to date and forecast outturn positions for the ICB in Leeds are as follows:

	YTD Plan	YTD Spend	YTD variance	Annual Plan	Forecast Spend	Annual Variance
	£000	£000	£000	£000	£000	£000
RESOURCE						
Allocation - Programme	529,989	529,989	0	1,580,379	1,580,379	0
Allocation - Primary Care Co-Commissioning	56,264	56,264	0	160,603	160,603	0
Allocation - Running Costs	1,970	1,970	0	5,910	5,910	0
TOTAL RESOURCE	**588,223**	**588,223**	**0**	**1,746,892**	**1,746,892**	**0**
SPEND						
Acute	286,724	286,640	84	856,784	856,850	-66
Mental Health	82,436	82,955	-519	247,309	248,884	-1,575
Community	74,709	74,715	-6	224,126	224,137	-11
Continuing Care Services	27,948	27,982	-33	83,845	83,995	-151
Prescribing and Primary Care	57,219	56,434	785	171,658	169,819	1,839
Primary Care Co-Commissioning	58,313	58,248	65	166,751	166,601	150
Other	3,049	3,097	-48	9,148	9,180	-32
Programme Reserves	-47	547	-594	-6,340	-5,907	-433
Subtotal programme spend	**590,353**	**590,618**	**-266**	**1,753,281**	**1,753,560**	**-278**
Running Costs	1,970	1,689	281	5,910	5,632	278
Total Spend	**592,323**	**592,307**	**-15**	**1,759,192**	**1,759,192**	**0**
Net Position	**-4,100**	**-4,084**	**-15**	**-12,300**	**-12,300**	**0**

2.6 Whilst the ICB in Leeds is reporting a balanced position at Month 4 we are already seeing pressures around risks emerging and challenges including ensuring that QIPP/Efficiency scheme delivery stays on track (see the efficiency update section below).

2.7 The main overspending area is within Mental health services which is forecasting a £1.6m overtrade due to the Learning Disability pool and rehab placements and there remains a further risk around ADHD referrals. This is currently being offset by a forecast underspend within the Prescribing budget based on May data and is subject to change as well as the impact of GP collective action as highlighted in the efficiency section. Within the forecast position risks around slippage on efficiencies schemes is currently being assumed to be mitigated before the end of the financial year.

2.8 The running costs for the ICB are showing a small forecast underspend of £278k at month 4 (see Appendix 1) and are currently on track to hit our reduced budget for 24/25 of £5.9m (down from £12.7m in 23/24).

2.9 Overall West Yorkshire is reporting a £12m adverse position to plan at Month 4 (£64m deficit). The variance of £12m to plan across West Yorkshire is driven by; direct costs of industrial action disputes, reduced achievement in Elective Recovery Fund, pay overspends and efficiency plans under delivery.

Organisation	Plan £m	Surplus / (Deficit) £m	Reported Variance £m
West Yorkshire ICB Total	6.5	6.5	0.0
West Yorkshire ICB Total	**6.5**	**6.5**	**0.0**
Airedale NHS Foundation Trust	(8.7)	(11.2)	(2.5)
Bradford District Care NHS Foundation Trust	(1.0)	(1.2)	(0.2)
Bradford Teaching Hospitals NHS Foundation Trust	(9.5)	(10.0)	(0.5)
Calderdale And Huddersfield NHS Foundation Trust	(11.8)	(12.1)	(0.3)
Leeds and York Partnership NHS Foundation Trust	(1.4)	(1.2)	0.2
Leeds Community Healthcare NHS Trust	0.3	(0.1)	(0.4)
Leeds Teaching Hospitals NHS Trust	(14.4)	(16.8)	(2.4)
Mid Yorkshire Hospitals NHS Trust	(11.9)	(15.4)	(3.5)
South West Yorkshire Partnership NHS FT	(0.5)	(1.5)	(1.0)
Yorkshire Ambulance Service NHS Trust	0.3	(1.0)	(1.3)
West Yorkshire Provider Total	**(58.61)**	**(70.52)**	**(11.91)**

4. Key Points – Month 4 Efficiency Update

Summary of QIPP Savings to date as at August 2024

Original Planning Assumption	**£38,532,000**
Month 4 Forecast	**£36,219,807*** **2x new schemes identified*
Expected Variance	**£2,312,193*** **Includes unidentified and known slippage*
Scheme forecasting to deliver but awaiting data	**£6,119,083**
Risks (Table 5 below)	**£3,309,250**
Worse Case	**£11,740,526**

Breakdown of Forecast Grouping

	Plan 24/25	Forecast 24/25	Variance
Technical Finance led schemes	**£20,243,000**	**£18,993,000**	**(£1,250,000)**
Pathway and System Integration	**£6,589,000**	**£6,173,478**	**(£415,522)**
Prescribing (Medicines Optimisation)	**£9,000,000**	**£8,853,329**	**(£146,671)**
CHC	**£2,200,000**	**£2,200,000**	**£0**
Unidentified	**£500,000**	**£0**	**(£500,000)**
Total	**£38,532,000**	**£36,219,807**	**(£2,312,193)**

Key Risks and Issues

a. Potential risks to delivery that are not included in the forecast.

Impact of DOAC switch to apixaban	**£1,500,000**
General Practice Collective Action Impact	**£1,500,000**
Outstanding QEIA	**£309,250**
Total	**£3,309,250**

b. Mitigation Scheme Awaiting Finalisation

Mitigation scheme in final stages of agreement with General Practice to employ third party to enact switch before they can progress to the delivery phase. Paper due to Directors on 28 August 2024.

Scheme No	Scheme Name	Value
O083	DOAC - Switch to apixaban	£1,500,000
	Total	**£1,500,000**

c. Impact of General Practice collective action on prescribing compliance

- Following the British Medical Association starting collective action in General Practice, there is a high risk that this has an impact on cost saving work through the switch-off of Medicines Optimisation software, however there is some mitigation through local incentive schemes. Primary Care teams are continuing to engage in local and regional scenario planning and continued engagement with the Local Medical Committee and practices is taking place.

Scheme No	Scheme Name	Value
N/A	Various Prescribing Schemes	£1,500,000
	Total	**£1,500,000**

It is possible there will be further financial risks associated with Primary Care Ballot which cannot be quantified at this stage:

- Disengagement to cost effective switching
- Active decision making to create cost pressures by prescribing outside the commission policy e.g. use of Optimise Rx.

Outstanding QEIAs

Schemes with **outstanding QEIAs** following the panel in July.

Scheme No	Scheme Name	Value	Issues
O065	Covid Urgent Eye Service	£209,250	• Proposal agreed, QEIA for week of 19 August. • Note value not at risk.
O052	Further integration and improving value within Adult Mental Health Crisis Pathway	£100,000	• Proposal for Crisis Cafes completed and confirmed with providers and QEIA being developed. Second scheme with LSCS will start April 2025. • Mitigated via Brudenell Road connections to offset in year.

O016	Support mobilisation of new model for SMEH - Community Emotional Mental Health Support	No value at risk	• Not ready for panel 4 assessment following recommended updates from panel 3 - however contract already awarded and mobilised
	Total	**£309,250**	

5. Risks and Conclusion

Given the emerging risks currently flagged in the first four months of the year, it is possible that the ICB in Leeds might be reporting an adverse variance from plan over the coming months and therefore looking for additional mitigations.

The current risks that are emerging relate to:

- The forecast slippage within the QIPP programme of £2.3m. On top of this there are potential risks relating to; capturing all independent sector activity within ERF; the impact of any GP collective action on assumed prescribing savings and delivery of assumed CHC savings.

- The main overspending area is within Mental health services which is forecasting a £1.6m overtrade due to the Learning Disability pool and rehab placements and there remains a further risk around ADHD referrals. Alongside this there is an LD CHC historic case with potential costs of between £0.5-£1.5m which requires decision. Further assurance is needed on delivery of CHC efficiency opportunities especially in the context of the ICB in Leeds being an outlier in this area.

6. Recommendations

The Leeds Committee of the West Yorkshire Integrated Care Board is asked to:

a. Review and Comment on the 2024/25 financial position at Month 4
b. Review and Comment on the QIPP position for 24/25 at Month 4
c. Note the national context and the extended WY review of finances building on from the WYATT commissioned review of acute trusts.
d. Discuss next steps across the Leeds System as we continue to focus on achieving a financially balanced position across the Leeds system and for the ICB in Leeds

Appendix 1 – Staffing (Running Costs and Programme Spend)

RC/Programme	Cost Centre	Description	Subjective Type	Values -YTD Budget	-YTD Actual	-YTD Variance	-Annual Budget	-Forecast Outturn	-Forecast Variance
PROGRAMME									
	945179	Primary Care IT: Leeds	NON PAY	1,130,695	1,121,272	-9,423	3,392,080	3,392,080	-
			PAY	210,780	113,627	-97,153	632,336	621,468	-10,868
		Primary Care IT: Leeds Sum		**1,341,475**	**1,234,899**	**-106,576**	**4,024,416**	**4,013,548**	**-10,868**
RUNNING COST									
	945585	Digital Corporate: Leeds	NON PAY	122,164	119,220	-2,944	366,500	366,500	-
			PAY	68,068	68,068	-	204,200	204,200	-
		Digital Corporate: Leeds Sum		**190,232**	**187,288**	**-2,944**	**570,700**	**570,700**	**-**
				1,531,707	**1,422,187**	**-109,520**	**4,595,116**	**4,584,248**	**-10,868**
RUNNING COST									
	945564	Integrated digital service business intelligence: Leeds	NON PAY	187,892	200,127	12,235	563,677	563,677	-
			PAY	461,496	427,563	-33,933	1,384,472	1,435,999	51,527
		Integrated digital service business intelligence: Leeds Sum		**649,388**	**627,690**	**-21,698**	**1,948,149**	**1,999,676**	**51,527**
	945587	Data Lab Recharges: Leeds	INCOME	0	-47,594	-47,594	0	0	-
			PAY	4	47,597	47,593	0	1	1
		Data Lab Recharges: Leeds Sum		**4**	**2**	**-2**	**0**	**1**	**1**
				649,392	**627,692**	**-21,700**	**1,948,149**	**1,999,677**	**51,528**
PROGRAMME									
	945045	Complex needs MH LD and autism: Leeds	NON PAY	744	819	75	2,232	2,232	-
			PAY	113,250	108,633	-4,617	339,743	345,656	5,913
		Complex needs MH LD and autism: Leeds Sum		**113,994**	**109,452**	**-4,542**	**341,975**	**347,888**	**5,913**
				113,994	**109,452**	**-4,542**	**341,975**	**347,888**	**5,913**
PROGRAMME									
	945512	Pathway and System Integration: Leeds	NON PAY	5,182	859	-4,323	15,550	15,550	-
			PAY	463,817	443,862	-19,955	1,391,450	1,404,938	13,488
		Pathway and System Integration: Leeds Sum		**468,999**	**444,721**	**-24,278**	**1,407,000**	**1,420,488**	**13,488**
				468,999	**444,721**	**-24,278**	**1,407,000**	**1,420,488**	**13,488**
PROGRAMME									
	945181	Pathway and System Integration PC : Leeds	NON PAY	6,001	602	-5,399	18,000	18,000	-
			PAY	322,671	320,813	-1,858	968,016	973,943	5,927
		Pathway and System Integration PC : Leeds Sum		**328,672**	**321,416**	**-7,256**	**986,016**	**991,943**	**5,927**
				328,672	**321,416**	**-7,256**	**986,016**	**991,943**	**5,927**
PROGRAMME									
	945157	Continuing care assessment and support: Leeds	NON PAY	198,538	209,301	10,763	595,611	597,843	2,232
			PAY	863,190	885,850	22,660	2,589,573	2,737,875	148,302
		Continuing care assessment and support: Leeds Sum		**1,061,728**	**1,095,152**	**33,424**	**3,185,184**	**3,335,718**	**150,534**
				1,061,728	**1,095,152**	**33,424**	**3,185,184**	**3,335,718**	**150,534**
PROGRAMME									
	945513	Strategy Planning and Performance: Leeds	INCOME	0	-7,539	-7,539	0	0	-
			NON PAY	1,049	1,516	467	3,150	3,150	-
			PAY	382,619	328,053	-54,566	1,147,850	1,128,246	-19,604
		Strategy Planning and Performance: Leeds Sum		**383,668**	**322,030**	**-61,638**	**1,151,000**	**1,131,396**	**-19,604**
				383,668	**322,030**	**-61,638**	**1,151,000**	**1,131,396**	**-19,604**
RUNNING COST									
	945590	Population Insight: Leeds	PAY	99,888	20,969	-78,919	299,658	213,493	-86,165
		Population Insight: Leeds Sum		**99,888**	**20,969**	**-78,919**	**299,658**	**213,493**	**-86,165**
				99,888	**20,969**	**-78,919**	**299,658**	**213,493**	**-86,165**
RUNNING COST									
	945563	Partnerships and Effectiveness: Leeds	NON PAY	17,332	918	-16,414	52,000	52,000	-
			PAY	244,000	94,425	-149,575	731,987	333,533	-398,454
		Partnerships and Effectiveness: Leeds Sum		**261,332**	**95,343**	**-165,989**	**783,987**	**385,533**	**-398,454**
	945575	Corporate Costs & Services	NON PAY	60,700	55,799	-4,901	182,100	182,100	-
		Corporate Costs & Services Sum		**60,700**	**55,799**	**-4,901**	**182,100**	**182,100**	**-**
				322,032	**151,142**	**-170,890**	**966,087**	**567,633**	**-398,454**

RC/Programme	Cost Centre	Description	Subjective Type	Values -YTD Budget	-YTD Actual	-YTD Variance	-Annual Budget	-Forecast Outturn	-Forecast Variance
RUNNING COST									
	945572	Communication and Involvement: Leeds	NON PAY	99,528	94,782	-4,746	298,551	298,551	-
			PAY	275,432	198,402	-77,030	826,294	744,813	-81,481
		Communication and Involvement: Leeds Sum		**374,960**	**293,184**	**-81,776**	**1,124,845**	**1,043,364**	**-81,481**
				374,960	**293,184**	**-81,776**	**1,124,845**	**1,043,364**	**-81,481**
RUNNING COST									
	945580	Estates	NON PAY	206,868	223,697	16,829	620,600	620,600	-
		Estates Sum		**206,868**	**223,697**	**16,829**	**620,600**	**620,600**	**-**
				206,868	**223,697**	**16,829**	**620,600**	**620,600**	**-**
PROGRAMME									
	945173	Medicines Optimisation: Leeds	NON PAY	5,434	810	-4,624	16,300	16,300	-
			PAY	672,779	615,652	-57,127	2,018,336	2,011,552	-6,784
		Medicines Optimisation: Leeds Sum		**678,213**	**616,462**	**-61,751**	**2,034,636**	**2,027,852**	**-6,784**
				678,213	**616,462**	**-61,751**	**2,034,636**	**2,027,852**	**-6,784**
PROGRAMME									
	945249	Clinical leadership: Leeds	INCOME	0	0	-	0	0	-
			NON PAY	11,333	20,434	9,101	34,000	34,000	-
			PAY	254,083	332,821	78,738	762,246	800,196	37,950
		Clinical leadership: Leeds Sum		**265,416**	**353,255**	**87,839**	**796,246**	**834,196**	**37,950**
RUNNING COST									
	945561	Clinical leadership Admin support: Leeds	NON PAY	764	0	-764	2,300	2,300	-
			PAY	32,760	33,567	807	98,277	103,208	4,931
		Clinical leadership Admin support: Leeds Sum		**33,524**	**33,567**	**43**	**100,577**	**105,508**	**4,931**
				298,940	**386,822**	**87,882**	**896,823**	**939,704**	**42,881**
RUNNING COST									
	945602	Leadership team: Leeds	NON PAY	5,284	-222	-5,506	15,850	15,850	-
			PAY	217,912	281,514	63,602	653,743	885,144	231,401
		Leadership team: Leeds Sum		**223,196**	**281,292**	**58,096**	**669,593**	**900,994**	**231,401**
				223,196	**281,292**	**58,096**	**669,593**	**900,994**	**231,401**
PROGRAMME									
	945273	PROG-Recharges RC to Prog	NON PAY	210,766	210,580	-186	632,300	632,300	-
		PROG-Recharges RC to Prog Sum		**210,766**	**210,580**	**-186**	**632,300**	**632,300**	**-**
RUNNING COST									
	945582	Reserves	PAY	80,652	80,652	-	241,959	241,959	-
		Reserves Sum		**80,652**	**80,652**	**-**	**241,959**	**241,959**	**-**
	945597	RC- Recharges RC to Prog	NON PAY	-210,580	-210,580	-	-631,744	-631,744	-
		RC- Recharges RC to Prog Sum		**-210,580**	**-210,580**	**-**	**-631,744**	**-631,744**	**-**
				80,838	**80,652**	**-186**	**242,515**	**242,515**	**-**
PROGRAMME				**4,852,931**	**4,707,966**	**-144,965**	**14,558,773**	**14,735,329**	**176,556**
RUNNING COST				**1,970,164**	**1,688,903**	**-281,261**	**5,910,424**	**5,632,184**	**-278,240**
				6,823,095	6,396,869	-426,226	20,469,197	20,367,513	-101,684

Appendix 2: QIPP Tracker

Key
Delivered / On Track
Awaiting Confirmation
Delivery with Slippage
Unidentified / Issue

Ref No.	Project	Overseeing Board / Area	Lead Individual	Director	Grouping	Planned Start Date	Status of Savings	Recurrent / Non-Recurrent?	QEIA Required?	QEIA Panel Assurance Outcome	£,000 Plan 24/25	£,000 Forecast 24/25	Difference	£,000 YTD Position 24/25	% Achieved YTD 24/25
N/A	Cost Pressure Mitigation MHIS Offset - MH related demand and cost pressures	Delivered as part of initial planning process.	Matt Turner	Alex Crickmar	Finance	N/A	Delivered	TBC	N/A	N/A	£5,128.000	£5,128.000	£0.000	£5,128.000	100%
N/A	Cost Pressure BCF Offset - community demand and cost pressures	Delivered as part of initial planning process.	Matt Turner	Alex Crickmar	Finance	N/A	Delivered	TBC	N/A	N/A	£2,774.000	£2,774.000	£0.000	£2,774.000	100%
N/A	HDFT Block Reduction	To be delivered as part of initial planning process. To be agreed.	Matt Turner	Alex Crickmar	Finance	N/A	Delivered	Recurrent	N/A	N/A	£1,500.000	£1,500.000	£0.000	£1,500.000	100%
N/A	Cost Pressure Mitigation Core20Plus5 - using existing QIS funding to achieve	Delivered as part of initial planning process.	Matt Turner	Alex Crickmar	Finance	N/A	Delivered	TBC	N/A	N/A	£3,900.000	£3,900.000	£0.000	£3,900.000	100%
N/A	Cost Pressure Mitigation CoPilot AI system not commissioned	Delivered as part of initial planning process.	Matt Turner	Alex Crickmar	Finance	N/A	Delivered	TBC	N/A	N/A	£93.000	£93.000	£0.000	£93.000	100%
N/A	Cost Pressure Mitigation Wegovy Service	Delivered as part of initial planning process.	Matt Turner	Alex Crickmar	Finance	N/A	Delivered	TBC	N/A	N/A	£1,188.000	£1,188.000	£0.000	£1,188.000	100%
N/A	Cost Pressure Mitigation Wegovy Drugs	Delivered as part of initial planning process.	Matt Turner	Alex Crickmar	Finance	N/A	Delivered	TBC	N/A	N/A	£1,160.000	£1,160.000	£0.000	£1,160.000	100%
O007	Re-focusing Primary Care Cancer Screening Champions programme	Cancer	Tom Daniels	Helen Lewis	Pathway and System Integration	01-Apr-24	Delivered	Recurrent	Yes	Full Assurance	£25.000	£25.000	£0.000	£25.000	100%

