Leeds Health & Care Partnership

NHS West Yorkshire Integrated Care Board

Leeds Committee of the
West Yorkshire Integrated Care Board

Thursday 22nd September 2022, 13:00 – 16:00
New Wortley Community Centre, 40 Tong Road, Leeds, LS12 1LZ

AGENDA

No.	Item	Lead	Page	Time
LC 19/22	**Welcome, Introductions**	**Rebecca Charlwood** Independent Chair	-	13:00
LC 20/22	**Apologies and Declarations of Interest** - To note and record any apologies. - Those in attendance are asked to declare any interests presenting an actual/potential conflict of interest arising from matters under discussion.	**Rebecca Charlwood** Independent Chair	-	
LC 21/22	**Minutes from the previous meeting** - To approve the minutes from the meeting held on 14 July 2022	**Rebecca Charlwood** Independent Chair	3	
LC 22/22	**Action Tracker** - To receive the action tracker for review	**Rebecca Charlwood** Independent Chair	16	
LC 23/22	**People's Voice** - To share a lived experience of health and care services.	**Rebecca Charlwood** Independent Chair	-	13:10
LC 24/22	**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	-	13:30
LC 25/22	**Place Lead Update** - To receive a report from the Place Lead	**Tim Ryley** Place Lead	17	13:40
ROUTINE REPORTS				
LC 26/22	**Quality & People's Experience Sub-Committee Update** - To receive an assurance report from the Chair of the sub-committee	**Rebecca Charlwood** Independent Chair	25	14:05
LC 27/22	**Delivery Sub-Committee Update** - To receive an assurance report from the Chair of the sub-committee, along with a revised version of the delivery performance report considered by the sub-committee	**Yasmin Khan** Independent Member Chair of Delivery Sub-Committee	27	

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LC 28/22	**Finance & Best Value Sub-Committee Update** - To receive an assurance report from the Chair of the sub-committee *(to follow)*	**Cheryl Hobson** Independent Member Chair of Finance & Best Value Sub-Committee	-	
BREAK 14:20 – 14:30				
LC 29/22	**Risk Management Report** - To receive and consider the risk management information provided	**Tim Ryley** Place Lead ***Supported by Anne Ellis, Risk Manager***	32	14:30
ITEMS FOR DECISION/ASSURANCE/STRATEGIC UPDATES				
LC 30/22	**Primary Care – Enhanced Access Service** - To agree the Enhanced Access Service Plan	**Gaynor Connor** Director of Primary Care and Same Day Response	41	14:45
FINANCE				
LC 31/22	**Medium Term Financial Plan** - To receive a presentation on the draft proposals for the Leeds medium term financial plan for submission in October	**Visseh Pejhan-Sykes** Place Finance Lead	-	15:15
FORWARD PLANNING				
LC 32/22	**Items for the Attention of the ICB Board** - To identify items to which the ICB Board needs to be alerted, on which it needs to be assured, which it needs to action and positive items to note.	**Rebecca Charlwood** Independent Chair	-	15:45
LC 33/22	**Forward Work Plan** - To consider the forward work plan	**Rebecca Charlwood** Independent Chair	53	
LC 34/22	**Any Other Business** - To discuss any other business raised and not on the agenda.	**Rebecca Charlwood** Independent Chair	-	
LC 35/22	**Date and Time of Next Meeting** The next meeting of the Leeds Committee of the WY ICB will be held at 1.30 pm on Tuesday 13 December, at a venue to be confirmed.		-	-

Draft Minutes

Leeds Committee of the West Yorkshire Integrated Care Board

Thursday 14 July 2022, 2.00pm – 4.45pm (Held via MS Teams)