Ref No.	Project	Overseeing Board / Area	Lead Individual	Director	Grouping	Planned Start Date	Status of Savings	Recurrent / Non-Recurrent?	QEIA Required?	QEIA Panel Assurance Outcome	£,000 Plan 24/25	£,000 Forecast 24/25	Difference	£,000 YTD Position 24/25	% Achieved YTD 24/25
O008	Community Cancer Review	Cancer	Tom Daniels	Helen Lewis	Pathway and System Integration	01-Apr-24	Delivered	Recurrent	N/A	N/A	£64.000	£64.000	£0.000	£64.000	100%
O009	Pre-Paid Cards	CHC	Andrea Dobson	Jason Brooch	Continuing Health Care	01-Aug-24	Awaiting Confirmation	Non-Recurrent	Yes	N/A	£500.000	£500.000	£0.000	£0.000	0%
O013	Review of spend on enhanced care (above framework) from CHC funded care home placement, alongside LCC	CHC	Andrea DobsonTony MeadowsTim Sanders	Jason Brooch	Continuing Health Care	01-Apr-24	On Track to Deliver	Recurrent	Yes	For Information Only	£220.000	£220.000	£0.000	£0.000	0%
O014	Improved utilisation of LCH night service to reduce spend on independent home care (fast Track) LCH Nights Team to also review CHC patients where capacity allows	CHC	Andrea Dobson	Jason Brooch	Continuing Health Care	01-Apr-24	On Track to Deliver	Recurrent	N/A	N/A	£790.000	£790.000	£0.000	£0.000	0%
O126	Review of Top 100 Packages of Care - this is very dependent on the implementation of commissioning principles O143 MERGED O015 and O126	CHC	Andrea Dobson	Jason Brooch	Continuing Health Care	01-Aug-24	On Track to Deliver	Non-Recurrent	Yes	For Information Only	£690.000	£690.000	£0.000	£0.000	0%
O016	Support mobilisation of new model for SMEH - Community Emotional Mental Health Support	Children and Young People	Caroline Townsend	Helen Lewis	Pathway and System Integration	01-Jul-24	Delivered	Recurrent	Yes	Limited Assurance	£9.000	£9.000	£0.000	£9.000	100%

Ref No.	Project	Overseeing Board / Area	Lead Individual	Director	Grouping	Planned Start Date	Status of Savings	Recurrent / Non-Recurrent?	QEIA Required?	QEIA Panel Assurance Outcome	£,000 Plan 24/25	£,000 Forecast 24/25	Difference	£,000 YTD Position 24/25	% Achieved YTD 24/25
O115	Improved cost effectiveness in CYP Mental Health Comms Commissioning	Children and Young People	Caroline Townsend	Helen Lewis	Pathway and System Integration	01-Apr-24	Delivered	TBC	Yes	Reasonable Assurance	£35.000	£30.000	£5.000	£30.000	100%
O022	Hospices uplift not in line with 'full offer'	End of Life	Helen Smith	Helen Lewis	Pathway and System Integration	01-Apr-24	Delivered	TBC	N/A	N/A	£75.000	£75.000	£0.000	£75.000	100%
O023	Leeds Bereavement Forum service reviews	End of Life	Lindsay McFarlane	Helen Lewis	Pathway and System Integration	01-Apr-24	Delivered	TBC	N/A	N/A	£43.000	£43.000	£0.000	£43.000	100%
O024	Neighbourhood Team top up funding	Frailty	Helen Smith	Helen Lewis	Pathway and System Integration	01-Apr-24	Delivered	TBC	Yes	Reasonable Assurance	£769.000	£769.000	£0.000	£769.000	100%
O025	Community Beds savings (Home First) Delivery of target -	Frailty	Helen Smith	Helen Lewis	Pathway and System Integration	01-Apr-24	Delivered	TBC	Yes	Reasonable Assurance	£1,989.000	£1,989.000	£0.000	£1,989.000	100%
O026	Reduction in spot purchased care home beds (25 from 1st June , FYE in 24/5)	Frailty	Helen Smith	Helen Lewis	Pathway and System Integration	01-Apr-24	Delivered	TBC	N/A	N/A	£1,362.000	£1,362.000	£0.000	£1,362.000	100%
O027	Virtual ward / Urgent Community response value review	Frailty	Helen Smith	Helen Lewis	Pathway and System Integration	TBC - see notes	Non-Viable	TBC	N/A	N/A	£143.000	£0.000	£143.000	£0.000	0%
O028	Review continuation of CRUSE contract	End of Life	Lindsay McFarlane	Helen Lewis	Pathway and System Integration	01-Apr-25	Delivery with slippage	TBC	Yes	Reasonable Assurance	£63.000	£12.228	£50.772	£0.000	0%
O029	Service review of Circles of Support (MAE Care)	Frailty	Lindsay McFarlane	Helen Lewis	Pathway and System Integration	01-Apr-25	Delivery with slippage	TBC	Yes	Reasonable Assurance	£15.000	£0.000	£15.000	£0.000	0%
O030	Service review of Touchstone BME dementia project	Frailty	Lindsay McFarlane	Helen Lewis	Pathway and System Integration	01-Apr-25	Delivery with slippage	TBC	Yes	Limited Assurance	£16.000	£0.000	£16.000	£0.000	0%
O036	Review of Social Prescribing Contracts and change of model from 24/5	Healthy Adults	Neil Maguire (supported by Kirsty Turner)	Helen Lewis	Pathway and System Integration	01-Apr-24	Delivered	Recurrent	Yes	Reasonable Assurance	£146.000	£146.000	£0.000	£146.000	100%

Ref No.	Project	Overseeing Board / Area	Lead Individual	Director	Grouping	Planned Start Date	Status of Savings	Recurrent / Non-Recurrent?	QEIA Required?	QEIA Panel Assurance Outcome	£,000 Plan 24/25	£,000 Forecast 24/25	Difference	£,000 YTD Position 24/25	% Achieved YTD 24/25
O052	Further integration and improving value within Adult Mental Health Crisis Pathway.	Mental Health	Caroline Townsend	Helen Lewis	Pathway and System Integration	01-Oct-24	Delivery with slippage	Recurrent	Yes	Full Assurance	£100.000	£100.000	£0.000	£31.778	32%
O055	Value review of current investment into building based housing support pathway	Mental Health	Local Authority (LCC) to lead (support from Caroline/Eddie)	Helen Lewis	Pathway and System Integration	01-Apr-24	Delivered	Recurrent	N/A	N/A	£152.000	£152.000	£0.000	£152.000	100%
O056	Reduction in high cost s117 and people no longer eligible for s117 (LCC reviewing team leading)	Mental Health	Max Naismith/Leeds City Council (supported by Eddie)	Helen Lewis	Pathway and System Integration	01-Apr-24	On Track to Deliver	N/A	N/A	N/A	£200.000	£200.000	£0.000	£200.000	100%
O057	Decommissioning of 6 contracts coming to an end, 4 Recurrently funded	Mental Health	Eddie Devine	Helen Lewis	Pathway and System Integration	01-Apr-24	Delivered	N/A	Yes	Reasonable Assurance	£167.000	£167.000	£0.000	£167.000	100%
O130	Transitional Housing Unit (LCC 3 flats for LYPFT use)	Mental Health	Eddie Devine	Helen Lewis	Pathway and System Integration	01-Apr-24	Delivered	Recurrent	Yes	Full Assurance	£50.000	£50.000	£0.000	£50.000	100%
O059	Cataract follow-up in line with current commissioning policies.	Planned Care	Matt Turner - see notes	Helen Lewis	Pathway and System Integration	TBD	Delivery with slippage		N/A	N/A	£100.000	£0.000	£100.000	£0.000	0%
O060	Ensure implementation of benign skin removal policy	Planned Care	Matt Turner - see notes	Helen Lewis	Pathway and System Integration	01-Apr-24	Delivered		N/A	N/A	£25.000	£25.000	£0.000	£25.000	100%
O061	Ensure consistent implementation of surgical commissioning policies	Planned Care	Tom Daniels	Helen Lewis	Pathway and System Integration	01-Apr-24	Awaiting Confirmation		N/A	N/A	£50.000	£50.000	£0.000	£0.000	0%
O062	Reduction in tariffs in line with new models of care. ENT and Adult Hearing Loss. (Microsuction).	Planned Care	Tom Daniels	Helen Lewis	Pathway and System Integration	01-Jul-24	On Track to Deliver		N/A	N/A	£263.000	£363.000	£0.000	£363.000	138%

Ref No.	Project	Overseeing Board / Area	Lead Individual	Director	Grouping	Planned Start Date	Status of Savings	Recurrent / Non-Recurrent?	QEIA Required?	QEIA Panel Assurance Outcome	£,000 Plan 24/25	£,000 Forecast 24/25	Difference	£,000 YTD Position 24/25	% Achieved YTD 24/25
O065	Value for money review of Covid Urgent Eye Service	Planned Care	Martin Earnshaw	Helen Lewis	Pathway and System Integration	01-Aug-24	Delivery with slippage	Recurrent	Yes	N/A	£279.000	£209.250	£69.750	£0.000	0%
O066	Tariff Consultation - cataracts.	Planned Care	Tom Daniels	Helen Lewis	Pathway and System Integration	01-Apr-24	Delivered	TBC	N/A	N/A	£180.000	£180.000	£0.000	£180.000	100%
O067	Melatonin cost avoidance	Prescribing - Children & Young People	Charlotte Young Jasmin Teja	Sarah Forbes	Prescribing	01-Sep-24	On Track to Deliver	TBC	N/A	N/A	£150.000	£100.000	£50.000	£2.731	2%
O070	Baby Milk	Prescribing - Children & Young People	Jo Alldred	Sarah Forbes	Prescribing	01-Sep-24	On Track to Deliver	TBC	N/A	N/A	£500.000	£47.961	£452.039	£0.000	0%
O072	Wounds (BNF Dressings chapter (excl Formulary dressings))	Prescribing - Frailty	Jo Alldred	Sarah Forbes	Prescribing	01-Apr-24	Delivery with Slippage	TBC	N/A	N/A	£125.000	£125.000	£0.000	£0.000	0%
O073	Buprenorphine patches	Prescribing - Frailty	Kate Edwards, Sameia Ahmed	Sarah Forbes	Prescribing	01-Apr-24	Awaiting Confirmation	TBC	N/A	N/A	£100.000	£50.000	£50.000	£0.000	0%
O074	Oral Nutritional Supplements (ONS)	Prescribing - Long Term Conditions	Toni Larter Gavin Powell	Sarah Forbes	Prescribing	01-Apr-24	On Track to Deliver	TBC	Yes	Reasonable Assurance	£500.000	£500.000	£0.000	£49.702	10%
O075	LMWH Switches	Prescribing - Long Term Conditions	Pei-Theng Aizlewood (CaReMe GP)	Sarah Forbes	Prescribing	01-Dec-24	Non-Viable	TBC	N/A	N/A	£126.000	£0.000	£126.000	£0.000	0%
O076	Keppra to generic Levetiracetam	Prescribing - Long Term Conditions	Pei-Theng Aizlewood, Kate Edwards	Sarah Forbes	Prescribing	01-Apr-24	On Track to Deliver	TBC	N/A	N/A	£500.000	£200.000	£300.000	£2.565	1%
O077	Gluten Free	Prescribing - Long Term Conditions	Abdha Parveen, Leah Sawicki	Sarah Forbes	Prescribing	01-Apr-24	On Track to Deliver	TBC	Yes	For Information Only	£100.000	£176.000	-£76.000	£21.177	12%
O079	Safety pen needles switch to LHP recommended product	Prescribing - Long Term Conditions	Clair Ranns (CaReMe GP)	Sarah Forbes	Prescribing	01-Apr-24	On Track to Deliver	TBC	N/A	N/A	£25.000	£111.521	-£86.521	£4.828	4%
O080	Sitagliptin - Switch to Generic due to patent expiry	Prescribing - Long Term Conditions	Clair Ranns	Sarah Forbes	Prescribing	01-Apr-24	Awaiting Confirmation	TBC	N/A	N/A	£200.000	£200.000	£0.000	£0.000	0%
O081	Other Gliptins - Switching to generic sitagliptin	Prescribing - Long Term Conditions	Lindsay McFarlane	Sarah Forbes	Prescribing	01-Apr-24	On Track to Deliver	TBC	N/A	N/A	£40.000	£250.000	-£210.000	£38.675	97%
O082	Blood Glucose Test Strip Spend >£10	Prescribing - Long Term Conditions	Clair Ranns, Mark Donley, Toni Larter	Sarah Forbes	Prescribing	01-Apr-24	Awaiting Confirmation	TBC	Yes	Full Assurance	£250.000	£45.000	£205.000	£0.000	0%
O083	DOAC - Switch to apixaban	Prescribing - Long Term Conditions	Lindsay McFarlane	Sarah Forbes	Prescribing	01-Apr-24	Awaiting Confirmation	TBC	N/A	N/A	£3,000.000	£3,000.000	£0.000	£0.000	0%

Ref No.	Project	Overseeing Board / Area	Lead Individual	Director	Grouping	Planned Start Date	Status of Savings	Recurrent / Non-Recurrent?	QEIA Required?	QEIA Panel Assurance Outcome	£,000 Plan 24/25	£,000 Forecast 24/25	Difference	£,000 YTD Position 24/25	% Achieved YTD 24/25
O085	Methylphenidate XL tablets and caps switch to cheaper Brands	Prescribing - Mental Health	Eddie Devine	Sarah Forbes	Prescribing	01-Apr-24	On Track to Deliver	TBC	N/A	N/A	£50.000	£101.232	-£51.232	£23.073	46%
O086	Items of Low Clinical Value/ OTC	Prescribing - Non-specific	Caroline Shanks, Azmat Khan	Sarah Forbes	Prescribing	01-Apr-24	On Track to Deliver	TBC	N/A	N/A	£250.000	£150.000	£100.000	£40.060	16%
O087	Specials	Prescribing - Non-specific	Sameia Ahmed Kim Mooring	Sarah Forbes	Prescribing	01-Apr-24	On Track to Deliver	TBC	N/A	N/A	£100.000	£142.411	-£42.411	£58.298	58%
O088	Metformin Strength change (1g switch to 2x500mg tablets)	Prescribing - Non specific	Terry Banks Mark Donley	Sarah Forbes	Prescribing	01-Apr-24	On Track to Deliver	TBC	N/A	N/A	£25.000	£31.200	-£6.200	£1.117	4%
O089	Co-codamol capsules to tablets	Prescribing - Non-specific	Nazia Mohammed, Asim Hussain	Sarah Forbes	Prescribing	01-Apr-24	On Track to Deliver	TBC	N/A	N/A	£15.000	£49.734	-£34.734	£2.599	17%
O090	Metformin Oral Solution	Prescribing - Non-specific	Terry Banks Mark Donley	Sarah Forbes	Prescribing	01-Apr-24	On Track to Deliver	TBC	N/A	N/A	£15.000	£43.495	-£28.495	£7.826	52%
O091	Aveeno Cream (Emollients)	Prescribing - Non-specific	Caroline Shanks	Sarah Forbes	Prescribing	01-Apr-24	Awaiting Confirmation	TBC	N/A	N/A	£30.000	£0.000	£30.000	£0.000	0%
O092	Low dose Vitamin D	Prescribing - Non specific	Caroline Shanks	Sarah Forbes	Prescribing	01-Apr-24	Awaiting Confirmation	TBC	N/A	N/A	£25.000	£25.000	£0.000	£0.000	0%
O093	Ghost Generics (Premium Generics)	Prescribing - Non-specific	Sobia Qureshi, Jignesh Shah	Sarah Forbes	Prescribing	01-Apr-24	Awaiting Confirmation	TBC	N/A	N/A	£30.000	£27.083	£2.917	£0.000	0%
O095	Rebates	Prescribing - Non-specific	Caroline Shanks	Sarah Forbes	Prescribing	01-Apr-24	On Track to Deliver	TBC	N/A	N/A	£300.000	£844.400	-£544.400	£211.100	70%
O096	OptimiseRx	Prescribing - Non specific	Terry Banks	Sarah Forbes	Prescribing	01-Apr-24	On Track to Deliver	TBC	N/A	N/A	£1,200.000	£2,000.000	-£800.000	£488.995	41%
O098	System wide review of stoma pathways	Prescribing - Planned Care	Helen Lewis / David Wardman / Kim Mooring	Sarah Forbes	Prescribing	01-Apr-24	Awaiting Confirmation	TBC	N/A	N/A	£100.000	£100.000	£0.000	£0.000	0%
O099	GP Confederation Support Post	Primary Care	Visseh Pejhan Sykes	Helen Lewis	Pathway and System Integration	01-Apr-24	Delivered	TBC	N/A	N/A	£54.000	£54.000	£0.000	£54.000	100%

Ref No.	Project	Overseeing Board / Area	Lead Individual	Director	Grouping	Planned Start Date	Status of Savings	Recurrent / Non-Recurrent?	QEIA Required?	QEIA Panel Assurance Outcome	£,000 Plan 24/25	£,000 Forecast 24/25	Difference	£,000 YTD Position 24/25	% Achieved YTD 24/25
O117	Planned Efficiency (Unidentified QIPP)	Prescribing - Non specific	David Wardman	Sarah Forbes	Prescribing	TBC	Unidentified	TBC	N/A	N/A	£536.400	£0.000	£536.400	£0.000	0%
O119	Switch Cialis to generic Tadalafil	Prescribing - Non-specific	David Wardman	Sarah Forbes	Prescribing	01-Jul-24	On Track to Deliver	TBC	N/A	N/A	£15.000	£50.000	-£35.000	£3.486	23%
O120	Switch Crestor to generic Rosuvastatin	Prescribing - Non-specific	David Wardman	Sarah Forbes	Prescribing	01-Jul-24	On Track to Deliver	TBC	N/A	N/A	£50.000	£33.000	£17.000	£0.749	1%
O121	Discontinue ticagrelor 60mg >3 years	Prescribing - Long Term Conditions	David Wardman	Sarah Forbes	Prescribing	TBC	On Track to Deliver	TBC	N/A	N/A	£300.000	£0.000	£300.000	£0.000	0%
O122	Acetylcysteine and carbocisteine	Prescribing - Non specific	David Wardman	Sarah Forbes	Prescribing	01-Dec-24	Awaiting Confirmation	TBC	N/A	N/A	£50.000	£50.000	£0.000	£0.000	0%
O123	Paracetamol 250mg/ml Oral suspension	Prescribing - Non-specific	David Wardman	Sarah Forbes	Prescribing	01-Jul-24	Awaiting Confirmation	TBC	N/A	N/A	£50.000	£50.000	£0.000	£0.000	0%
O124	Hypromellose 0.3% ED	Prescribing - Non-specific	David Wardman	Sarah Forbes	Prescribing	01-Jul-24	Awaiting Confirmation	TBC	N/A	N/A	£25.000	£25.000	£0.000	£0.000	0%
O125	Omeprazole Liquid (10mg/5 and 20mg/5) - Omeprazole suspension 10mg & 20mg to orodispersible	Prescribing - Non-specific	David Wardman	Sarah Forbes	Prescribing	01-Jul-24	On Track to Deliver	TBC	N/A	N/A	£25.000	£132.692	-£107.692	£0.000	0%
O127	Palliative Care Network	End of Life	Lindsay McFarlane	Helen Lewis	Pathway and System Integration	TBC	On Track to Deliver	TBC	Yes	Reasonable Assurance	£18.000	£18.000	£0.000	£0.000	0%
O128	Dying Matters	End of Life	Lindsay McFarlane	Helen Lewis	Pathway and System Integration	01-Apr-24	Delivered	TBC	Yes	Full Assurance	£5.000	£5.000	£0.000	£5.000	100%
P129	William Merrit	Long Term Conditions	Lindsay McFarlane	Helen Lewis	Pathway and System Integration	01-Apr-25	Delivery with slippage	TBC	Yes	Reasonable Assurance	£96.000	£0.000	£96.000	£0.000	0%

Ref No.	Project	Overseeing Board / Area	Lead Individual	Director	Grouping	Planned Start Date	Status of Savings	Recurrent / Non-Recurrent?	QEIA Required?	QEIA Panel Assurance Outcome	£,000 Plan 24/25	£,000 Forecast 24/25	Difference	£,000 YTD Position 24/25	% Achieved YTD 24/25
O131	Teen Connect	Children and Young People	Caroline Townsend	Helen Lewis	Pathway and System Integration	01-Jan-25	Delivery with slippage	Recurrent	Yes	N/A	£29.000	£9.000	£20.000	£3.434	12%
O132	Trauma	Children and Young People	Karren Leach	Helen Lewis	Pathway and System Integration	01-Apr-24	Delivered	Recurrent	N/A	N/A	£67.000	£67.000	£0.000	£67.000	100%
N/A	Planned Efficiency (Unidentified QIPP)	TBD	Alex Crickmar	Alex Crickmar	Finance	N/A	Unidentified	TBC	N/A	N/A	£500.000	£0.000	£500.000	£0.000	0%
N/A	Shared Care Record commissioning intention	Delivered as part of initial planning process.	Finance	Alex Crickmar	Finance	N/A	Delivered	TBC	N/A	N/A	£750.000	£750.000	£0.000	£750.000	100%
N/A	Increased ERF	Finance	Matt Turner	Alex Crickmar	Finance	N/A	Awaiting Confirmation	TBC	N/A	N/A	£2,000.000	£2,000.000	£0.000	£0.000	0%
N/A	CDC Savings	Finance	Matt Turner	Alex Crickmar	Finance	N/A	Delivery with slippage	TBC	N/A	N/A	£1,750.000	£500.000	£1,250.000	£0.000	0%
O145	Closure of 5 additional intermediate care beds (Harrogate Lodge)	Frailty	Helen Smith	Helen Lewis	Pathway and System Integration	01-Jul-24	Non-viable	TBC	Yes	N/A	£0.000	£0.000	£0.000	£0.000	0%
O146	COPD	Long Term Conditions	Lindsay McFarlane?	Helen Lewis	Pathway and System Integration	TBC	Non-Cash Releasing Savings	Non-Recurrent	Yes	Full Assurance	£0.000	£0.000	£0.000	£0.000	#DIV/0!
O147	Glycopyrronium Bromide tablets to branded	Prescribing - Non Specific	David Wardman	Sarah Forbes	Prescribing	01-Apr-24	On Track to Deliver	TBC	N/A	N/A	£115.600	£115.600	£0.000	£0.000	0%
O148	Vagifem to generic estradiol	Prescribing - Non Specific	David Wardman	Sarah Forbes	Prescribing	01-Apr-24	Awaiting Confirmation	TBC	N/A	N/A	£77.000	£77.000	£0.000	£0.000	0%

Key
Delivered / On Track
Awaiting Confirmation
Delivery with Slippage
Unidentified / Issue

Meeting name:	Leeds Committee of the West Yorkshire Integrated Care Board (ICB)
Agenda item no.	35/24
Meeting date:	11th September 2024
Report title:	Assurance and update on our plan for financial sustainability in 24/25
Report presented by:	Tim Ryley
Report approved by:	Tim Ryley
Report prepared by:	Joanna Bayton-Smith, Nick Earl, Helen Lewis, Alex Crickmar, Nicola Nicholson, Zebunnisa Ahmed, Sharon Moore, Amanda Sykes, Caroline Mackay

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

Previous considerations:

This follows a prior report on the NHS Financial Plan in Leeds, brought to the Leeds ICB Committee Meeting in March 2024, which detailed many of the schemes. This paper focusses on the ICB's component of the financial plan in the context of the wider financial position across Leeds.

Executive summary and points for discussion:

This report describes the updated financial plan for the ICB in Leeds in 2024-5, and the work undertaken to risk assess, assure and (in some instances) engage on efficiency schemes that sit outside of core provider contracts.

It first provides an overview of the financial context within which decisions are being made, and highlights some of the protected areas of spend/ additional investments. It then summarises the checks and balances that have been established in Leeds Place to ensure proposed schemes fully consider the quality and equality impact at an individual scheme and population level prior to any decisions.

Committee members are asked to review our local assurance processes, and provide support for the delivery of schemes, noting the greater level of scrutiny on both process and decisions being requested this year.

Which purpose(s) of an Integrated Care System does this report align with?

☒ Improve healthcare outcomes for residents in their system ☒ Tackle inequalities in access, experience and outcomes ☒ Enhance productivity and value for money ☐ Support broader social and economic development
Recommendation(s)
The Leeds Committee of the West Yorkshire Integrated Care Board is asked to: 1. Note and suggest further improvements on the processes used to meet our duties to involve and to consider impacts on quality and inequality. 2. Note progress towards assessing overall impact in light of the balance of protected, new additional, and reduced funding to address health inequality recognising challenges this presents. 3. Note and ratify the outcomes of the processes on those areas that were designated for review (where applicable) in the annual Financial Plan approved by the Committee in March 2024. 4. Note the current level of risk within the health system, and the potential impact not taking these decisions may have on the financial stability and performance of the Leeds Health and Care System implications of the outcomes on the financial plan as submitted and the remedial action.
Does the report provide assurance or mitigate any of the strategic threats or significant risks on the Corporate Risk Register or Board Assurance Framework? If yes, please detail which:
The report summarises our approach to manage financial sustainability schemes in Leeds and a need to balance two key strategic risks of the West Yorkshire Board Assurance Framework. **Mission 1, specifically risk 1.1:** Reduce Inequalities, there is a risk that our local priorities to narrow inequalities are not delivered due to the impact of wider economic social and political factors. **Mission 3, specifically risk 3.2:** Use our collective resources wisely, there is a risk that we breach our statutory duties to operate within the resource envelope available by not delivering efficiency targets and/or controlling costs.
Appendices
1. QEIA Assurance Panel ToR 2. QEIA Process Flow
Acronyms and Abbreviations explained

1.	QEIA- Quality and Equality Impact Assessment
2.	EIA – Equality Impact Assessment
3.	LHCP – Leeds Health and Care Partnership

What are the implications for?

Residents and Communities	Changes and reductions in some services may impact on some groups of service users.
Quality and Safety	The report notes the risks and mitigations associated with productivity challenges and proposed decisions to reduce some services
Equality, Diversity and Inclusion	The assurance process is predicated on understanding, considering and where necessary mitigating the impact on specific communities and involving them in decision-making
Finances and Use of Resources	The Paper reports on the process to deliver the financial plan and agreed deficit for the Leeds Office of the ICB.
Regulation and Legal Requirements	The NHS has a statutory duty to live within its means whilst delivering a comprehensive health service free at the point of delivery. The Health and Social Care Act 2012, as amended by the Health and Care Act 2022 introduced the first legal duties about health inequalities and it includes specific duties for health bodies to have due regard to reducing health inequalities between people. We are required to properly and seriously, take account of health inequalities when making decisions or exercising functions.
Conflicts of Interest	All partners are impacted by the approach
Data Protection	**None**
Transformation and Innovation	The paper describes a set of decisions that need to be implemented to transform some services in a few key areas to improve productivity.
Environmental and Climate Change	**None**
Future Decisions and Policy Making	There will be an ongoing requirement to continuously review the spend of the ICB at place. Feedback on the process this year will guide future decisions and policy making. A

	lessons learned review is being used to inform business planning processes.
Citizen and Stakeholder Engagement	The paper summarises the public engagement and involvement process undertaken and any outstanding requirements relating to the schemes.

Background and Financial Context

1.1 At the March Leeds Committee of the ICB (the Committee) we set out in detail the financial plan for 2024-2025 noting the underlying c£50m opening ICB in Leeds deficit. The plan detailed action that had been taken in 2023-2024 and was being taken as we entered 2024-2025. It also included a number of areas which were proposed for service review and potential decommissioning or reduction in investment, and on which the Committee would need to be updated. In total these actions meant the Committee set a deficit plan for the ICB in Leeds of £12.3m.

1.2 The committee whilst approving the overall plan asked for further evidence that the impact on inequalities of the plans had been considered, what involvement was undertaken and asked that they would be sighted on the outcome of the proposed service reviews. This report provides the updates sought by the Committee in March.

1.3 Alongside statutory duties associated with continually improving patient outcomes and experience, and reducing health inequalities, the ICB also has a statutory duty to ensure its "resource use does not exceed the limit specified in a direction by NHS England" (Health and Care Act, 2022). The Leeds ICB Committee and its members have delegated responsibility for ensuring that the ICB balances these three duties.

1.4 After a challenging financial planning process for 24/25 the West Yorkshire ICB has agreed a £50m planned deficit with NHS England. Within this position the Leeds Place has a net financial plan deficit of £8.2m with the ICB in Leeds having a £12.3m deficit financial plan. To get to this position, efficiencies of £181.7m across the Leeds NHS organisations have been required and not delivering these would lead to non-delivery of the overall financial plan. This would in turn lead to NHS England intervention within the system with loss of autonomy, tougher restrictions on spend and with further decisions on potential disinvestments required.

	24/25 Plan	24/25 Efficiency plan
	£m	£m
LTHT	2.1	110.4
LCH	1.0	15.8
LYPFT	1.0	16.9
Leeds Place of the ICB	(12.3)	38.6
Leeds Place TOTALS	**(8.2)**	**181.7**

2.0 Leeds QEIA Assurance Process and Panel

2.1 Given the scale of the financial challenge and associated changes this year, the Leeds Office of the West Yorkshire ICB has worked to establish a robust and consistent evaluation and assurance process to oversee numerous Quality & Equality Impact Assessments (QEIAs) and provide an additional layer of scrutiny to our change proposals.

2.2 To do this, we have set up a QEIA Assurance Panel. The Panel considers completed QEIAs and is in place to assure that the risks and impacts of any proposition have been appropriately considered. The Panel includes an ICB place Non-executive Director, a representative of the Medical Director and the West Yorkshire Director of Nursing for the Leeds place. The QEIA Assurance Panel does not make the decision to proceed or not proceed with a proposal. Scheme proposals and their associated impact assessments are submitted in advance, and panel members are asked to consider whether:

2.2.1 The proposed changes are clearly articulated and understood.
2.2.2 They are assured that the proposal has considered the quality, equality and people impacts or risks associated with the change.
2.2.3 They are assured that people have had an opportunity to input into these.
2.2.4 They are assured that the proposal has considered potential mitigations that might address or reduce these impacts.
2.2.5 They are assured that the proposed changes (and any remaining risks)
2.2.6 have been appropriately considered, are reasonable and proportionate in the context of wider system risks and can be taken forward for decision.

2.3 Panel members then offer a position of full, reasonable, limited or no assurance. Where the panel members consider they have received insufficient evidence members have challenged, assessed risks, and have requested further detail that has included key lines of enquiry asked of

scheme leads and those involved in the completion of the QEIA documentation.

2.4 The West Yorkshire ICB Director of Nursing group has peer reviewed processes across West Yorkshire, and the West Yorkshire ICB Quality Committee received a report on EQUIA processes at its meeting on the 4th of June.

2.5 Having established a stronger QEIA process given the scale of work in the last six months, it is now being embedded into our business planning processes for 25/26 and the assurance process will extend to any new scheme/s that are proposed, including procurement of existing services or de-commissioning / funding reduction decisions.

2.6 Appendix 1 provides for Terms of Reference Flow for the QEIA Panel.

2.7 All the 23/24 and 24/25 efficiency schemes (where a QEIA was required) have now been through this assurance process. If a scheme has been assessed as providing limited assurance, then detailed feedback has been shared with the scheme leads relating to gaps in evidence or areas for further clarification. No scheme can progress without at least reasonable assurance. Any gaps have now all been addressed and updated within the QEIA documentation, and all schemes have now been given full or reasonable levels of assurance through this process.

2.8 All the QEIA's are in the process of being published online.

3.0 Requirement to Involve and Engage - The ICB in Leeds approach

3.1 NHS Commissioners and Trusts must ensure that patients and / or the public are involved in certain decisions that affect the planning and delivery of NHS services (Section 242 of the NHS Act 2006 as amended by the Local Government & Public Involvement in Health Act 2007– the "Duty to Involve").

3.2 Such decisions usually fall under the remit of Section 242 if a service provision is changing from the patients or service-users perspective. It is, at heart, about embedding good decision-making practice by ensuring that the patients' / service-user's point of view is considered when planning or changing services.

3.3 The need for, and level of, involvement required for each scheme has been assessed in line with the statutory public involvement duty (Section 14Z2 of the 2006 NHS Act) and included reference to, and guidance from, the Consultation Institute.

3.4 Our focus on transformation and efficiency opportunities that might be possible without impacting patient experience mean that not all schemes require involvement.

3.5 Insight from patient / service user experience data held by the ICB / predecessor organisations and providers themselves has contributed to this process. The ICB in Leeds's Involvement team have undertaken the following steps to determine the level of Involvement required for the various QEIA schemes.

3.5.1 Met with Quality and Equality colleagues to review QEIAs submitted, to understand the proposed change, consider whether any involvement is required and raise questions to the QEIA where there were gaps in our understanding.
3.5.2 Met with QEIA authors to seek clarification on the proposed changes, timelines, and potential impacts of the changes on patients / people, especially people at risk of, or already, experiencing health inequalities or with protected characteristics.
3.5.3 Requested existing patient / service-user experience feedback / carried out insight reviews into what we already know about people's experiences of using the service.
3.5.4 Met with third sector representatives to better understand the flow of patient / service-user feedback from third sector service providers into the process.
3.5.5 Met with QEIA authors to revisit developments to the QEIAs and further clarify the need for Involvement and, if required, at what level.
3.5.6 Provided the outcome of our considerations to the team facilitating the QEIA Assurance panels.

4.0 Impact on Items Recommended for Review in March

4.1 A number of items were proposed for review to decommission or significantly change in 2024-2025 as part of the plan that came to the Committee in March. These have been through the Involvement and EQUIA processes described above. There have been four outcomes from this process: no change and continue to invest, remodel service with reduced level of funding, cease due to end of non-recurrent funding, or decommission proposed.

4.2 The committee are asked to note in particular item 4.9 which is recommended to be decommissioned. A summary of the EQUIA reviews, Involvement, and financial impact can be found for all these reviews at Appendix 2.

4.3 BME Dementia (Touchstone): – On the basis of the emerging Third Sector strategy with a focus on inequality and equity of access, and a recognition that withdrawal of this would directly require other services this will continue to be

funded at the existing level going forward. We will be working with Touchstone to ensure best value for money.

4.4 Social Prescribing: - We have made a Direct Award to the existing Social Prescribing provider, at a reduced value in support of our financial challenge. We have worked with the provider on ways in which they can maintain their productivity (shorter and more focused appointments, more group work etc) while also maintaining a person-centred approach to the interventions which we know evaluate well. This work is continuing, led by the provider, and they will continue with service user engagement as part of this work to ensure that they maintain as much capacity as possible. The provider will be mindful of ensuring capacity is prioritised for those areas of greatest need within the City in line with our commitments on inequalities, working alongside other social prescribing staff commissioned by Primary Care directly (and wider members of the Local Care Partnership) to continue to relieve pressure on general practice. In addition, the provider is developing a pilot for 'proactive' social prescribing, reaching out to identified cohorts of people with certain risk factors, representing a shift from the traditional referral-based model.

4.5 CRUSE Bereavement Support - The issue of NHS funding for bereavement support has been highly emotive, particularly since the Leeds Bereavement Forum recently closed after many years. Originally the proposal was to remove this funding completely. The revised plan is for a 20% reduction in the NHS funding, while there is a full-service review of all the bereavement offers in the city. We are also reviewing the evidence to ensure the NHS funded service sees those most at risk of adverse long-term outcomes.

4.6 William Merritt, (All Age Advice on information and assessment of assistive technology equipment) - It is acknowledged that this service has been delivering good outcomes for the people of Leeds for many years. Due to system wide financial constraints, there is a need to review the commissioning of additional services for specific cohorts where there is already a population wide offer these cohorts of individuals can access. We are also aware that some of the added value is in enabling patients to access resources over and above the core statutory NHS provision. Therefore, from April 2025 the intention is to continue to fund this albeit at a 50% lower contribution from the NHS. However, there is a wider community equipment review and redesign currently taking place to consider all the services in the city provided through the jointly funded LCC & NHS Equipment Service.

4.7 Community Eye Service – the original model unlike any other model had no gatekeeping provision which was driving excessive costs. However, there are

elements of the service that it is important to retain, so we are in dialogue with providers to establish a more focussed and lower cost alternative pathway.

4.8 Community Ambulatory Paediatric Service - this service was funded through the GP Confederation using non-recurrent money. There was no additional funding identified to continue this and it has therefore closed. As partial mitigation we have agreed that some of our winter resilience money will be used to target additional respiratory clinics at particular pressure points going forward.

4.9 Circles of Support – MAE Care Dementia. This is a small service which was historically funded as a pilot and has retained this funding. Following involvement and EQUIA process we feel unable to justify this exceptionality, whilst recognising there is the potential for significant concern from the service users at its loss. We will map the wide range of support offers to people in the early stages of dementia across the city and consider as a Partnership whether there are significant gaps for particular geographical or other at-risk populations. We will also work with the Frailty Board to ensure that there is an effective city-wide post diagnosis approach in place.

4.10 The Committee are asked to note that these outcomes, along with delays during the pre-election period have added an additional c£230k of in-year risk to the Leeds position. The ICB team are working to mitigate these.

4.11 The Committee should also note failure to progress at this point would worsen the position further and limit ability to deliver on our financial duty.

5.0 **Impact on Inequality**

5.1 The Committee in March whilst recognising the statutory duty to live within our resources also expressed some concerns that the financial plan as set out in March would have an adverse impact on Health Inequalities duties.

5.2 Clearly the EQUIA process described above is designed to ensure that if there are impacts in specific schemes that we consider mitigation where possible. However, it is important that as well as looking at individual scheme level we take an overall view of funding changes in the current financial year.

5.3 The LHCP segments populations according to their needs, with each population segment overseen by Population Boards representing key system partners. This allows us to ensure we take decisions from a person (not organisational) perspective where possible. We also have cross-cutting Boards for Planned Care, Same Day Response and Primary Care. We continue to work with partners to explore how across the LHCP we can

improve our collective and cumulative view of populations and impact from service changes across all our providers.

5.4 We have aggregated our individual service change proposals and QEIAs where they impact the same population segment, which has allowed us to consider the cumulative effect of decision making taken across individual services and schemes on each population segment in totality. This has helped us consider how individual decisions, taken in isolation, do not combine in ways that might severely impact certain segments of our population. These population-level QEIAs, whilst rudimentary and in their first year of use, serve as an additional check and balance to ensure that the ICB in Leeds is not inadvertently compounding inequalities or creating an outsized burden on a specific group.

5.5 It is also important to note that the vast majority of the £187m efficiency savings required in the opening plan (See 1.4) are just that, efficiency and productivity savings looking at how we deliver the same service within a reduced cost envelope.

5.6 So, turning to look at inequalities in light of the financial plan as a whole it is important the committee notes what has been protected and where additional investment has gone as well where reductions have been made.

5.7 ***Mental Health – growth of £7.1m (Mental Health Investment Standard)***: There is a strong link between health inequalities and mental health. Demand has been growing for mental health support from mainstream services and also for specialist packages of care. In line with the Mental Health Investment Standard our budget for mental health services has increased by £7.1m in 24/25. This increased spend will help address the growth in numbers and complexity of individual care packages and contribute towards addressing high levels of acute bed occupancy and out-of-area placements which are particularly detrimental to individuals and families with low incomes.

5.8 ***Community Mental Health Transformation*****.** The NHS in Leeds had already invested recurrently £4.8m in community mental health service transformation in 2023-2024 and importantly has protected its plans in 2024-2025 for an additional £0.5m This transformation investment has been in both statutory and third sector providers and the NHS in Leeds has met the national 33% target for investment in this transformation going to the Third Sector.

5.9 ***Weight Management:*** The NHS provides treatment for a number of people with obesity for whom less interventionist approaches have not worked. Since Leeds City councils' removal of Tier 1 and Tier 2 services, the NHS Tier 3 services have been overwhelmed with a very significant waiting list. Whilst we

continue to treat individuals, we have had to close the list. We have made funding available this year, c£500k, to continue to address the waiting list and to introduce Wegovy, a medical treatment, to those most in need. This is not at the scale that we would ideally want to invest (c£2.5m), given the long-term implications, but we are hopeful this should enable us to re-open the list in due course and introduce Wegovy to those who will most benefit. The benefits will fall mostly in our Core20plus5 most deprived populations.

5.10 **Core20Plus:** We are meeting this standard in 2024-25 in line with national guidance. We have adjusted the support to GP schemes to give a much stronger focus on the Core20Plus disease pathways as well as protecting for example funding for Black Young Minds and Cancer Screening Champions.

5.11 **Children and Young People:** The increase in the needs and numbers of Children and Young people, especially those who are the most vulnerable including Looked After Children continues to present a considerable challenge. We have committed to an increase in this area of c£3m.

5.12 It is not a simple calculation to summarise these in a single number given they are a mix of additional investments, protection to existing schemes and changes in the focus of existing work. However, the current years financial plan has probably seen additional and protected funding of somewhere between £10-15m which will have had some differential impact on addressing health inequality.

5.13 In protecting these areas, we have reduced the ICB in Leeds's room for manoeuvre in other areas, particularly NHS spending outside of core contracts and Medicines Optimisation.

5.14 However, there have also been reductions. The application of an c3% reduction across Third Sector contracts and grants will have had an impact, as well not continuing the non-recurrent funding of for example Childrens Ambulatory Paediatric Service. Not all these contracts were entirely related to addressing health inequality and at the same time impact on the wider sustainability of small organisations has to be acknowledged. So again, producing a specific figure is difficult but it would probably be between £0.5 and £1m.

6.0 Recommendations

The Leeds Committee of the West Yorkshire Integrated Care Board is asked to:

1. Note and suggest further improvements on the processes used to meet our duties to involve and to consider impacts on quality and inequality.

2. Note progress towards assessing overall impact in light of the balance of protected, new additional, and reduced funding to address health inequality recognising challenges this presents.
3. Note and ratify the outcomes on those areas that were designated for review (where applicable) in the annual Financial Plan approved by the Committee in March 2024.
4. Note the current level of risk within the health system, and the potential impact of not taking these decisions may have on the financial stability and performance of the Leeds Health and Care System implications of the outcomes on the financial plan as submitted and the remedial action.