Members	Initials	Role	Present	Apologies
Rebecca Charlwood	**RC**	Independent Chair, Leeds Committee of the WY ICB	✓	
Tim Ryley	**TR**	Place Leeds, ICB in Leeds	✓	
Cheryl Hobson	**CH**	Independent Member – Finance and Governance	✓	
Yasmin Khan	**YK**	Independent Member – Health Inequalities	✓	
Thea Stein	**TS**	Chief Executive, Leeds Community Healthcare		✓
Bryan Machin (on behalf of Thea Stein)	**BM**	Deputy Chief Executive, Leeds Community Healthcare	✓	
Sara Munro	**SM**	Chief Executive, Leeds & York Partnership Foundation Trust	✓	
Julian Hartley	**JH**	Chief Executive, Leeds Teaching Hospital Trust	✓	
Dr Chris Mills	**CM**	Chair, GP Confederation	✓	
Cath Roff	**CR**	Director of Adults & Health, Leeds City Council	✓	
Victoria Eaton	**VE**	Director of Public Health, Leeds City Council	✓	
Shanaz Gul	**SG**	Third Sector Representative		✓
Francesca Wood (on behalf of Shanaz Gul)	**FW**	Third Sector Representative	✓	
John Beal	**JBe**	Chair, Healthwatch	✓	
Dr Jason Broch	**JBr**	Chief Strategic Clinical Information & Innovation Officer, ICB in Leeds	✓	
Additional Attendees				
Sam Ramsey	**SR**	Head of Corporate Governance & Risk, ICB in Leeds	✓	
Manraj Khela	**MK**	Head of Health Partnerships	✓	
Anne Ellis	**AE**	Risk Manager, ICB in Leeds	✓	
Robert Hakin	**RH**	Associate Director of Corporate Planning, Leeds Teaching Hospital Trust	✓	
Richard Noble	**RN**	Associate Director for Estates Strategy, Leeds Teaching Hospital Trust	✓	
Clare Gaunt	**CG**	Assistant Director of Finance, Leeds Teaching Hospital Trust	✓	
Hannah Davies	**HD**	Chief Executive of Healthwatch Leeds	✓	
Kirsten Wilson	**KW**	Head of Insights, Communications & Involvement, ICB in Leeds	✓	

Members of public/staff observing – 2

No.	Agenda Item	Action
01/22	**Welcome and Introductions** Rebecca Charlwood opened the inaugural Leeds Committee of the West Yorkshire Integrated Care Board (ICB) and invited all members to introduce themselves. It was noted that the Committee meeting would be recorded and available online following the meeting. A short video was shown, outlining the partnership journey taken so far across West Yorkshire and the role of the West Yorkshire ICB and the five places that make up West Yorkshire.	
02/22	**Apologies and Declarations of Interest** Apologies had been received from Thea Stein and Shanaz Gul. Bryan Machin was deputising for Thea and Francesca Wood was deputising for Shanaz Gul. Members were asked to declare any interests presenting an actual or potential conflict of interest arising from matters under discussion. It was noted that future meetings would include a full register of interests circulated with papers in advance of the meeting. There were no specific interests raised.	
03/22	**Action tracker** The Committee was asked to note the updates provided in the action tracker. It was highlighted that a formal action log would be put in place now the Committee was formally established.	
04/22	**Questions from Members of the Public** There were no questions received from members of the public in advance of the meeting.	
05/22	**People's Voice** The Chair outlined the importance of starting the Committee meeting with an example of a lived experience of health and care services, starting with people in everything that we do. Members were informed that the work was part of the 'How does it feel for me?' Programme which many of the members of the Committee would have seen through the Partnership Executive Group (PEG) and the Health and Wellbeing Board. Hannah Davies, Chief Executive at Healthwatch outlined that the programme had identified several key themes that people in Leeds have highlighted are consistently not working in terms of their experience and outcomes, named the three C's - communication, co-ordination and compassion. The programme was a system wide piece of work, represented by partners across the system. The story shared gave an insight from two residents in Leeds. The video was presented, and members were invited to share reflections. Tim Ryley shared that the experiences reported in the video were positive, however it was important to recognise the previous videos and consistency in the care	