Appendix 1

Quality Equality Impact Assessment (QEIA) Assurance Panel

Terms of Reference

Version: 1.0
Approved by: ICB Director Team
Date approved: May 2024
Date issued: May 2024
Review date: April 2025

1. Introduction and Context

1.1 These terms of reference set out the membership, remit, and responsibilities of the Quality Equality Impact Assessment Assurance Panel.

1.2 The current Quality Equality Impact Assessment (QEIA) tool being deployed by the ICB in Leeds is used to assess the impact of a proposed commissioning or transformation decision which includes stopping, starting, or adjusting a service. It is important to ensure that commissioning / transformation decisions made are evaluated for their impact on quality, equality, and the wider health and care system.

1.3 From an involvement perspective it is key to ensure we are meeting our legal duties to involve patients in decisions about service changes where appropriate.

1.4 The existing process relating to QEIAs/ EIAs (where required) outlines that all QEIAs should be undertaken using an evidence based decision-making process and discussed at population board/ matrix discussions.

2. Role of the Panel

QEIA's are used to document the assessment of impact, risks and mitigations of any service change. They are completed by Scheme leads (often, but not always from within Pathway and System Integration Teams) who have the best knowledge of the services in question and with support from wider teams where needed.

2.1 The purpose of the panel is to consider completed QEIAs/ and EIAs and seek

assurance that a clear and robust assessment of the impact of the schemes has been undertaken and that mitigating actions are in place.

2.2 The panel will ask a series of assurance questions of each of the QEIAs to determine how fully the scheme has considered the wider risks, impact and consequences, offering a position of full assurance, reasonable assurance, limited assurance and no assurance. Through the pre-scoring process, panel members will consider the following questions:

- Is the proposed change clearly articulated and understood by panel members?
- Are we assured that the proposal has considered the quality, equality and people impacts of risks associated with the change?
- Are we assured that the proposal has considered potential mitigations that might address or reduce these impacts?
- Are we assured that these proposed changes (and any remaining risks) have been appropriately considered, are reasonable and proportionate in the context of wider system risks, and should be put forward to the Leeds Committee for a decision?

2.3 Where the panel receives insufficient assurance, it will challenge, assess risks and may require further detail and key lines of enquiry asked of those who have been involved in the QEIA completion.

2.4 Following initial review by the panel and subsequent planned public involvement relating to the schemes where required, the panel will provide a level of assurance to the Leeds Committee of the WY ICB that the processes have been followed where decisions are being proposed about changes to services.

3.0 Membership

3.1 The membership of the panel will be as follows:

- Director of Quality & Nursing (or deputy)
- Medical Director (or deputy)
- Independent Member

The panel will also have facilitation support from the governance and QEIA project teams.

3.2 The Chair will be a member of the QEIA project team.

3.3 Agreed deputies may attend on behalf of members although preference is for consistent membership where possible.

3. Quoracy and voting

4.1 The panel does not have formal delegated decision-making authority, however given the limited membership, it is advised that each member of their deputy is in attendance.

4. Declarations of interest

5.1 All panel members will comply with the ICB policy on conflicts of interest. This will include but not be limited to declaring all interests on a register that will be maintained by the ICB. All declarations of interest will be declared at the beginning of each meeting.

6. Operation of the Panel

6.1 The panel will meet as and when required and the frequency will be agreed as part of the overall business planning processes.

6.2 The Panel agenda, supporting papers, including copies of all QEIAs and a scoring matrix will be circulated to all members at least three working days before the date of the panel.

6.3 Panel members will be asked to evaluate and score in advance all QEIAs (where possible) and also submit any clarification questions ahead of the meeting.

6.4 Pre-scoring will be reviewed by the QEIA project team and only those QEIAs with variation in scores and clarification questions will be discussed in detail at the Panel meeting itself.

6.5 A summary of the assurance levels agreed for each QEIA and a summary of the discussion will be captured at each panel.

6.6 Governance support will be provided to ensure appropriate support to the members in relation to the organisation and conduct of the panel meetings.

7. Behaviours and practice all members will demonstrate

7.1 Members of the panel will act across the Leeds health and care system in line with Nolan's Seven Principles of Public Life: Selflessness, Integrity, Objectivity, Accountability, Openness, Honesty, Leadership.

8. Review of Assurance Panel

8.1 These terms of reference will be reviewed at least annually following their approval and in line with new business processes.

Appendix 2

These are the schemes that have been reviewed since March 24 with the outcomes and financial position

Ref No.	Project	Overseeing Board / Area	Grouping	QEIA Panel Assurance Outcome	Level of Engagement Required	£,000 Plan 24/25	£,000 Forecast 24/25	£,000 Additional savings from Full year effect in 25/26
O028	Review continuation of CRUSE contract	End of Life	Pathway and System Integration	Reasonable Assurance	Insight review underway of what is already known about people's experiences in Leeds. Will feed into review of citywide offer of bereavement support, with a focus on health inequalities / communities with the greatest need.	£63,000	£12,228	£0
O029	Service review of Circles of Support (MAE Care)	Frailty	Pathway and System Integration	Reasonable Assurance	Mapping of and signposting to other support services needed to support existing service users and their families / carers.	£15.000	£0.000	£30.000
O065	Value for money review of Covid Urgent Eye Service	Planned Care	Pathway and System Integration	Full Assurance	Planning underway for engagement to inform revised service model e.g. in relation to potential change to how people might access the service.	£279.000	£209.250	£69.750
P129	William Merritt	Long Term Conditions	Pathway and System Integration	Reasonable Assurance	Engagement required, with staff, customers and their families / carers as part of rescoping of service spec for 25/26.	£96.000	£0.000	£96.000
O036**	Review of Social Prescribing Contracts and change of model from 24/5	Healthy Adults	Pathway and System Integration	Reasonable Assurance	Undertaken with provider to develop changed service model	£146.000	£146.000	£0
O041	CAPS (Community Ambulatory Paediatric Service)	Children and Young People	Pathway and System Integration	Reasonable Assurance	This scheme relates to non-recurrent funding associated with additional winter capacity. QEIA has been completed to assure that the risks are considered and mitigated			£0

Meeting name:	Leeds Committee of the West Yorkshire Integrated Care Board
Agenda item no.	36/24
Meeting date:	11 September 2024
Report title:	Leeds Joint Working Agreement (JWA) with Astra Zeneca for the Leeds MART Project Phase 2
Report presented by:	Dr Jason Broch, Medical Director
Report approved by:	Lindsay McFarlane, Interim Associate Director, Pathway and System Integration, Leeds Health and Care Partnership
Report prepared by:	Lindsay McFarlane, Interim Associate Director, Pathway and System Integration, Leeds Health and Care Partnership Kate Edwards and Auzma Yousaf, Medicines Optimisation Team, Leeds Health and Care Partnership

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

Previous considerations:

This proposal is an extension of the MART Project; SABA-free Leeds Project that ran in 4 PCNs in Leeds from March to December 2023, the outcomes and evaluation of which has been concluded and reviewed by the Leeds Long Term Conditions Board; who wish to recommend a Phase 2 to the Leeds ICB Committee.

The Leeds ICB Committee approved the phase 1 Joint Working Agreement in December 2022.

Phase 2 of the project is supported by members of the Leeds Respiratory Steering Group, which includes membership from Leeds Teaching Hospital, Leeds Community Healthcare, Leeds and York Partnership NHS Foundation Trust and Primary Care. The Leeds Respiratory Steering group reports into the Leeds Long Term Conditions Population Board. The Leeds Long Term Conditions Population Board supports this proposal (08/08/2024). The evaluation of Phase 1 and progressing Phase 2 was also welcomed by the Leeds Local Medical Council (LMC) when discussed at its meeting on the 20th August 2024.

Executive summary and points for discussion:

This paper outlines the proposed Joint Working Agreement between the Leeds Health and Care Partnership and Astra Zeneca which aims to transform asthma management in adults with poorly controlled asthma. With consideration of the successes highlighted in the evaluation of first phase of the Leeds Maintenance and Reliever Therapy (MART) Joint Working Project completed by 4 PCNs in Leeds in 2023, this paper outlines a proposed Phase 2.

It is anticipated that the Joint Working Agreement will run from October 2024 if agreed, through to October 2025. Phase 2 will extend the project to eight Primary Care Networks (PCNs) across 40 general practices in Leeds to promote a SABA-free approach to asthma treatment, utilising a single inhaler Maintenance and Reliever Therapy (MART) regimen, which is a NICE recommended treatment option for uncontrolled asthma.

As in phase 1, the project will focus on adults with asthma who are identified as high users of SABA inhalers (6 or more inhalers per year), and/or using frequent (3 or more) courses of oral corticosteroids. The PCNs that will be approached initially for engagement have higher than the Leeds average volume of prescribing in these two areas. In addition to this, there are localities within all 8 PCNs that are in the 10% most deprived in the city, according to the Index of Multiple Deprivation (IMD) data from 2019 so some individuals within these PCNs are at increased risk of premature death and impairment of quality of life due to poor physical or mental health. Phase 2 of the MART project aims to impact positively on asthma outcomes in these areas. The PCNs that have been identified to engage first are shown in **Appendix A**. Based on learning from phase 1, it is likely not all practices will want to participate in the project, so there is a reserve list of practices and PCNs who have expressed an interest in MART Phase 2; these practices/PCNs can be approached should participation in the first group be unsuccessful.

The expected outcomes of the project are to improve asthma control in patients with uncontrolled asthma, thus potentially reducing unplanned use of healthcare services e.g., hospital admission, urgent nurse/GP appointments, associated with asthma exacerbations. This is one of the two goals of the Healthy Leeds Plan. The project also aims to improve self-management of asthma and reduce the environmental impact of carbon emissions associated with SABA inhalers thus contributing to Net Zero as part of the Healthy Leeds Plan and wider West Yorkshire ICB priorities. It is for these reasons that the Leeds MART Project Phase 2 should be prioritised.

Phase 2 poses the opportunity to increase the number of people in Leeds using a single inhaler MART regimen. Potentially, there are enough clinic appointments being offered to see 2080 patients across the 40 practices. However, data from phase 1 did show some DNAs and lack of uptake. Using data from Phase 1, the project is aiming to conduct 1,500 reviews (**Appendix B**).

Phase 1 showed that approx. 68% of patients were switched to MART following consultation with the pharmacist – the same would be expected for Phase 2. In Phase 1, the Leeds Data Model estimated a 54% reduction in exacerbations in patients switched to MART, potentially saving approx. £3 per patient in terms of follow up GP consultations (MART evaluation report data) against those who had a review but no switch. It would be expected that these findings would be reflected in Phase 2, however they are indicative only; more time and larger cohorts would be needed to draw more robust conclusions. Furthermore, variations in clinical coding make data analysis difficult.

An approximate reduction in carbon footprint for Phase 1 is calculated as a minimum of 102,000kg CO_2e due to the stopping of SABAs and switches to a dry powder inhaler, which have lower global warming potential (GWP). Potentially, Phase 2 would reduce the carbon footprint by double the amount.

To realise these expected outcomes, Phase 2 will also aim to upskill primary care clinicians e.g., general practice nurses, pharmacists, in the use of MART regimes as an option for uncontrolled asthma through a variety of mechanisms such as TARGET sessions, participation in consultations alongside the pharmacist and support for individual patient level queries from the consultant

pharmacist if needed. There is recognition that embedding changes in clinical practice such as the implementation of MART, needs to be accompanied by a range of educational resources and training opportunities as well as via professional CPD. The participating practices will have access to the SENTINEL Plus suite of resources (see 1.5.1. in report detail below) however additional support may need to be considered in conjunction with workforce and training partners e.g., Primary Care Workforce Training Hub, to build longer term sustainability in clinical practice in this area.

Other positive outcomes associated with Phase 2 and shown in Phase 1 include increasing the number of patients with assessment of management against NICE guidance, supporting general practice to achieve QoF asthma indicators, educating healthcare professionals about MART and it's benefits of use and how to implement it and supporting patients to self-manage their condition.

The estimated financial value of the Joint Working Agreement totals £254,300; 40% from WY ICB Medicines Optimisation Team (£102,400) and 60% from AstraZeneca (£151,900) when workforce commitments/ resources are considered as a monetary value although there will be no exchange of finances under the JWA, as per phase 1, in line with the ABPI and Department of Health.

In line with the West Yorkshire ICB Pharmaceutical and Related Industries Collaborative Working Policy (Feb 2024), proposals for joint working must be reviewed by the organisations Quality and Finance teams, and if supported taken to a public committee meeting for formal meeting approval i.e., LTC Board and the ICB Committee.

Which purpose(s) of an Integrated Care System does this report align with?

☒ Improve healthcare outcomes for residents in their system

☒ Tackle inequalities in access, experience and outcomes

☒ Enhance productivity and value for money

☒ Support broader social and economic development

Recommendation(s)

The Leeds Committee of the West Yorkshire Integrated Care Board is asked to:

1. **Approve** the recommendation that the Leeds place enters into a second Joint Working Agreement (JWA) with AstraZeneca for phase 2 of the Leeds MART Project as described in this paper.

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

N?A

Appendices

A. PCNs and practices identified for phase 2
B. Calculating patient numbers for review

Acronyms and Abbreviations explained

1. SABA - short-acting beta2-agonist – A type of inhaler used to relieve asthma symptoms e.g., wheezing, breathlessness.

2.	Maintenance and Reliever Therapy (MART)
3.	ICS/LABA inhaler – A type of inhaler combining an inhaled corticosteroid (ICS) and a long acting beta2-agonist (LABA) used to “prevent” asthma symptoms
4.	IIF – Investment and Impact Fund
5.	JWA – Joint Working Agreement
6.	EQIA - Equality and Quality Impact Assessment
7.	DPIA – Data Privacy Impact Assessment
8.	PCN – Primary Care Network

What are the implications for?

Residents and Communities	This initiative will improve outcomes for adult asthma patients living in Leeds who are registered in a General Practice signed up to the project.
Quality and Safety	An Equality and Quality Impact Assessment has been completed; where there are potential impacts, these have been recognised and an action plan implemented to mitigate these. The project will improve patient outcomes.
Equality, Diversity and Inclusion	An Equality and Quality Impact Assessment has been completed. Where there are potential impacts, these have been recognised and an action plan implemented to mitigate these.
Finances and Use of Resources	The estimated financial resource is outlined within this paper and is supported by the Head of Medicines Optimisation at Leeds Place and the Respiratory Steering Group.
Regulation and Legal Requirements	This development and Joint Working Agreement complies with the West Yorkshire ICB, Pharmaceutical and Related Industries Collaborative Working Policy (2024).
Conflicts of Interest	The Joint Working Agreement has been developed in line with the West Yorkshire ICB, Pharmaceutical and Related Industries Collaborative Working Policy (2024) which addresses conflicts of interest. AstraZeneca manufacture Symbicort Turbohaler, which has a license to be used as maintenance and reliever therapy and will be an option for patients reviewed as part of this joint working project. However, the project is not reliant upon the prescribing of any AstraZeneca medicine; prescribing of appropriate medication will be the responsibility of the treating clinician (Interface Clinical Service pharmacists) and shall be entirely independent of AstraZeneca. Whilst prescribing recommendations are made to the GP practice, the clinician agreed by the GP

	Practice will be responsible for approving and making all prescribing decisions in line with local prescribing formula/guidelines. There will be no use of any Astra Zeneca promotional materials in the project.
Data Protection	A Data Protection Impact Assessment has been undertaken with no risks identified.
Transformation and Innovation	This agreement allows us to innovate and improve patient outcomes around asthma care in general practice.
Environmental and Climate Change	Positive Impact – initiative aims to reduce avoidable carbon emissions through encouraging choice of lower carbon inhaler alternatives, where clinically appropriate thus lowering Global Warming potential from inhaler usage. It will also reduce the carbon footprint associated with SABA usage through reducing prescribing volume in the participating PCNs.
Future Decisions and Policy Making	The learnings and evaluation from this work will inform future commissioning intentions within the West Yorkshire ICB.
Citizen and Stakeholder Engagement	Patient engagement will be managed by individual General Practices/PCNs but will be supported by the Medicines Optimisation MART project team with guidance from engagement and involvement colleagues as needed. Follow up to a medication change will be managed by the general practice/PCN in line with their usual processes. Feedback will be sought from patients as per Phase 1.

1. Main Report Detail

1.1 The proposed Joint Working Agreement between the Leeds Health and Care Partnership (via the WY ICB) and Astra Zeneca aims to transform asthma management in adults with poorly controlled asthma as defined by excessive use of short-acting beta2-agonist (SABA) reliever inhaler and/or frequent rescue courses of prednisolone through increased use of single inhaler Maintenance and Reliever Therapy (MART) using an inhaler licensed for use in MART from the West Yorkshire Adult Asthma Guidance.

1.2 The use of an ICS/LABA inhaler as a MART regimen reduces the risk of asthma attacks by 38% and 23% compared to the same equivalent dose, or higher dose respectively, of conventional fixed doses of inhaled corticosteroid/long-acting beta2-agonist (ICS/LABA), with similar effects on quality of life, asthma control, lung function and asthma medication use.[1] MART regimens are currently not widely prescribed in Leeds, despite being an option in the Leeds asthma guidelines and recommended by NICE if asthma is uncontrolled in adults on at least a low dose ICS and LABA.

1.3 The Joint Working Agreement will involve pharmacist-led reviews with adults with a diagnosis of asthma, who remain uncontrolled (using at least 6 SABA inhalers per year, and/or requiring at least three courses of systemic corticosteroids per year). The reviews will consist of patient education, inhaler technique training and the optimisation of asthma treatment to:

- Improve outcomes for adult asthma patients by addressing SABA over-reliance, increasing appropriate anti-inflammatory treatment, and implementing a single inhaler maintenance and reliever therapy (MART) focussed strategy for appropriate patients to improve asthma control and avoid asthma attacks.
- Reduce the environmental impact of adult asthma management through reduction in SABA over-reliance, as well as improving patient health. It is envisaged that this incentive will also enable reductions in unnecessary SABA prescribing (and therefore carbon emissions) by improving disease control. Three of the four inhalers on the local guidance are dry powder inhalers (DPIs) which have lower global warming potential compared to pressurised meter dose inhalers (pMDIs) which use a propellant.
- Contribute to the achievement of Net Zero carbon emissions in Leeds as per the Healthy Leeds Plan 2023-28, the Greener NHS agenda and British Medical Association (BMA) ambitions to reduce avoidable carbon emissions through encouraging choice of lower carbon inhaler alternatives, where clinically appropriate (lowering Global Warming potential).

- Provide education, training and awareness. TARGET sessions run by the Consultant Respiratory Pharmacist have already been delivered to primary care staff in Leeds. Interface Clinical Services can support practice staff to ensure a lasting legacy of this service by allowing practice healthcare staff to sit in on consultations to learn and understand the review process. The Consultant Pharmacist will advise GP/PCN staff should they require clinical support and advice relating to MART initiation in specific patients. Astra Zeneca will provide support, if required, to GP/PCN in the form of access to a non-promotional medical educator. Access to the SENTINEL Plus quality improvement suite of resources will be available to participating PCN/GP staff which are educational resources for HCPs and patients funded by AstraZeneca and co-developed with Hull York Medical School and Hull University Teaching Hospitals NHS Trust following the SENTINEL clinical trial.

1.4 It is anticipated that the Joint Working Agreement will run from October 2024 if agreed, through to October 2025. Eight PCNs will be recruited to work with, to promote a SABA-free approach to asthma prescribing, utilising the single inhaler MART regimen. Focus will again be on adults with asthma who are identified as high users of SABA inhalers (6 or more inhalers per year), and/or using frequent (3 or more) courses of oral corticosteroids. These patients, by definition, have uncontrolled asthma and should be a priority for an asthma review to optimise their treatment.

1.5 The commitments from each partner in participating in the JWA is:

1.5.1 AstraZeneca

AstraZeneca will provide the following support:

- AstraZeneca medical educator resource to support non-promotional education, implementation, and project management.
- Support of timely asthma reviews via Interface Clinical Services to run face to face review clinics, where possible, although virtual or telephone reviews are acceptable too where the pharmacists will work under the direction of Leeds ICB/general practice clinicians. An additional benefit of this specific service is that the pharmacists have been upskilled in asthma reviews and how to implement the transition to a SABA-free treatment option for patients. Learning from phase 1 will be utilised.
- Deploy the SENTINEL Plus suite of non-promotional educational resources – structured, nurse supported, virtual support programme to optimise adherence, inhaler technique, asthma knowledge, and self-management in newly transitioned patients.

- Provide feedback, along with the Interface Clinical Service team at monthly project group meetings with the MOT regarding practice sign up to the review service, number of patients attending clinics and performance against agreed project KPI's.

1.5.2 Leeds Health & Care Partnership

- Consultant pharmacist (LTHT), Principal Pharmacy Technician, Service Improvement Lead and Senior Pharmacy Technician (Leeds MOT) will be supporting the project set up and delivery. This is a change of skill mix to Phase 1.
- The consultant pharmacist will be available to support with ad-hoc queries and provide advice about MART initiation, should a GP/PCN request it. This is a change to Phase 1 which showed poor uptake of the offer of case review with the consultant pharmacist and advanced pharmacist.
- Follow-up meetings can be arranged with the Medicines Optimisation MART Project team should a GP/PCN require this.
- Interface Clinical Services, who are providing the pharmacist-led reviews in general practice as part of this work, will work to a defined protocol in line with the project scope and West Yorkshire Adult Asthma Guidelines.
- The Interface Clinical Service pharmacist will make prescribing recommendations to the agreed clinician(s) in the GP/PCN. The clinician (GP/ NMP) agreed by the GP Practice/PCN will be responsible for approving and making all prescribing decisions.
- Follow up review after the initial intervention will be completed by the practice in line with their usual practice when changing treatment however the consultant pharmacist can support case review if requested.
- Local community pharmacies will be briefed about this project (via Community Pharmacy West Yorkshire), so that they are aware there may be a potential increase in the inhalers currently recommended on the WY Adult Asthma Guidelines. This will support the pharmacies with their stock holding and avoid delays in dispensing new prescriptions. It will also allow pharmacies to potentially offer other services to support the patients e.g., with inhaler checks, and use of the New Medicines Service.

1.6.

The estimated financial value of the Joint Working Agreement totals £254,300; 40% from WY ICB Medicines Optimisation Team and 60% from AstraZeneca when the above workforce commitments/resources are considered as a monetary value although there will be no exchange of finances under the JWA, as per phase 1, in line with the ABPI and Department of Health.

1.7 In line with the West Yorkshire ICB, Pharmaceutical and Related Industries Collaborative Working Policy (2024) proposals for joint working must be reviewed by the organisations Quality and Finance teams, and if supported (which this

proposal is) taken to a Governing Body/Committee meeting for formal meeting approval. The Long Term Conditions Population Board is supportive of this project/Joint Working Agreement and thus the Leeds Committee is asked to agree to this project, so that the Leeds Place of the WYICB can enter into the Joint Working Agreement with AstraZeneca. Please note that a Data Privacy Impact Assessment and Quality and Equality Impact Assessment have been completed for this project.

2. Next Steps

Subject to agreement by the Leeds ICB Committee, the next steps will be followed:

- Joint Working Agreement signed by all parties in September 2024.
- First PCN commences reviews in October/November 2024.
- Additional PCNs will join throughout the year as agreed with Interface Clinical Services.
- The project will be evaluated throughout the year, as with Phase 1, with a final project summary report being published 6 months post project completion, circa March 2026.
- Learnings from the Phase 1 evaluation will be considered throughout the project and included in the final evaluation.

3. Recommendations

The Leeds Committee of the West Yorkshire Integrated Care Board is asked to:

3.7 Approve the recommendation that the Leeds place enters into a Joint Working Agreement (JWA) with AstraZeneca for the Leeds MART Project Phase 2 as described within this paper.

Appendix A – PCNs and practices identified for Phase 2

B86003	ARMLEY MEDICAL CENTRE (DR G LEES & PARTNERS)	Armley
B86024	PRIORY VIEW MEDICAL CENTRE	
B86060	THORNTON MEDICAL CENTRE	
B86096	ARTHINGTON MEDICAL CENTRE	Middleton & Hunslet
B86642	CHURCH STREET SURGERY (DR S HUSSAIN)	
B86042	LINGWELL CROFT SURGERY	
B86035	SOUTH BANK SURGERY	
B86055	ASHFIELD MEDICAL CENTRE	Crossgates
B86075	COLTON MILL MEDICAL CENTRE (DR T P FOX & PARTNERS)	
B86648	FAMILY DOCTORS	
B86009	MANSTON SURGERY	
B86094	THE GABLES SURGERY (DR S M CHEN & PARTNER, GLENLEA)	West Leeds
B86011	HILLFOOT SURGERY	
B86015	MANOR PARK SURGERY	
B86018	MULBERRY STREET MEDICAL PRACTICE	
B86014	ROBIN LANE HEALTH AND WELLBEING CENTRE	
B86050	WEST LEEDS FAMILY PRACTICE (WEST LODGE SURGERY, CALVERLEY)	
B86016	SHAFTESBURY MEDICAL CTR. (CHURCH VIEW SURGERY)	York Rd
B86054	THE GARDEN SURGERY	
B86062	THE MEDICAL CENTRE	
B86667	BEESTON VILLAGE SURGERY	Beeston
B86002	CITY VIEW MEDICAL PRACTICE	
B86005	OAKLEY MEDICAL PRACTICE (DR N DUMPHY & PARTNERS)	
B86012	LEEDS CITY MEDICAL PRACTICE (PARKSIDE SURGERY)	
B86678	DRIGHLINGTON MEDICAL CENTRE (R F GUPTA'S PRACTICE)	Morley
B86101	GILDERSOME HEALTH CENTRE	
B86064	LEIGH VIEW MEDICAL PRACTICE	

B86028	SOUTH QUEEN MEDICAL CENTRE (Dr JJ MCPEAKES)	
B86067	FOUNTAIN MEDICAL CENTRE (THE DEKEYSER GROUP PRACTICE)	
B86057	WINDSOR HOUSE GROUP PRACTICE	
B86106	FOUNDRY LANE SURGERY	Seacroft
B86022	OAKWOOD LANE MEDICAL PRACTICE	
B86093	PARK EDGE PRACTICE	
B86007	WINDMILL HEALTH CENTRE	
B86623	ASHTON VIEW MEDICAL CTR	Burmantofts & Harehills
B86081	BELLBROOKE SURGERY	
B86108	CHAPELTOWN FAMILY SURGERY	
B86103	CONWAY MEDICAL CENTRE	
B86043	EAST PARK MEDICAL CENTRE	
B86061	HAREHILLS CORNER SURGERY	
B86675	LINCOLN GREEN MEDICAL CENTRE	
B86666	NEWTON SURGERY	
Y02494	SHAKESPEARE MEDICAL PRACTICE	
B86013	THE NORTH LEEDS MEDICAL PRACTICE (MILAN STREET)	
B86643	THE ROUNDHAY ROAD SURGERY	
B86669	YORK STREET HEALTH PRACTICE	

Appendix B – calculating patient numbers for review:

(i) Phase 2 targets 43 practices, compared to 20 in Phase 1, so scaled up from 811 patients seen in Phase 1, aim for 1,743 reviews.
(ii) In Phase 1, 811 patients were reviewed out of 13,126 on the asthma register (6.2% of patients were reviewed), whereas Phase 2 targets an asthma register size of 23,973, so a 6.2% uptake is 1,481 patient reviews

Agreed aim: 1,500 patient reviews.

Not

Meeting name:	Leeds Committee of the West Yorkshire Integrated Care Board
Agenda item no.	37/24
Meeting date:	11 September 2024
Report title:	Risk Management and Board Assurance Framework Report
Report presented by:	Tim Ryley, Place Lead, ICB in Leeds
Report approved by:	Aimee Willett, Head of Corporate Governance and Risk, WY ICB
Report prepared by:	Harriet Speight, Corporate Governance Manager, WY ICB

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

Previous considerations:

Quality and People's Experience Sub-Committee – 17 July 2024

Finance and Best Value Sub-Committee – 31 July 2024

ICB in Leeds Directors Team Meeting – 28 August 2024

Executive summary and points for discussion:

This paper presents the ICB in Leeds High-Scoring Risk Report (risks scoring 15+) during risk cycle 2. All risks have been reviewed by the Risk Owner, the allocated Senior Manager and by the EMT of the ICB in Leeds. In addition to the high-scoring risks (15+), risks scoring 12 and above that are directly aligned to the Leeds Committee (rather than to the sub-committees) are highlighted in the report. The total number of risks during the current cycle and the numbers of Critical and Serious Risks are set out in the report.

Which purpose(s) of an Integrated Care System does this report align with?

☒ Improve healthcare outcomes for residents in their system

☒ Tackle inequalities in access, experience and outcomes

☒ Enhance productivity and value for money

☒ Support broader social and economic development

Recommendation(s)

The Leeds Committee of the West Yorkshire ICB is asked to:

1. **RECEIVE** and **NOTE** the High-Scoring Risk Report as a true reflection of the risk position in the ICB in Leeds, following any recommendations from the relevant sub-committees.
2. **RECEIVE** and **NOTE** the WY ICB Board Assurance Framework (BAF) Summary and Heat Map.
3. **CONSIDER** whether it is assured in respect of the effective management of the risks aligned to the Committee and the controls and assurances in place.

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

This report provides details of all high-scoring risks and risks aligned to the Leeds Committee on the Risk Register. The Risk Register supports and underpins the ICB Board Assurance Framework and relevant links are drawn between risks on each.

Appendices

Appendix 1: Risk Register extract (High Scoring risks and risks aligned to the Leeds Committee)

Appendix 2: West Yorkshire ICB Risk Report Extract (Common Risks) submitted to the WYICB 25 June 2024 (link)

Appendix 3: Leeds Health and Care Partnership Partner Top Risks (as at August 2024)

Appendix 4: Risk on a Page Report

Appendix 5: BAF Summary and Heat Map

Acronyms and Abbreviations explained

1. ICB – Integrated Care Board
2. CMH – Community Mental Health
3. ND - Neurodiversity
4. PICU - Psychiatric Intensive Care Units
5. IG – Information Governance
6. LTHT – Leeds Teaching Hospitals NHS Trust
7. LCH – Leeds Community Healthcare NHS Trust
8. LYPFT – Leeds and York Partnership Foundation NHS Trust

What are the implications for?

Residents and Communities	Any implications relating to individual risks are outlined in the Risk Register.
Quality and Safety	
Equality, Diversity and Inclusion	
Finances and Use of Resources	
Regulation and Legal Requirements	
Conflicts of Interest	None identified
Data Protection	

Transformation and Innovation	Any implications relating to individual risks are outlined in the Risk Register.
Environmental and Climate Change	
Future Decisions and Policy Making	
Citizen and Stakeholder Engagement	

1 Introduction

1.1 The report sets out the process for review of the Leeds Place risks during risk cycle 2 which commenced on 25 June 2024 and will end after the ICB Board meeting on 24 September 2024.

1.2 The report shows all high-scoring risks (scoring 15 and above) recorded on the Leeds Place risk register. In addition to the high-scoring risks, risks scoring 12 and above that are directly aligned to the Leeds Committee (rather than to the sub-committees) are highlighted in the report. Details of the risks are provided in Appendix 1.

2 Leeds Place Risk Register

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

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

This report includes the high-scoring ICB in Leeds Place risks and indicates where these risks are common to more than one place.

2.2 All high-scoring place risks, corporate risks, and all risks common to more than one place are reported to the WY ICB Board. Please see pages 18 to 29 of the West Yorkshire ICB Risk Report 25 June 2024 for the Corporate Risk Register, and pages 40 to 50 for the common risks.

As part of the risk cycle process the WY ICB Director of Corporate Affairs meets with the Risk Management Operational Group to review the risks on each place risk register. This supports the identification of place risks scoring 15+ and common risks on the registers. The detailed review and mapping of the risks also enables the flagging of potential anomalies in scoring or wording between different places, supporting the discussions that ensure the continued evolution of the risk register.

2.3 Risks scoring 15 and above and common risks will be presented to the relevant WY ICB committee on the following dates:

- West Yorkshire Integrated Care Board – 24 September 2024
- West Yorkshire ICB Finance, Investment & Performance Committee – 3 September 2024 (AM)
- West Yorkshire ICB Quality Committee – 3 September 2024 (PM)

2.4 The Place Risk Register reflects both risks relevant to the ICB in Leeds (risks associated with delivery of the ICB's statutory duties delegated to Place) and risks associated with the delivery of system objectives/priorities (risks associated with the delivery of transformation programmes, for example).

2.5 The Place Risk Register will not capture risks which are owned by ICS System Partners, that they are accountable for via their individual statutory organisations. However, in order to support triangulation of risks and provide visibility of the risk profile across the Leeds Health and Care Partnership, partners have been requested to provide their highest scoring risks that they want the membership of the Leeds Committee to be sighted on. The approach taken by system partners to identify risks for inclusion has included consideration of risks that require partnership working and a system-based solution and has also involved the senior management / leadership teams within the partners. Common risk areas across the partnership include financial pressures, increased demand for services, access to mental health and learning disability services, and workforce issues. The top risks identified by system partners are detailed at Appendix 3. Partners are also consulted when populating and managing the Population and Care Board risk registers.

2.6 The last reported position to the Leeds Committee set out a total of 10 open risks on the risk register. There are currently 10 risks on the Leeds Place Risk Register, with risks removed or added since cycle 1.

2.7 An overview of the Leeds Place risks exposure during the current risk cycle (risk cycle 2) is provided at Appendix 4, the Risk on a Page Report. Information that can be found includes:

- An overview of the risk profile, with details of the number of risks.
- A graph showing the changing number of risks on the register – over time, this can help to highlight the management of the ICB's risks.
- A graph showing the average score – again, this helps to demonstrate the risk profile, and help to alert if the overall risk score is increasing over time.
- Static risks – the graph will demonstrate over time how long risks have remained static for. A risk that remains static over a number of cycles, may be an indication that further work is needed to control the risk.

Following an update of the Risk Register by Risk Owners and review of individual risks by the allocated Senior Manager, all risks are reviewed by

the Directors of the ICB in Leeds. Risk cycle 2 of 2024/25 was reported at the sub-committee meetings that took place throughout July 2024. Feedback from the sub-committee risk discussions may be provided through the Alert, Assure and Advise report or verbally at the Leeds Committee of the WY ICB.

2.8 At the last Leeds Committee meeting, it was agreed that there would be a full review of the Leeds Place Risk Register, to look in more detail at the articulation of the current risks, with a particular focus on ensuring that each risk is person-centred, and whether any additional risks are required to be added. A report was taken to the ICB in Leeds Director Team Meeting on 21 August 2024 setting out the proposal to undertake a full risk review. The Director's reflected on the challenge associated with balance of accountability for management of risks as a WY organisation, the Leeds partnership (including NHS providers, local authority and the third sector), and the ICB in Leeds. It was agreed that work to fully review the risk register should be slowed until the outputs of wider work is undertaken, including work to develop the BAF (see paragraph 5) and ongoing discussions taking place amongst the Director of Operational Finance at each Place in WY around consistency of angle, articulation and scoring of financial risks. The risks set out on the risk register will continue to be reviewed individually through cycle 3, with additional guidance around aligning risk descriptions, gaps, mitigations and assurances to the Leeds Health and Care Partnership vision, goals and objectives and the overarching purposes of integrated care systems.

3 High Scoring Risks (15+)

3.1 The last report to the Leeds Committee of the WY ICB provided an update on the risk position during risk cycle 1 (2024/25).

3.2 There are six open high scoring risks and the following changes have taken place during cycle 2:

Risk	Cycle 1 2024/25	Cycle 2 2024/25	Movement
2413 – There is a risk that the financial position across the Leeds system will not achieve financial balance	20	20	Static Risk - Development of Financial Performance Framework added as an additional assurance control to support the delivery of the financial plan for the ICB in Leeds in 24/25.

Risk	Cycle 1 2024/25	Cycle 2 2024/25	Movement
2414 – There is a risk that measures being taken to control expenditure in Leeds City Council will have an impact on other place partners	16	16	Static Risk – This risk was aligned to both the Delivery Sub-Committee and the Finance and Best Value Sub-Committee following request during the last risk cycle. No change to risk score or description - finance teams meeting bi-weekly to update on any relevant issues.
2019 – There is a risk of harm to patients in the Leeds system due to people spending too long in Emergency Departments (ED)	16	16	Static Risk – Risk impact and likelihood remain unchanged due to occupancy currently at 95% and 12-hour waits remaining fairly static. However, the NR2R numbers are reducing over the summer months but the upcoming planned industrial action by junior doctors is likely to add further pressure.
2018 – There is a risk of increased rates of avoidable deteriorations in mental health	16	12	Decreased Risk – LCH report work to reduce waiting list for access to step 3 CBT in NHS talking therapies has had significant impact with many people now able to commence high intensity therapy within 4 months and target for waiting list anticipated to be met by October. LYPFT report reductions in community mental health team caseloads, although complexity of need is greater. Whilst Leeds has achieved OOA target trajectory in both May and June 2024, delayed transfer of care remains high. Access to urgent crisis assessment within the MH trust within 4hrs whilst improved remains under-target at 57.14%. LYPFT continue to report OPEL 3E and significant ongoing pressures.
2415 – There is an increasing risk of widening health inequalities and poorer health outcomes across Leeds due to the reduction or loss of VCSE services	16	16	Static Risk – Key controls, mitigations, assurances and gaps have been identified and added to the risk by the Accountable Officer, detailed in Appendix 1.

Risk	Cycle 1 2024/25	Cycle 2 2024/25	Movement
2301 – There is a risk of Children and Young People being unable to access a timely diagnostic service for neurodevelopmental conditions (Autism and ADHD)	15	15	Static Risk – Joint process mapping and redesign meeting undertaken for the under 5's. Working on an agreed pathway by September. Clinical reference group further developed with agreed funded capacity for attendance of clinicians. Additional challenges presented by LCH, due to staffing shortages and the need to go into business continuity mode, which may result in limiting new nonpriority referrals into the service. Correspondence jointly drafted but not gone out yet due to imminent elections. LCH have expressed the need to possibly refocus MindMate Spa to priority CAMH cases. Further work to understand the implications of the challenges and any possible future changes is underway.
2354 – There is a risk of unsustainable Neurodevelopmental assessment and treatment pathways for adults (autism and ADHD)	15	15	Static Risk – Key controls have been added - ICB Place resource is focussed on supporting the development of a WY accredited provider list to support and manage quality and tariffs associated with RTC referrals; ADHD service is developing an impairment ladder to manage clinical prioritisation; and Leeds Data Model will include ADHD data.

3.3 Of these risks, all are marked as common risks, common to more than one place but not a corporate risk. Appendix 2 details the common risks across the places to provide further context to the Committee.

4 Risks Aligned to the Leeds Committee

4.1 There are two risks aligned directly to the Leeds Committee. Of these risks:

a) One risk is scored at 12
b) One risk is scored at 9 and included in Appendix 1

4.2 **High Scoring Risks (12+)**

Risk Number and Risk Title	Cycle 1 2024/25	Cycle 2 2024/25	Movement since previous risk cycles
2024 – Deprivation of liberty (DoLS) legislation	12	12	Static Risk - Though this is regularly monitored and the team continue to prioritise DoLS in the community the risk remains static. The team continues to have a large vacancy factor and a recruitment freeze as all organisations across the city try to meet their financial targets. The plan in Q2 is to identify training money to increase number of staff to support this work.

5 Board Assurance Framework (BAF)

5.1 The WY ICB BAF provides the ICB with a method for the effective and focused management of the principal risks and assurances to meeting its objectives. By using the BAF, the ICB can be confident that the systems, policies, and people in place are operating in a way that is effective in delivering objectives and minimising risks.

5.2 The WY ICB received an Internal Audit report focused on the BAF that concluded with a 'limited assurance' rating, and made a number of recommendations for action, all of which have been approved by the WY ICB Audit Committee and Board. The report concluded that the new Operating Model with a centralised Governance team should help with deployment but, although coordinated by that team, it would require the commitment from Place Teams and Committees across the ICB to fulfil its purpose and potential. Therefore, please be aware that each Place will be asked to contribute to the recommendations made which will form part of a full developmental review of the BAF over the coming months. The Board Assurance Framework and Heat Map is attached at Appendix 5 for information.

6 Next Steps

6.1 Subsequent to the Leeds Committee meeting, the risks will be carried forward to the next risk review cycle which commenced after the WY ICB Board meeting on 24 September 2024.

7 The Leeds Committee of the West Yorkshire ICB is asked to:

1. **RECEIVE** and **NOTE** the High-Scoring Risk Report as a true reflection of the risk position in the ICB in Leeds, following any recommendations from the relevant sub-committees.

2. **RECEIVE** and **NOTE** the WY ICB Board Assurance Framework (BAF) Summary and Heat Map.
3. **CONSIDER** whether it is assured in respect of the effective management of the risks aligned to the Committee and the controls and assurances in place.