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	received. Committee members then reflected on the three C's and how the system could strengthen coordination given the difficulties in navigating the system. It was noted that the Quality and People's Experience Sub-Committee will have a key role in ensuring delivery of a person-centred care model. Sara Munro highlighted that care coordination was a well-defined role within mental health and there would be a change in the new model with the aim of simplifying and ensuring it is easier to access services. Independent members welcomed further details in relation to the changes to mental health services. Cath Roff highlighted the difficulties that can occur with cross border collaboration and a suggestion was made for insight to be undertaken for those people living on the borders. It was flagged by Healthwatch that this could be considered from a West Yorkshire perspective across five local places, starting with the insight that already exists.	
06/22	**Approach to We Start with People** The Chair introduced the item by outlining that a discussion had taken place at the Leeds Shadow Committee of the ICB on 17 March and work had been underway to consider how we ensure people's voices are embedded at every level. Hannah Davies and Kirsten Wilson were in attendance to present the report. Background information was provided to members, outlining the commitment to putting people's voices at the centre of decision making which has been championed by the Health & Wellbeing Board and through the Health & Wellbeing Strategy. Under the leadership of the Health and Wellbeing Board, the Peoples Voices Partnership (PVP) group was established to bring together involvement leads from across the partnership to work together as one health and care listening team ensuring that the ambition is integrated within organisations and across the partnership. Members recognised that a huge amount of work had been undertaken over the last few years including the Big Leeds Chat and the 'How does it feel for me?' workstream. It was iterated that as a partnership the involvement principles align with those developed by the West Yorkshire ICB and they will support the Leeds Committees' work to model a 'We start with people' approach. Members were reminded of the discussions taken at the Shadow Leeds Committee meeting in March 2022 and the high level of ambition and commitment to this from the Committee and that as a PVP work had been ongoing to describe the work taking place with different partners across the system. Kirsten Wilson presented an overview of the involvement ambitions identified, the work already ongoing and the additional work planned to support public involvement in the work of the Committee. A summary was provided as to how the Committee can help and take forward the involvement ambitions. The Committee was asked to review and approve the ambitions as set out and support and commit to the actions outlined within the report. The Chair expressed her thanks and highlighted that in ensuring involvement and influence, it gives empowerment to the citizens of Leeds. It was also expressed that	

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	we should use this as an innovation tool to make services more efficient and improve integration. YK commented that the report had been informative and useful and shared the view that it would also be helpful to hear the diversity of voice coming through the Delivery Sub-Committee. In relation to the insight reports, a query was made in relation to those groups that may not be heard. An observation was made in relation to the webpage and the 'You Said, We Did' reference, that this could be presented in a more powerful way. KW agreed and advised that the team would take forward this suggestion. In relation to the comment on the insights work and ensuring we are hearing from various groups; it was shared that a gap analysis would be undertaken to consider what other areas of information should be sought and from which groups. HD expressed that the priority across the partnership was to hear the voice of inequalities and adapting the approaches to do so. The importance of insight reports was highlighted and how it is not just about listening, it is about acting on what people have said. VE commented that it felt positive in relation to under-represented groups and meaningful engagement in terms of the approach and welcomed the discussion. A challenge was raised in relation to maximise opportunities across other systems, for example community housing, and how do we continue to build so it is a city process and not only a health and care process. The value of better understanding lived experience was recognised but also the opportunity to explore the more difficult areas and ensuring we remain connected with how people feel, with a particular focus raised in relation to safeguarding within the system. The Place Lead praised the document and emphasised three areas. The ambition to be systematic about the involvement ambitions, recognising that there are pockets of excellence but that as a partnership we should strive for excellence everywhere. Furthermore, to consider coproduction and the importance of lived experience and relational matters and the challenge of the voice as it is happening. It was also challenged as to how we test that it has made a real difference and demonstrably making things better, particularly in relation to communication and coordination. The comments were welcomed, and thanks expressed to members for their commitment. The importance of working closely with the Population Health Boards was also noted and listening to all community groups as a continual conversation which the PVP was committed to. The Chair summarised the importance of the piece of work and asked the Committee to approve the recommendations outlined within the report. **The Leeds Committee of the WY ICB:**	

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	a) **Reviewed** and **approved** the ambitions set out in the '*Embedding Involvement in the Leeds Committee'* document; b) **Supported** and **committed** to the actions outlined in the report; and c) **Agreed to receive** the costed workplan in September 2022 outlining the resources necessary to further embed people's voice in decision-making.	
07/2	**Leeds Committee of the ICB Terms of Reference** The Leeds Committee of the ICB terms of reference were presented for information. The Chair informed members that these had been reviewed previously by the Leeds Shadow Committee of the WY ICB and that they had been formally approved by the WY ICB Board on 1 July 2022. **<u>The Leeds Committee of the WY ICB:</u>** a) **Noted** the Committee's Terms of Reference and were **assured** that the Terms of Reference were approved by the West Yorkshire ICB Board on 1 July 2022.	
08/22	**Sub-Committee Terms of Reference** The Chair presented the report and highlighted to members that the terms of reference for each of the three sub-committees had been developed over the last 6 months. These had been included within the papers for approval by the Leeds Committee of the ICB. Members were asked to note that there had been minor amendments since the previous iteration that was presented to the Leeds Shadow Committee. The terms of reference would continue to be reviewed as the sub-committees developed and any major changes would return to the Leeds Committee for approval. A query was raised in relation to membership and clarification of those who were members and those who would act in attendance as this would affect the quoracy. It was agreed that this would be reviewed and amended where required. There was a further suggestion that people's voice could be strengthened in the terms of reference in relation to the sub-committees and it was agreed that these would be reviewed as the sub-committees develop. **<u>The Leeds Committee of the WY ICB:</u>** a) **Approved** the terms of reference for the following sub-committees: - Leeds Delivery Sub-Committee - Leeds Finance & Best Value Sub-Committee - Leeds Quality & People's Experience Sub-Committee	
09/22	**Place Lead Update** The Place Lead provided members with a verbal update, focussing on four key points.	