8 Appendices

Appendix 1: Risk Register extract (High Scoring risks and risks aligned to the Leeds Committee)
Appendix 2: West Yorkshire ICB Risk Report Extract (Common Risks) submitted to the WYICB 25 June 2024 (link)
Appendix 3: Leeds Health and Care Partnership Partner Top Risks (as at August 2024)
Appendix 4: Risk on a Page Report
Appendix 5: BAF Summary and Heat Map

Risk ID	Date Created	Risk Type	Strategic Objective	Risk Rating	Risk Score Components	Target Risk	Target Score Components	Risk Owner	Senior Manager	Principal Risk	Key Controls	Key Control Gaps	Assurance Controls	Positive Assurance	Assurance Gaps	GBAF Ref No(s)	GBAF Entry Description(s)	Risk Status
2413	20/03/2024	Finance and Best Value Committee	Enhance productivity and value for money	20	(4x5)	6	(3x2)	Matthew Turner	Alex Cricknar	There is a risk that the financial position across the Leeds system will not achieve financial balance due to the combination of undelivered CIPP and new cost pressures in 2024 – 25. This could result in the system as a whole not meeting its statutory duties to break even.	Budgetary reporting and control meetings with DMT and budget holders/managers. SFI's/SO's Monthly meetings with DoFs and CEOs/AOs through the SFEG. Internal and external audit West Yorkshire finance framework Weekly Leeds DoF meetings Fortnightly meetings with Leeds Council	There is an active approach adopted across the ICB in Leeds and the wider WY ICB means that all parts of the WY system are actively looking at further opportunities to ensure that the ICB can deliver its agreed financial plan for 2024-25. Development of a medium term strategic financial plan to demonstrate the path to recurrent balance is ongoing across Leeds and West Yorkshire.	Policies and Procedures Financial performance framework Weekly Leeds DoF meetings Fortnightly meetings with Leeds Council	We are starting the financial year with a £12m planned deficit at the ICB and a total £8m deficit across all NHS partners in Leeds. This is the lowest level of deficit compared to other places in West Yorkshire. There is ongoing benchmarking work across West Yorkshire to identify further potential opportunities to close the financial gap.	Limited further options to close the remaining gap at the ICB at this time, with limited data on benchmarking opportunities. Medium term financial plan yet to be produced to achieve recurrent financial balance.			Static - 1 Archive(s)
2415	21/03/2024	Delivery Committee	Tackle inequalities in access, experience, outcome	16	(4x4)	9	(3x3)	Sam Ramsey	Tim Ryley	There is an increasing risk of widening health inequalities and poorer health outcomes across Leeds due to the reduction or loss of VCSE services and closure of VCSE organisations in the current economic and financial context. Loss of VCSE services will result in increased demand on already overstretched mainstream and community NHS services.	Annual position statement published which includes overview of NHS spend in the sector and commitments to increase NHS funding in the sector in line with underlying NHS allocations and stronger focus on community and inequalities. Forum Central and wider Third Sector participation in Leeds Health & care strategy and prioritisation processes.	Factors outside the NHS - NHS England financial regime - NHS investment in Third Sector is only one part of the picture with Local authority, Grant Funding, Revenue generating activity. - NHs investment limited to those areas that link to its role in the system in providing services, secondary prevention and equity of access	West Yorkshire ICB level review of place approaches Leeds Committee of the ICB oversight of financial plans Two meetings per year with Sector to review progress	Further to be added in Q3	Need to develop broader partnership overview in Leeds at the moment still too fragmented so assurance is limited.			Static - 1 Archive(s)
2414	20/03/2024	Both Delivery and Finance and Best Value	Enhance productivity and value for money	16	(4x4)	6	(3x2)	Matthew Turner	Alex Cricknar	There is a risk that measures being taken to control expenditure in Leeds City Council will have an impact on other place partners, due to the financial pressures being experience by most councils across West Yorkshire and their statutory requirement not to overspend against budgets. This may lead to a potential impact on hospital discharges resulting in higher costs being retained within the Leeds and WY NHS system (additional costs borne by NHS provider organisations for which there may not be mitigations, therebv resultine in	1. Working with Leeds City Council to understand the issues, options being considered and the potential impact on system partners. 2. Review use of intermediate care capacity 3. System leadership oversight and consideration of options to minimise impact	WY councils are separate statutory organisations with no NHS oversight	System oversight of wider health and care financial position	Close working relationships between the NHS and councils in place and representation of councils on system partnership board	Lack of medium term plan to understand how recurrent financial balance position can be achieved.			Static - 1 Archive(s)
2019	30/06/2022	Both Delivery and Quality and People's Experience	Improve healthcare outcomes for residents	16	(4x4)	9	(3x3)	Helen Smith	Helen Lewis	There is a risk of harm to patients in the Leeds system due to people spending too long in Emergency Departments (ED) due to high demand for ED, the numbers, acuity and length of stay of inpatients and the time spent by people in hospital beds with no reason to reside, resulting in poor patient quality and experience, failed constitutional targets and reputational risk. In combination with the risk of harm to those people who remain in hospital when they no longer have a reason to reside from hospital-related harms and deconditioning while they wait for ongoing services, where their wait is longer than 72h.	Strong surge plan in place as necessary (within LTHT) Transfer of Care hub completely staffed and working 7 days and Transfer of Care workplan rolling out new model into ward based model Home First Programme refreshed and overseen by LTHT Chief Exec as System SRO Detailed seasonal surge plans developed and overseen by PEG through Active System Leadership Structures System Escalation Actions and Processes revised continuously OPEL & System Pressures Reporting Regime - refreshed in view of the revised OPEL (Nov 23) Communications work with Public to suggest alternatives to ED Home First programme well underway - initial improvements have allowed the closure of 2 nR2R wards over the summer of 23. These were than available for seasonal surge Investment in Home First services and in assessment capacity through Adult Social Care Discharge Fund Improvements have been seen over 2023 and the LTHT occupancy dropped to 93% and 2 no Reason to Reside wards were closed. Winter capacity plans in place to support discharge capacity	Key controls in place responding to high levels of demand. Current controls are still not sufficient to reduce the risks when there is exceptionally high demand on the system or where outflow is constrained through Industrial Action or other absence While occupancy has improved, this isn't always correlated with a reduction in people spending a long time in ED - this needs further analysis Increased winter demand for acute care coupled with a increase demand for support on discharge has created longer waiting times and backlogs in hospital where capacity has been unable to meet the demand. This is in the context of additional winter capacity in primary care and social work. (Apr 24)	Health & Social Care Command & Control Groups: System Resilience Operational Group (Bronze), System Coordination Group (Silver) and System Resilience and Reset Assurance Board (Gold) Integrated Commissioning Executive Partnership Executive Group Quality and Performance Committee New System Visibility Dashboard is in place to support assurance and decision making	Weekly meeting in place for services to report on capacity /demand Reviewed Silver Action cards Revised System Resilience Structure System Visibility dashboard in place and driving change Strong programme of Home First work in place Short Term Assessment pathway developed in the interim for winter to support the city's Home First ambition, while the Active Recovery service eligibility criteria is expanded. Improvements in the waiting times for pathway 3 have been made by process changes Occupancy in LTHT was 93% over summer and we have seen a reduction in the 12h breaches.	All Beckett Wing wards remain open at LTHT with patients placed into ESAs - pressures remain high with significant delays placing people from ED and step downs from critical care. OPEL reporting system under development for ASC but not yet finalised or shared. Recruitment and retention remain significantly challenging and limit the ability to create additional capacity, particularly in the Reablement service. (Mitigating over winter with Short Term Assessment Service) Still too many people over 6 and over 12 hours in ED which we know is linked to risk of harm Patients in LTHT have on occasions been placed in exceptional surge areas including corridors and in day rooms due to the lack of availability for inpatient beds (unsatisfactory environments have been mitigated as far as possible with the provision of call bells and other basic requirements) . Long waits for admission in inappropriate ED environments for mental health beds have resulted in clinical incidents in Dec 2023. Funding to maintain capacity within LTHT and to support Social care assessments is likely to become more difficult in coming months SW capacity, recruitment and retention remain a key risk alongside groups such as therapists Additional winter capacity in primary care			Static - 5 Archive(s)
2354	14/08/2023	Both Delivery and Quality and People's Experience	Tackle inequalities in access, experience, outcome	15	(3x5)	9	(3x3)	Philip Chan	Helen Lewis	There is a risk of unsustainable Neurodevelopmental assessment and treatment pathways for adults (autism and ADHD) due to demand for services surpassing the capacity resulting in unmet need of patients, long waiting list and increased right to choose requests which will cause impact to patient outcomes and significant financial impact.	Established ND programme steering group to provide oversight of service development and transformation projects. Reporting to place Learning disability and ND population board ICB Place resource is focussed on supporting the development of a WY accredited provider list to support and manage quality and tariffs associated with RTC referrals. This also aims to improve patient outcomes and experience when seeking treatment and entering shared care in the local area. Developments intended to allow flexibility for Leeds' plans to develop the assessment and treatment pathways in Leeds. LYPFT Neurodevelopmental Service improvement work: ADHD service continuing waiting list validation and management. The service is developing an impairment ladder to manage clinical prioritisation. Service specification review to be considered. Leeds Autism Diagnostic Service has improved pathway efficiency and waiting times. The increased number of people diagnosed is putting strain on post-diagnostic offer. Focus of pathway development on - ADHD primary care prescribing hub conversations ongoing with the GP Confederation - Pre-diagnostic support to support 'waiting well' including to develop and curate the support offer from third sector organisations. A neurodiversity working group has been	There continues to be a significant strain on staff capacity of the ADHD service due to consultant resource for prescribing. Demand for assessment continues to outstrip capacity for assessment. Seeking funding/grants to support pre- and post diagnostic support offer. Lack of access to targeted funding to support service development and transformation projects. No explicit national ADHD Strategy although there is now an NHS England task force. Gap in accessibility to information, resources and personalised pre-diagnostic needs-led support through VCSE/social prescribing for Adults with ADHD. Regular reporting for Right to Choose information especially linked to shared care spend.	Autism and ADHD diagnostic waiting list times ADHD treatment waiting list times ADHD annual review waiting list times. ND service annual quality report. Service specification reviews Oversight of Right to Choose ND diagnostic pathway referrals and spend Neurodiversity priorities agreed though Learning Disability and Neurodiversity Population Board Leeds Autism Strategy	Service annual quality board ND programme plan outlining key workstreams and work progressing Learning Disability and Neurodiversity Population Board report.	- Lack of targeted/identified recurrent funding streams provide ongoing challenge for sustainable improvement through non-recurrent mechanisms. - Operating model changes impacting the project support resource			Static - 5 Archive(s)

2301	16/05/2023	Both Delivery and Quality and People's Experience	Tackle inequalities in access, experience, outcome	15	(I3xL5)	6	(I3xL2)	Karren Leach	Helen Lewis	There is a risk of CYP being unable to access a timely diagnostic service for neurodevelopmental conditions (Autism and ADHD) due to rising demand for assessments and capacity of service to deliver this (ICAN for under 5, CAMHS for school age). Delays in access to timely diagnosis may impact upon children's outcomes, access to other support services across health, education and social care, and also compliance with NICE standards for assessment within 3 months from referral.	Development of "ND - thinking differently case" presented to PEG in March and outlining the need to think about a needs based approach to providing support to CYP who are neurodivergent Priority workstream for year 1 within SEND Inclusion plan Development of pre assessment support (MindMate ND hub, pilot delivering ND support with a cluster for 23/24) Links made to West Yorkshire ND programme of work particularly looking at how we as a WY ICB address the rising demand around the right to choose agenda and ensure a consistent method of delivery across the ICB. ND citywide development workshop undertaken on 13th July. Representatives from across health came together (including Education and parent/carer representation) to understand the current position and challenges facing us both locally, regionally and nationally. Forwards plan for working groups following this and a further education focussed time out in October. Links made to the West Yorkshire programme of work particularly in relation to responding to the ND choice financial pressure. Funding has moved to LCH to outsource assessments for our most vulnerable cohorts. Outsourcing to commence in September. Provider has now been sourced (update from last cycle)	Development of ND governance under development to include working group to develop and set out strategy for plans over next year Awaiting support from Education colleagues to hold a workshop with education partners A shared communication is being developed alongside LCH colleagues to share with all across the system (including general public). Continued shortfall in capacity for about 2600 assessments this financial year, at a cost of about £5m. Escalating increase in choice referrals due to this, costs projected for this year so far £1m (£700k greater than last year). Available funding and workforce will make rapid improvements difficult. Vacancy in Under 5s assessment service in LCH has led to a pause in assesments. New postholder due to start in May 24 but gap will further increase waiting times and/or choice and has caused significant concern to local education colleagues. Staff availability with appropriate skills remains a key risk nationally and locally	Data from LCH on waiting times Once working group established this will report regularly to SEND Partnership board and CYP population board Meeting in place with ICB, LCH and LCC to determine development plan and shared position statement	Capacity in IS confirmed for highest risk cases LCH workshop held in January to identify how /when to restart assesments and create alternative provision models ICB establishing a clinical reference group to support model design	Increasing public focus with request from Scrutiny to update Cllrs in September and increasing letters from MPs to service provider (LCH).			Static - 6 Archive(s)
2024	30/06/2022	Leeds Committee of the WY ICB	Improve healthcare outcomes for residents	12	(I4xL3)	1	(I1xL1)	Andrea Dobson	Jason Broch	There is a risk of not meeting legislative responsibilities in relation to community deprivation of liberty for fully funded CHC cases; due to assessor capacity and availability of court of protection time; resulting in deprivation of liberty in breach of legislation. There is a significant additional risk that patients will not have the advocacy they need to go through the process due to a lack of commissioned resource. Family members can act as the RPR if they are objective, however in the majority of cases that is difficult.	Monthly meetings held with Health Case Management managers to monitor current position, plan LPS and maintain numbers. Prioritise cases based on complexity and risk of challenge Assessments are completed in line with the availability of court time to ensure they do not go out of date. However, delays to court proceedings have meant that a large number of cases have had to be redone as they became 'out of date' whilst awaiting a hearing. This has increased the workload of the HCM team. MCA Lead is working in collaboration with the health case management team and appointed solicitors to minimise delays and maximise performance. More case managers have received relevant training and experience to complete the assessments. Fast track equivalent moved to Continuing Care	Please add actions in addition to the controls listed to reduce risk to target - with date for completion- see guidance p4. The following have been copied from Datix: Liberty Protection Safeguards LPS has been delayed in its implementation indefinitely. There is insufficient budget and resource at place to undertake preparatory work for all potential cases of DoL or to engage legal representation in order to progress all cases to the court of protection. The court has raised concerns on a number of occasions about the use of family members as appropriate rule 1.2 representatives, this requires additional legal support and HCM work.	LCH provide performance reports, highlighting the current position. The ICB Mental Capacity Act Lead meets with LCH quality Leads and Beachcroft solicitors quarterly to track progress and unpick any delays or performance issues	Regular meetings with the HCM Managers to ensure issue remains in focus. Mental Capacity Act Lead is working both at the place and ICB level to monitor all associated risks. Adam (CHC System) has been updated to record DoLS, enabling improved monitoring and recording of DoLS	No current gaps identified			Static - 6 Archive(s)
2018	29/06/2022	Both Delivery and Quality and People's Experience	Tackle inequalities in access, experience, outcome	12	(I4xL3)	9	(I3xL3)	Eddie Devine	Helen Lewis	There is a risk of increased rates of avoidable deteriorations in mental health due to demand outstripping capacity to provide access to proactive community mental health intervention, hospital beds or to support wider social determinant needs , exacerbated by sustained workforce recruitment and retention challenges; resulting in increases in numbers and severity of acute /crisis presentations, with consequent increased lengths of stay and reduced system flow within LYPFT MH inpatient provision, resulting in increased utilisation of out of area placements for acute mental health beds that impacts quality, experience and service user outcomes.	Improving Flow Programme -led by LYPFT in collaboration with system partners- workstreams established to optimise flow through inpatient settings by focusing on maximising our alternative to hospital provision, ensuring that all admissions are purposeful, reducing prolonged length of stay and proactively discharging our service users at the right time to the right place. Remodelling of crisis alternatives provision in Leeds informed by MH crisis pathways to optimize targeting resources to meet the needs of population cohorts most at-risk. This has incorporated focused improvement to strengthen the integrated delivery of Oasis crisis house with LYPFT crisis team and utilisation of a single information system to increase occupancy as an alternative to hospital admission. Mobilisation of integrated primary-community mental health new model of care from March 2024- for testing and refining ahead of phased rollout from Q3 24/25 Crisis Transformation Programme- Consolidating integrated commissioning (ICB in Leeds and Leeds City Council) for supported accommodation for people with complex mental health needs into a single re-procurement process, targeted to reduce unnecessary delays in discharge from MH inpatient beds- remodelling underway, with LYPFT connected into work to agree specification	Whilst Leeds has achieved has achieved OOA target trajectory in both May and June 2024,delayed transfer of care remain high	Waiting and access times to services monitored through performance metrics, Healthy Leeds Plan, and Mental Health Board data dashboard and Outcomes Framework Inpatient Flow Oversight Group within LYPFT	Review Community Mental Health Transformation- mobilisation/phased roll out of the new model of care within integrated community mental health hubs has commenced in three early implementer sites from March 2024. LYPFT report reductions in community mental health team caseloads, although complexity of need is greater. Annual report for Leeds Committee/sub-committees for MH Population Board describes progress update and evidences increased access with nationally mandated target to increase access to community mental health services--Leeds achieved 20% above plan for increase in access 23/24 and are maintaining trend. LCH report work to reduce the waiting list for access to step 3 CBT in NHS talking therapies has had significant- with many people now able to commence high intensity therapy within 4 months and target for waiting list anticipated to be met by October.	Whilst Leeds has achieved OOA target trajectory in both May and June 2024,Delayed transfer of care remain high, Access to urgent crisis assessment within the MH trust within 4hrs whilst improved remains under-target at 57.14%. LYPFT continue to report OPEL 3E and significant ongoing pressures			Decreasing

2016	29/06/2022	Both Delivery and Quality and People's Experience	Tackle inequalities in access, experience, outcome	12	(I4xL3)	12	(I4xL3)	Lindsay Mcfarlane	Helen Lewis	As a result of the longer waits being faced by patients and limited capacity for treatments, there is a risk of harm, due to failure to successfully target patients at greatest risk of deterioration and irreversible harm, resulting in potentially increased morbidity, mortality and widening of health inequalities.	Joint working between ICB places and WYAAT trusts to maximise access to Independent Sector (IS) provision with a focus on increasing complexity and longest waiters. From October 2023, patients who have waited more than 40 weeks for an appointment or who have a decision to treat but do not have treatment date have been able to request a transfer to another provider with a shorter waiting list (PIDMAS) Consistent messaging to patients re waiting times. Greater use of advice and guidance to help manage patients pre-referral / whilst waiting for appointments Implementation of patient initiated follow up (PIFU) LTHT using methodologies to account for learning disability and deprivation in assessing clinical priority (as part of Healthy Hospitals Network) LTHT implementation of clinical harm reviews of patients awaiting treatment longer than 52 weeks - ICB should be made aware of issues/ concerns as update is shared with ICB post review at the LTHT Quality Assurance Committee on patient harm whilst awaiting treatment. ICB attend weekly LTHT Service Delivery meetings, at which progress on reducing lists of long waiters are shared, risks assessed and appropriately escalated, and mitigating actions agreed (covers cancer and planned	Uncertainty of sustained deliverability of recovery plans linked to industrial action, workforce and funding Awaiting clarification of process with ICB Quality team and LTHT re quarterly monitoring reports on patient harm whilst awaiting treatment. Capacity gaps in pressured specialties are similar across other regions so the actual opportunities to access care in alternative locations will be limited.	Monthly meetings with Leeds ICB and providers (LTHT/ LCH and community /IS providers) to identify and maximise opportunities to support with waiting lists. Choice Agenda now operational (from October 2023) patients who have waited more than 40 weeks for an appointment or who have a decision to treat but do not have a treatment date will be able to request a transfer to another provider with a shorter waiting list. Advice and guidance and PIFU agreed key components of outpatients strategy/ management of long waiters and fully supported by the Planned Care Delivery Board - January 2024. Monthly Corporate Performance reporting in place / Planned Care Delivery Board oversight 2 x HI funded projects - Waiting well for Planned Care - to support people attending at A&E who are on a Planned Care waiting list also developing BI capacity to facilitate supporting people who are on multiple provider waiting lists. Plus a focus on range of products to support people whilst they are waiting including broadening engagement with the Patient Hub and addressing barriers to access services LTHT Harm Review process in place for long waiters, to be included as part of LTHT contract 23/24 quarterly update requested - awaiting October 2023 update report. Cancer - data driven discussion at WY&H Cancer Alliance Board levels and follow up	Consistent reduction in long waiters over recent months until December - LTHT update Planned Care Delivery Board January 2024 - every month without Industrial Action LTHT have been able to reduce the waiting list substantially, by circa 500 patients. Progress has stalled following extended period of IA. Elective Recovery Funding clarified for 24/25, but against a very significant Cost Improvement programme for LTHT	Intermittent industrial action particularly by medical staff will set back progress due to need to prioritise those patients of greatest clinical need. Size of the overall waiting lists needs to reduce to ensure longer term sustainability and to meet trajectories Initial updates from PIDMAS/ Choice work is that of those patients who initially suggested they would access care outside of Leeds there has been very low levels of actual take up. 2 x funded posts within LTHT (initially funded by city wide HI funding) due to end 24/25 - no alternative funding identified, this is included on LTHT risk register and cost pressures.			Static - 7 Archive(s)
2011	29/06/2022	Leeds Committee of the WY ICB	Improve healthcare outcomes for residents	6	(I3xL2)	6	(I3xL2)	Gina Davy	Tim Ryley	There is a risk that the ICB in Leeds is perceived by partners in the Leeds Health and Care Partnership (LHCP) as not 'adding value' to the LHCP due to 1) a lack of understanding about the purpose of the ICB in Leeds across the LHCP 2) a misalignment of priorities and areas of focus between the ICB in Leeds and other members of the LHCP and 3) behaviours of members of the ICB in Leeds This could result in the LHCP not being able to operate effectively to deliver its ambition to use collective resources to improve outcomes and reduce inequalities for the population of Leeds and the WYICB being unable to effectively discharge its duties through the ICB in Leeds.	02.07.24 - Proposals supported through PEG meeting (28.06.24) outlining improved arrangements for the role and purpose of PLT (formerly PEG). Work undertaken by ICB in Leeds Partnership and Effectiveness BU and was well received within partnership and demonstrates value-add of ICB in Leeds 05.2024 - Highly positive feedback received about place-based risk workshop, facilitated and convened by Clinical Leadership and Partnership and Effectivess BUs in Leeds 27.03.24 - Implementation of new operating model, more targeted to resource to progress Partnership Development across 4 PD questions and est. of core business processes within the partnership will demonstrate greater value-add of ICB n Leeds 28.11.23 ICB in Leeds leading work across LHCP to progress Partnership Development - provides opportunity to demonstrate value-add of ICB in Leeds within LHCP 26.09.23 Plans to progress KLOI and seek learning with Si PPS about strengthening relationship and adding value between partners and 'integrator' 20.07.23 Sessions at Leeds Committee Development Session (Aug 9) and PEG (Aug 11) to share proposed place based design and seek feedback on perceived value-add Development of clear 'story / elevator pitch' about the core purpose of the ICB in Leeds within the LHCP and opportunity to engage with partners of the proposed future Operating Model. Ongoing engagement with LHCP AOs re development of WYICB Operating Model and	WYICB Operating Model design currently underway, phase one of design to conclude by June 23 Agree all 23/24 objectives to progress Business Unit contributions to all and explicit focus on value-add Add specific standing item on EMT agenda to share feedback and learning relating to the perceived value-add of the LOICS and agree any required actions. Appetite to provide ad-hoc progress updates with PEG or Leeds Committee of the ICB private workshops? - In discussion with Head of Governance re adding to forward plan Draft ICB in Leeds objectives to be socialised with AOs and Equivalent Directors (in the LHCP) during Spring 23 and as part of the responsibility of senior leaders through their networks (ongoing)	27.03.24 - Operating Model predominantly recruited to readiness to go-live from April 24 - overview of structure provided to PEG 22.03.24 TR 1:1s with all LHCP AOs re value-add of LHCP Development of WYICB Operating MOdel being led by TR so strong connection back to LHCP Anticipate that we might see this reduce to a six by End June when we will be through the Implementation and further developed partnership.	Feedback from LHCP chairs that supportive of Option 4 and appetite to move to option 5 within 24 months.	Engagement with partners on detail of proposed ICB in Leeds Operating Model yet to commence No central process/system/mechanism to capture and act on anecdotal feedback re perception and value-add of LOICS. Appraisal system not yet updated to systematically require feedback on value-adding contribution of senior leaders from partners within the LHCP			Decreasing

Leeds Health & Care Partnership

NHS West Yorkshire Integrated Care Board

Appendix 3

Leeds Health and Care Partners - Top Risks – as at August 2024						
The ICB in Leeds	20	**Financial Position** There is a risk that the financial position across the Leeds system will not achieve financial balance due to the combination of undelivered QIPP and cost pressures in 2023 – 24. This could result in the system not meeting the statutory duties.	16	**Risk of Harm – Emergency Department Waiting Times** There is a risk of harm to patients in the Leeds system due to people spending too long in Emergency Departments (ED) due to high demand for ED, the numbers, acuity, and length of stay of inpatients and the time spent by people in hospital beds with no reason to reside, resulting in poor patient quality and experience, failed constitutional targets and reputational risk.	16	**Mental Health Access** There is a risk of increased rates of avoidable deteriorations in mental health, due to increased mental health demand, alongside insufficient capacity to provide access to proactive community mental health intervention and support, exacerbated further by sustained workforce recruitment and retention challenges; resulting in increases in numbers and severity of acute /crisis presentations, with consequent adverse impact on mental health presentations to ED and YAS, increased lengths of stay and reduced system flow in mental health beds, and increased numbers of out of area acute mental health and PICU bed days.
Leeds Teaching Hospital Trust	16	**High occupancy levels and insufficient capacity and flow across the health and social care system causing impact on**	20	**Delivery of the financial plan and operational capital plan for 2024/25**. There is a risk that the Trust does not achieve its planned control	16	**Workforce risk** There is a risk in filling staff vacancies across all professional groups and support workers, caused by

Key: ⇔ = risk score static; ↑ - risk score increasing; ↓ = risk score decreasing; New = new risk this cycle

		patient safety, outcomes, and experience There is a risk to maintaining sufficient capacity to meet the needs of patients attending hospital and being admitted for planned/elective care and unplanned (acute) care caused by demand being greater than the available hospital capacity. Efficiency of patient flow and placement due to high occupancy across the health and care system impacts on patient safety, outcomes, and experience. There is a risk of patient harm, including healthcare associated infection, and deconditioning due to prolonged hospital stay. There is also a risk to the delivery of constitutional standards, impacting on the Trust's delivery and efficiency ratings and reputation.		total and deliver the operational capital plan in 2024/25 due to a under-delivery of WRP, additional cost pressures and under-delivery of ERF. This would have the following impact: Reducing the internal funding for the Trust's ambitious Five-Year Capital programme, including Building the Leeds Way. Cash shortfall and risk to supplier payment. Potential non-compliance with regulatory requirements, including new medical devices regulation (Regulation EU 2017/45). Limiting the capital programme / not replacing equipment. Increased clinical risk due to inability to replace capital assets within agreed replacement schedules. Greater reliance on external sources of funding. Potential to contribute to the Integrated Care System not meeting its overall control total. Reputational damage, as the Trust fails to deliver on a key statutory duty (financial plan) and the Trust fails to invest in		local and national shortages of qualified and unqualified staff, exacerbated by external financial pressures impacting on decisions to recruit to vacant posts; resulting in a potential failure to provide safe care and treatment, protect staff from psychological and physical harm (burn-out), loss of stakeholder confidence and/or material breach of regulatory conditions of registration.

				equipment, estate, and digital infrastructure to support service development.		
Leeds Community Healthcare Trust	⇔	**Neurodiversity Waiting Times** There is a risk of unsustainable Neurodevelopmental assessment and treatment pathways (autism and ADHD) due to demand for services surpassing the capacity resulting in unmet need of patients and long waiting lists which will cause impact to patient outcomes.	⇔	**Imbalance of Capacity and Demand** Increasing demand for services (specific risks on the risk register relate to Neighbourhood Teams, CAMHS, Speech and Language Therapy, ICAN) coupled/reflected with increased complexity of the services required, resulting in reduced quality of patient care, delay in treatment, deterioration in health and wellbeing of patients, and additional pressure on staff, exacerbated by vacancies to some hard to recruit to roles.	⇔	**Financial Position 2024/25** Risk of not being able to deliver a balanced revenue financial plan for 2024/25 given underlying deficit and range of cost pressures. This is exacerbated by the reported planning positions of partner NHS organisations in Leeds, Leeds City Council and across the West Yorkshire Integrated Care System. There is expected to be little or no real terms growth in 2024/25, and a significant national efficiency ask to which will be added a requirement for LCH to address its own underlying deficit and play a major part in a Leeds place response to the Leeds financial planning gap. Whilst work across Leeds and the ICS has commenced to identify savings from transformation, improved system working and efficiencies, difficult decisions to be made about services the Trust is able to offer patients

						may be required and is being managed through the Quality and Value Programme. It is likely that require service changes will impact on stakeholders.
Leeds and York Partnership Foundation Trust	⇔	**System flow and Out of Area Placements** There is a risk to the quality of care of our service users as a result of ineffective patient flow within the system with an increasing use of Out of Area Placements, compounded by a lack of recurrent funding and a resulting financial cost to the system.	⇔	**Community Mental Health Services redesign** The Community Mental Health redesign and recovery plan will result in the need to do things differently across the city, and impact on the way partners provide their services. If this is not sufficiently addressed there is a risk to the overall quality of patient care and experience.	⇔	**Investment in Mental Health and Learning Disability Services** There is insufficient capacity to meet the level of demand of mental health needs within Leeds; this is manifested through the availability of core funding for our workforce and impacts on resource.
Leeds GP Confederation	⇔	**Strategic**: There is a risk that both main aspects of the Confederation's purpose are compromised due to strategic decisions that are out with of our control. Voice & representation; if the funding for this is reduced or lost. Combined with PCNs taking Enhanced Access 'in-house' the combined affect will be a much-compromised Confederation infrastructure with limited ability to deliver purpose.	⇔	**Financial**: Following an efficiency review we have mitigations for our 2024/25 deficit. Mitigations include increasing income through winning tenders but there is a risk that these contracts do not yield the level of income required. In addition, reducing running costs largely through changing the workforce profile. Whilst being closely monitored there is a risk that mitigations will not work and we will return to a risk of deficit.	⇔	**Operational**: Being agile for PCN requirements. Standing down services and standing up new services; all require workforce flexibility. Where workforce is limited, this may compromise the ability to flex services at the speed required. Delivery of new collaborative contracts and responding to tenders.

Forum Central - Voluntary, Community and Social Enterprise	↑	**Strategic:** Reduced capacity to provide a strategic voice for health & care third sector and manage rep & eng across the ICB/LHCP systems, compounded by changing structures and roles means incr number of risks; issues and opportunities missed. Missed opportunities due to extreme system financial pressures not looking to VCSE sector to mitigate wider system pressures. Reducing and ending contracts rather than investing on best value cost benefit options which support system goals. Lack of clarity of where system decisions made so uncertainty of where to focus limited resources to support the most effective decision making as a system. Significant risk of health inequalities being missed/not recorded/not escalated due to immature systems and processes that are focused on no. of people affected not level of health inequality faced. i.e. discussions of risks at pop board level not	↑	**Financial:** Where reduction in VCSE service capacity means these service users have no alternative but to present directly to NHS services such as A&E or crisis centres (increasing service demand) or are unable to return home after a stay in hospital (reducing service efficiency). VCSE is effectively being stopped from supporting HLP priority goals. If resources could be shifted it would relieve system pressures. System is making counterproductive decisions due to financial pressures. Loss of contracts and / or lack of full cost recovery leading to closure of local Third Sector organisations. Resulting in loss cannot be built back from and learning from previously successful programmes. Pilots and new services should have legacy planning prior to being commissioned/funded as s/t funding decreases cost / benefit of service due to balance of time spent budgeting / recruitment rather than delivery.	↑	**Operational:** Increased demand and level of complexity of need of people accessing VCSE services, alongside reduced capacity due to reduced contract values and contracts ending / short term funding. As VCSE sector is increasingly unable to support existing as well as rising demand amongst the most vulnerable groups and communities we expect to see Harm to people, especially those with the greatest Health Inequalities (HIs) Cuts and restrictions on NHS/LCC services, in addition to rising poverty, mean VCSE Organisations are reporting increased demand from new users who cannot be safely or appropriately supported by third sector providers: this represents an additional harm to people, both using services and workforce.

		captured/ escalated to committee level due to not hitting risk scoring threshold e.g. redn in commissioned bereavement support.				
Leeds City Council	⇔	**Workforce** Workforce resource not in place to deliver the service to the required standard. Worsening workforce pressures (including health, safety and wellbeing) and market sustainability position. Problems in both Adults and Health and Children and Families directorates in recruiting and retaining care staff (in particular: social workers, professionals, educational psychologists, schools) leading to increased resource pressures and adverse impact on our ability to deliver a wider range of services. Risk that the workforce capacity gap could worsen. Sources: Increased demand and complexity and experience of working in increasingly complex community contexts, including at times, heightened community tension.	⇔	**Major cyber incident** Cyber-attack / major IT outage has an adverse impact on our ability to keep delivering critical services (including those for Health and Social Care). Sources: Internal and external threats to cyber security e.g., human error, malware, ransomware and increasing sophistication of cyber-criminal activity. Cyber disruption from geopolitical conflicts.	⇔	**Sustained financial pressures** Financial and budgetary pressures within the organisation - in particular for Adults & Health and Children & Families directorates - is still very real/relevant and is high risk.

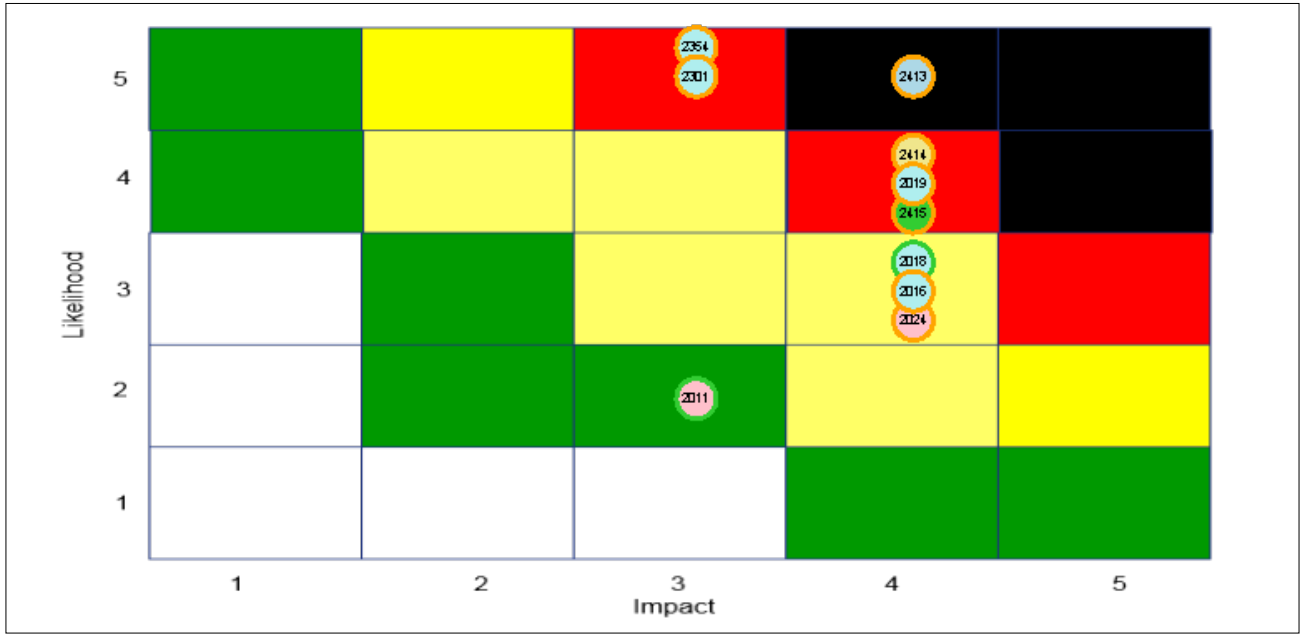
		High vacancy factors that are proving difficult to fill. Market sustainability and competition in the labour market (internal and external to the sector). Underinvestment in the labour market. Staff leaving the sector(s) for better paid and less stressful jobs in other industries. Long term problems from the pandemic and Brexit.				

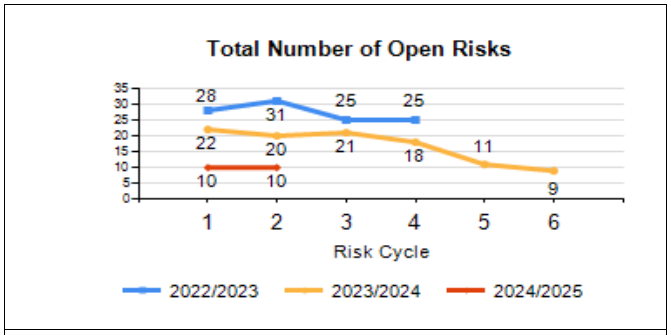
Appendix 4: Risk on a Page Report for the Leeds Committee of the West Yorkshire Integrated Care Board
Risk Cycle 2: June - September 2024

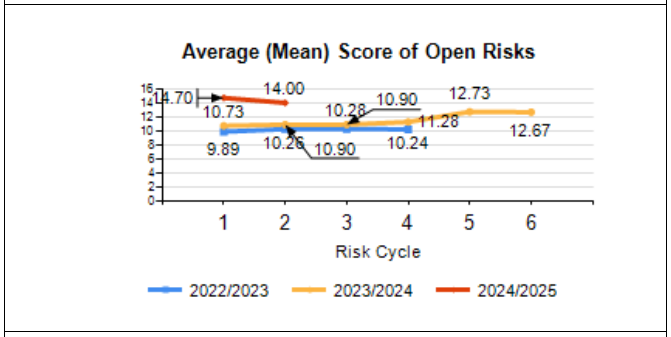
Total Risks	10
Delivery	1
QPEC	0
Delivery and QPEC	5
Finance & Best Value	1
Delivery and Finance & Best Value	1
Leeds Committee	2

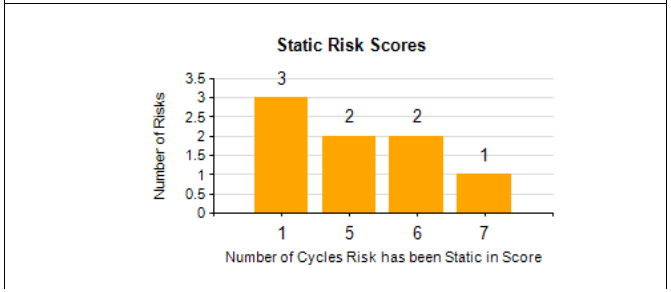
Movement of Risks	
New	0
Marked for Closure	0
Risk score increasing	0
Risk score static (1 cycle)	3
Risk score static (2+ cycles)	5
Risk score decreasing	2

Risk Overview









Key

- Finance and Best Value Committee
- Delivery Committee
- Leeds Committee of the WY ICB
- Both Delivery and Quality and People's Experience
- Both Delivery and Finance and Best Value

- New Risk
- Closed Risk
- Risk Score Increasing
- Risk Score Decreasing
- Risk Score Static

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

Appendix 5 – Board Assurance Framework Summary and Heat Map

West Yorkshire Integrated Care Board - Board Assurance Framework - Summary						Version: 1.4	Date: March 2024
Mission		**Strategic risk**	**Risk appetite**	**Target WY score**	**Current WY score**	**Lead director(s) / board lead**	**Lead committee / board**
(1) Reduce inequalities	1.1	There is a risk that our local priorities to narrow inequalities are not delivered due to the impact of wider economic social and political factors.	Bold	16	20	Ian Holmes	ICB Board
	1.2	There is a risk that operational pressures and priorities impact on our ability to target resources effectively towards improving outcomes and reducing inequalities for children and adults.	Open	9	12	Ian Holmes / Jonathan Webb	Finance, Investment and Performance Committee
	1.3	There is a risk that we ration services due to insufficient resources in a way that does not reduce (or exacerbates) heath inequalities.	Open	8	8	Ian Holmes / Jonathan Webb	ICB Board
	1.4	There is a risk that we fail to join up services in our communities which means that we do not improve outcomes and reduce health inequalities.	Open	8	12	Ian Holmes	ICB Board *(linked to place committees)*
(2) Manage unwarranted variation in care	2.1	There is a risk that our inability to collectively recruit and retain staff across health and care impacts on the quality and safety of services.	Cautious	8	12	Kate Sims	Transformation Committee
	2.2	There is a risk that as a system we fail to innovate, learn lessons and share good practice that allows us to respond to service pressures resulting in widening variations across our footprint.	Open	4	12	James Thomas	Quality Committee
	2.3	There is a risk that we are unable to measure and assess performance across the system in a timely and meaningful way, which impacts on our ability to respond quickly as issues arise.	Open	6	6	Anthony Kealy	Finance, Investment and Performance Committee
	2.4	There is a risk that our infrastructure (estates, facilities, digital) hinders our ability to deliver consistently high quality care.	Open	9	16	Jonathan Webb / James Thomas	Finance, Investment and Performance Committee.Transformation Committee for Digital
(3) Use our collective resources wisely	3.1	There is a risk that we invest resources in a way which does not allow us to join up services nor maximise value for money.	Open	4	9	Jonathan Webb	Finance, Investment and Performance Committee
	3.2	There is a risk that we breach our statutory duties to operate within the resource envelope available by not delivering efficiency targets and/or controlling cost.	Cautious	6	20	Jonathan Webb	Finance, Investment and Performance Committee
	3.3	There is a risk that ICB capacity and infrastructure is not sufficient nor targeted effectively towards key priorities.	Open	4	12	Rob Webster	ICB Board
(4) Secure benefits of investing in health and care	4.1	There is a risk that partnership working on wider societal issues is deprioritised in order to meet current operational pressures.	Open	8	12	Ian Holmes	ICB Board
	4.2	There is a risk that we are unable to achieve our ambitions on equality diversity and inclusion due to ingrained attitudes that persist in society and across our health and care organisations.	Bold	8	12	Ian Holmes	Quality Committee
	4.3	There is a risk that threats to our people and physical and digital infrastructure, e.g. from cyber-attacks, terrorism and other major incidents, prevents us from delivering our key functions and responsibilities.	Averse	9	12	Anthony Kealy / James Thomas	Transformation Committee
	4.4	Due to climate change, there is a risk of increased demand for health and care services and disruption to the provision of services. This will result in health and care services that cannot effectively meet population needs.	Open	12	16	Ian Holmes	Transformation Committee

West Yorkshire Integrated Care Board - Board Assurance Framework - Heat map			Version 1.4													
Mission		Strategic risk	WYICB and 5 Places	West Yorkshire		Bradford District and Craven		Calderdale		Kirklees		Leeds		Wakefield	
			Risk appetite (All)	Target score (WYICB)	Current score (WYICB)	Target score (BD&C)	Current score (BD&C)	Target score (Cald'e)	Current score (Cald'e)	Target score (Kirk's)	Current score (Kirk's)	Target score (Leeds)	Current score (Leeds)	Target score (Wake'd)	Current score (Wake'd)
Reduce inequalities	1.1	There is a risk that our local priorities to narrow inequalities are not delivered due to the impact of wider economic social and political factors.	Bold	16	20	16	20	16	20	16	20	16	20	16	20
	1.2	There is a risk that operational pressures and priorities impact on our ability to target resources effectively towards improving outcomes and reducing inequalities for children and adults.	Open	9	12	9	12	9	9	12	16	12	16	9	12
	1.3	There is a risk that we ration services due to insufficient resources in a way that does not reduce (or exacerbates) heath inequalities.	Open	6	8	8	8	8	12	8	8	8	8	8	8
	1.4	There is a risk that we fail to join up services in our communities which means that we do not improve outcomes and reduce health inequalities.	Open	8	12	8	12	8	12	8	12	8	12	8	12
Manage unwarranted variation in care	2.1	There is a risk that our inability to collectively recruit and retain staff across health and care impacts on the quality and safety of services.	Cautious	8	12	6	12	8	12	8	8	9	12	8	12
	2.2	There is a risk that as a system we fail to innovate, learn lessons and share good practice that allows us to respond to service pressures resulting in widening variations across our footprint.	Open	4	12	4	6	4	6	4	12	4	12	4	12
	2.3	There is a risk that we are unable to measure and assess performance across the system in a timely and meaningful way, which impacts on our ability to respond quickly as issues arise.	Open	6	6	2	4	6	6	8	8	6	9	3	6
	2.4	There is a risk that our infrastructure (estates, facilities, digital) hinders our ability to deliver consistently high quality care.	Open	9	16	9	12	9	16	6	9	9	12	9	12
Use our collective resources wisely	3.1	There is a risk that we invest resources in a way which does not allow us to join up services nor maximise value for money.	Open	4	9	4	9	4	12	8	12	4	9	4	9
	3.2	There is a risk that we breach our statutory duties to operate within the resource envelope available by not delivering efficiency targets and/or controlling cost.	Cautious	6	20	6	20	6	20	8	20	6	20	6	20
	3.3	There is a risk that ICB capacity and infrastructure is not sufficient nor targeted effectively towards key priorities.	Open	4	12	4	12	4	16	2	12	4	16	4	12
Secure benefits of investing in health and care	4.1	There is a risk that partnership working on wider societal issues is deprioritised in order to meet current operational pressures.	Open	8	12	8	12	8	12	8	12	8	12	8	12
	4.2	There is a risk that we are unable to achieve our ambitions on equality diversity and inclusion due to ingrained attitudes that persist in society and across our health and care organisations.	Bold	8	12	8	12	8	12	8	12	4	9	8	12
	4.3	There is a risk that threats to our people and physical and digital infrastructure, e.g. from cyber-attacks, terrorism and other major incidents, prevents us from delivering our key functions and responsibilities.	Averse	9	12	Not required	Not required	Not required	Not required	Not required	Not required	Not required	Not required	Not required	Not required
	4.4	Due to climate change, there is a risk of increased demand for health and care services and disruption to the provision of services. This will result in health and care services that cannot effectively meet population needs	Open	12	16	Not required	Not required	Not required	Not required	Not required	Not required	Not required	Not required	Not required	Not required

Meeting name:	Leeds Committee of the West Yorkshire Integrated Care Board
Agenda item no.	38/24
Meeting date:	11 September 2024
Report title:	Urgent Decision: Direct award of new contract for Social Prescribing service in Leeds
Report presented by:	Rebecca Charlwood, Independent Chair
Report approved by:	Tim Ryley, Accountable Officer and Rebecca Charlwood, Independent Chair
Report prepared by:	Harriet Speight, Corporate Governance Manager

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

Previous considerations:

N/A

Executive summary and points for discussion:

Due to timescales, a decision was taken on 17th July 2024 by the Chair and Accountable Officer, in line with the urgent decisions section of the terms of reference, on behalf of the Leeds Committee of the West Yorkshire Integrated Care Board (WY ICB) to approve the Provider Selection Regime (PSR) route for the Social Prescribing service: Direct Award C.

Leeds Committee members were consulted on the proposal via email in advance of the decision and were provided with the report. There was a request for additional information to be provided at the Leeds Committee meeting on 11th September 2024 to provide assurance that the 15% reduction in contract value will not compromise the quality of the service provided and that the Social Prescribing service has found ways to mitigate the reduction which does not impact on the equity of the service they provide. The following information has been provided:

'*Leading up to the review there was an evaluation of social prescribing (both the Linking Leeds and PCN offers). We were able to review the impact of the Linking Leeds provision by analysing service use pre and post receiving Linking Leeds social prescribing. Evidence was telling us that the Linking Leeds service improves mental and emotional wellbeing, it reduces GP appointments, emergency department admissions, and mental health referrals. Owing to these strong outcomes, we've committed to maintaining the model of service delivery. The service will therefore continue to offer light touch signposting, holistic 1:1 support (for up to 8 weeks) and extended holistic 1:1 support for more complex service users (for up to 12 weeks). To try and maintain as much through put (the number of people that capacity allows the service to connect with per year) as possible, we are piloting reducing the appointment time from 75 minutes to 60 minutes. For this change we are monitoring the impact of this on outcomes on a quarterly basis.*

In addition, the service will now include targeted and proactive social prescribing - a shift from the traditional purely referral-based model. This element of the service aims to target those who may not typically access services but who may benefit significantly from the service. Work is

ongoing in the social prescribing steering group to define and design what best practice targeted social prescribing could look like.'

Members are asked to note that all Committees of the WY ICB must report urgent decision to the West Yorkshire Audit Committee. This will be reported to the next WY Audit Committee meeting on 24th September 2024.

Which purpose(s) of an Integrated Care System does this report align with?

☐ Improve healthcare outcomes for residents in their system

☒ Tackle inequalities in access, experience and outcomes

☐ Enhance productivity and value for money

☐ Support broader social and economic development

Recommendation(s)

The Leeds Committee of the West Yorkshire Integrated Care Board is asked to:

1. **RATIFY** the decision taken on 17 July 2024 to approve the Provider Selection Regime (PSR) route for the Social Prescribing service: Direct Award C.

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

N/A

Appendices

1. Direct award of new contract for Social Prescribing service in Leeds – Report dated 10 July 2024
2. Urgent Decision Notice (Signed) 17 July 2024

Acronyms and Abbreviations explained

N/A

What are the implications for?

Residents and Communities	**Appendix 1 refers.**
Quality and Safety	
Equality, Diversity and Inclusion	
Finances and Use of Resources	
Regulation and Legal Requirements	
Conflicts of Interest	
Data Protection	
Transformation and Innovation	
Environmental and Climate Change	
Future Decisions and Policy Making	
Citizen and Stakeholder Engagement	

Appendix 1

Meeting name:	Leeds Committee of the West Yorkshire Integrated Care Board
Agenda item no.	UD1
Meeting date:	10 July 2024
Report title:	Direct award of new contract for Social Prescribing service in Leeds
Report presented by:	Helen Lewis, Director of Pathway Integration
Report approved by:	Helen Lewis, Director of Pathway Integration
Report prepared by:	Neil Maguire and Jaspreet Bhuhi

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

Previous considerations:

A detailed paper was put forward to the ICB in Leeds Director's Meeting (formerly known as EMT) for review, evaluating the current Social Prescribing service and its positive impact on our system. Linking Leeds is the West Yorkshire ICB procured city wide social prescribing service available for anyone aged 16+ registered with a GP surgery in Leeds. It was decided that, from the 1st September 2024, the contract will be renewed at 85% of its current value.

The current provider has met the existing contractual requirements and is expected to fulfil the new contract requirements. Since the proposed contracting arrangements are not significantly changing, it is recommended to proceed with the Provider Selection Regime (PSR) procurement route **Direct Award C**.

Executive summary and points for discussion:

This paper is being presented for a decision on the recommended procurement route for the Social Prescribing service in Leeds from September 2024.

The Chair and Accountable Officer on behalf of the Leeds Committee is asked to approve the choice of selected Provider Selection Regime (PSR) process to use (direct award, most suitable provider or competitive process). This is in line with the West Yorkshire ICB financial scheme of delegation as the contract value exceed £5m. The scheme of delegation stipulates that the appropriate PSR process and principles must be followed, as outlined in the ICB Standing Financial Instructions and Procurement Policy.

The recommended procurement route is Direct Award C process through the Provider Selection Regime (PSR), as detailed in the main body. It is proposed to award the contract for 3 years and 7 months, with the option to extend for up to 2 years totalling £7,743,245 (lifetime value). This

recommendation is based on the positive impact and value the service provides, as evidenced by evaluation work and quarterly monitoring data.

Which purpose(s) of an Integrated Care System does this report align with?

☒ Improve healthcare outcomes for residents in their system

☒ Tackle inequalities in access, experience and outcomes

☐ Enhance productivity and value for money

☐ Support broader social and economic development

Recommendation(s)

The Leeds Committee of the West Yorkshire Integrated Care Board is asked to:

1. Approve the Provider Selection Regime (PSR) route for the Social Prescribing service in Leeds. The recommended route is **Direct Award C Process**.

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

N/A

Appendices

1. None

Acronyms and Abbreviations explained

PSR – Provider Selection Regime

PCN – Primary Care Network

LCP – Local Care Partnerships

What are the implications for?

Residents and Communities	Improvements to individuals in Leeds to promote health and wellbeing. Individuals are connected to services and activities in their community to benefit from overall health and wellbeing.
Quality and Safety	Areas of quality improvements have been identified for the integration with PCNs and wider LCP partners. The current provider delivers a high-quality service and will maintain this standard while staying flexible to adapt to system changes as needed.
Equality, Diversity and Inclusion	The service will support individuals to proactively manage their health and wellbeing and address wider determinants of health for people in their communities.

Finances and Use of Resources	The renewal contract value is a reduction from the current spend. As a contribution to the system cost pressures over the next years we have reduced the value by 15% and the provider is working on productivity improvements to mitigate the impact of the reduced value.
Regulation and Legal Requirements	The recommended PSR route will address all legal requirements under the new Provider Selection Regime.
Conflicts of Interest	N/A
Data Protection	N/A
Transformation and Innovation	Greater emphasis has most recently been placed on the importance of working in partnership on a locality footprint. Innovation priorities set out in the refreshed service specification are connecting and collaborating with LCPs. The wellbeing coordinators to the service are regular contributors to their LCPs and have worked in partnership on key transformational programmes, including the community mental health transformation programme.
Environmental and Climate Change	The service aims to maximise social value by contributing to improvements in environmental conditions aligned to local priorities.
Future Decisions and Policy Making	The refresh of the service specification and proposed length of contract will support the delivery of a city-wide offer and any future changes to the service because of potential future decisions or changes in policy.
Citizen and Stakeholder Engagement	User involvement is embedded within the provider model and the provider has a strong track record in listening to and responding to user feedback and continues to use this to refine its offer.

1. Main Report Detail

1.1 This paper is being presented for a decision on the recommended provider selection route for the Social Prescribing service in Leeds from September 2024 for decision as per the scheme of delegation.

2. The Service

2.1 The contract for the Social Prescribing service is due to end on 31st August 2024. The service supports primary care to proactively manage health and wellbeing and address wider determinants of health for people in their communities. The aim of the service is to connect people to services and activities in their community to benefit overall health and wellbeing. The service is structured across 3 localities and has a presence and connection with all PCN's across Leeds. The service offers a tiered service to its users; signposting, holistic support and extended holistic support.

3. Value and length of the proposed contract

3.1 The annual cost of the new contract will be reduced by 15% (annual value £1,392,223) recurrently to meet the 24/25 QIPP savings required. The proposed contract length is 3 years and 7 months with the option to extend up to 2 years, with a lifetime contract value of £7,743,245. The contract length takes into consideration the service delivery model and workforce and ensures there is a city-wide offer of social prescribing.

4. Recommended procurement route

4.1 The PSR route recommended for approval is direct award C process. The rationale for this recommendation is set out below:

- **Is the service within scope of the PSR?** Yes

  The Social Prescribing service in Leeds is in scope of the PSR as it is a healthcare service, as per Regulation 3(1), and defined in section 275(1) of the 2006 Act as a "comprehensive health service designed to secure improvement in the physical and mental health of the people of England, and in the prevention, diagnosis and treatment of physical and mental illness."

- **Choosing Direct Award C process**

  The options are to use direct award A, direct award B, direct award C, most suitable provider, and competitive process.

The options to use direct award A or direct award B are not available as the criteria is not fulfilled.

Criteria to be fulfilled to utilise the processes:

Criteria to be fulfilled to utilise process	**Fulfilled ✗ / ✓**
Direct Award A; *The type of service means there is no realistic alternative to the current provider. This process must not be used to award contracts when establishing a new service.*	
Direct award process A must be used when all of the following apply:	
there is an existing provider of the health care services to which the proposed contracting arrangements relate	✓
the relevant authority is satisfied that the health care services to which the proposed contracting arrangements relate are capable of being provided only by the existing provider (or group of providers) due to the nature of the health care services.	✗
Direct Award B; *People have a choice of providers, and the number of providers is not restricted by the relevant authority.*	
Direct award process B must be used when all of the following apply:	
the proposed contracting arrangements relate to health care services in respect of which a patient is offered a choice of provider	✗
the number of providers is not restricted by the relevant authority	✗
the relevant authority will offer contracts to all providers to whom an award can be made because they meet all requirements in relation to the provision of the health care services to patients	✗
the relevant authority has arrangements in place to enable providers to express an interest in providing the health care services	✗
Direct Award C; *The existing provider is satisfying the existing contract and likely to satisfy the new contract, and the proposed contracting arrangements are not changing considerably from the existing contract.*	
Direct award process C may be used when all of the following apply:	
the relevant authority is not required to follow direct award processes A or B	✓
the term of an existing contract is due to expire and the relevant authority proposes a new contract to replace that existing contract at the end of its term	✓
the proposed contracting arrangements are not changing considerably	✓
Considerable change being met where the change; a) renders the proposed contracting arrangements materially different in character to the existing contract when that existing contract was entered into or:	

b) meets all the following: • the change, (to the proposed contracting arrangements as compared with the existing contract), is attributable to a decision made by the relevant authority • the lifetime value of the proposed new contract is at least £500,000 higher (i.e., equal to or exceeding £500,000) than the lifetime value of the existing contract when it was entered into • the lifetime value of the proposed new contract is at least 25% higher (i.e., equal to or exceeding 25%) than the original lifetime value of the existing contract when it was entered into.	
the relevant authority is of the view that the existing provider (or group of providers) is satisfying the existing contract and will likely satisfy the proposed contract to a sufficient standard	✓

- **Viable Direct Award C process**

The PSR permits a contract to be awarded without a tender process, so a competitive process does not need to be followed. Since this is an existing contract that is being renewed, the existing provider's contract performance will be sufficient to direct award without the need for a competitive procurement. To use the most suitable provider process, it is necessary to identity the most suitable provider without running a competitive exercise. Since this identification cannot be achieved without a competitive process, the criteria for the most suitable provider process would not be met.

Due to the options of direct award A and B not being available the ICB can follow direct award C process as all the criteria has been met. The existing provider is currently satisfying the contract and is likely to satisfy the new contract, and the proposed contracting arranging are not changing considerably from the existing contract.

5. Next Steps

5.1 Following the refresh of the service specification and further oversight from the Healthy Adults Board and the Social Prescribing Steering Group, the next step is to renew the contract under direct award C process from 1st September 2024. It is planned to award the contract to the incumbent provider by 1st August 2024 to allow for the appropriate standstill and potential representations period.

6. Recommendations

The Leeds Committee of the West Yorkshire Integrated Care Board is asked to:

a) **APPROVE** the Provider Selection Regime (PSR) route for the Social Prescribing service:

   The recommended route for procurement is **Provider Selection Regime: Direct Award C**.

REQUEST FOR URGENT ACTION

Urgent action is required from the Leeds Committee of the West Yorkshire Integrated Care Board (WY ICB) to approve the Provider Selection Regime (PSR) route for the Social Prescribing service:

The recommended route for procurement is Provider Selection Regime: Direct Award C.

RESPONSIBLE DIRECTOR: Helen Lewis, Director of Pathway Integration

RESPONSIBLE MANAGER: Jaspreet Bhuhi, Contracts Manager (Community)

APPROVAL BY:

Leeds Committee of the WY ICB Chair

Signature:  Date: 17/07/2024

Name: Rebecca Charlwood

Place Lead and Accountable Officer

Signature: Date:_17/7/24_____

Name: Tim Ryley

To be ratified at the Leeds Committee of the West Yorkshire Integrated Care Board meeting on 11 September 2024.

Leeds Health & Care Partnership

NHS West Yorkshire Integrated Care Board

LEEDS COMMITTEE OF THE WEST YORKSHIRE INTEGRATED CARE BOARD
WORK PROGRAMME 2024-25

ITEM	May 24	Sept 24	Nov 24	Feb 25	Lead
STANDING ITEMS					
Welcome & Introductions	X	X	X	X	Chair
Apologies & Declarations of Interest	X	X	X	X	Chair
Minutes of previous meeting	X	X	X	X	Chair
Matters Arising	X	X	X	X	Chair
Action Tracker	X	X	X	X	Chair
Questions from Members of the Public	X	X	X	X	Chair
Summary & Reflections	X	X	X	X	Chair
People's Voice	X	X	X	X	JP/JM
Place Lead Update	X	X	X	X	TR
Forward Work Plan	X	X	X	X	Chair
Items for the Attention of the ICB	X	X	X	X	Chair
Population and Care Delivery Board Update	X	X	X	X	Various
GOVERNANCE & FINANCE ITEMS					
Sub-Committee Alert, Assure Advise (AAA) Reports	X	X	X	X	Chairs
Risk Management Report and Board Assurance Framework (BAF)	X	X	X	X	TR
Financial Position Update	X	X	X	X	AC
Terms of Reference Review	X				Chair
Sub-Committee Annual Reports	X				Chairs
ITEMS FOR DECISION					
GP Procurement / Merger / Closure of Practices	X		X		KT
Financial Plan 2025/26				X	TR/AC
Procurement - Provider Selection Regime Approval	X				HL
Assurance and update on our plan for financial sustainability in 24/25		X			TR
Joint Working Agreement – MART Phase 2		X			LM
STRATEGY & ASSURANCE					
Marmot City Update		X			VE
Medium Term Plan			X		TR
Director of Public Health Annual Report		X			VE