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	The West Yorkshire Integrated Care Board was formally inaugurated on 1 July and held the first Integrated Care Board meeting on 1 July. It was noted that the agenda was mainly governance items, approving necessary appointments, policies, terms of reference and the scheme of delegation. The Place Committee terms of reference had been approved and therefore the necessary delegation of powers had been approved to the Leeds Committee of the ICB, along with the four other places across West Yorkshire. Members were informed that Majid Hussain, former Chair of Oldham CCG, and Professor Arunangsu Chatterjee, Professor of Digital Health and Education, School of Medicine, had been appointed as non-executive members to the WY ICB. An update was provided on system pressures and the situation in Leeds, outlining that Covid rates are high with considerable pressure on the system. Due to other pressures, including the heat warning, this had resulted in the Leeds system declaring Opel Level 4, the highest level. It was acknowledged that this had been stepped back down on 14 July, however members recognised the very difficult and challenging position the system was in. TR outlined that there were 212 people in hospital beds and as an immediate action, City Silver and City Gold had been stood up as needed. TR drew attention to the importance of understanding the transformation programme in place; Phase 1, doing all that can be done in the first 90 days to improve the position ahead of Autumn and Winter; Phase 2 building additional community capacity and Phase 3, a fundamental programme of work to make changes to both process and capacity and culture in terms of the system. All members acknowledged that the situation in Leeds was very challenging. Members were provided with an update in relation to the Leeds Prospectus that was currently being developed to draft a written document that would pull together the enormous amount of work across the city in order to communicate our ambitions as a health and care partnership. It was noted that this document would be shared widely and with members of the Committee and would return to the Leeds Committee in September to share in public. The Committee heard that Leeds would be a place pilot following an ask from NHS England (NHSE) to a number of Integrated Care Systems across England. Leeds would be one of the places working with colleagues from NHSE to consider and develop what a good place looks like in an ICS. It was noted that there was hard work and input across the system. It was suggested that this was discussed at the next Committee meeting to be informed how this has developed and be informed of the exciting work being undertaken. An example provided was the Long-Term Conditions Board working with the Mental Health Board, linking strongly to our desire and ambition to improve the lives of people with mental health. **ACTION – SR to add items to the forward plan for the September Committee meeting** John Beal highlighted the approval of the Scheme of Delegation at the WY ICB and requested that this was circulated to members as an individual paper. **ACTION**	**SR** **SR**

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	JH reiterated the pressures and the challenging operational position, which was evident through the escalation to Opel Level 4. It was noted that a system we are working together to tackle these issues, however it is important not to lose sight of the challenges and what it means for patients and citizens of Leeds. The pressures were significant in relation to the knock-on effect of Covid on workforce and the number of patients in hospital with no reason to reside. It was recognised that as a Place Committee, the challenges that are being faced cannot be underestimated, but recognise the huge amount of work to tackle those issues and working as a system. A positive issue was raised, that we continue to work well on in Leeds, in relation to ambulance handover and an example where we demonstrate that we are putting the safety of patients first. TR reflected that an agenda item would return in September in relation to current system pressures, including a robust review of where we are at, the actions underway and what escalation might need to be put in place. A query was raised on the importance of the resource aimed at tackling the issue in relation to system pressures and whether the resources are directed to the right place. TR assured members that as a system we are constantly reviewing the amount of resource, considering both the urgent system pressures but also the long-term perspective in order to manage both. It was suggested that the agenda for September should reflect the balance of this in considering both the immediate and urgent issues, alongside what we are doing longer term.	
10/22	**Healthcare Inequalities Funding 2022/23** The Chair outlined that due to the timescales and given the CCG was still a statutory organisation when the decision on funding needed to be made, the CCG Governing Body delegated authority to Tim Ryley as the Accountable Officer and the funding was signed off in June. The Leeds Committee were sent the report and invited to feed in any comments prior to the final sign off. The paper is being brought to the Committee for ratification of the allocation of funding. TR provided an overview of the report and highlighted it was important to note that the money came through with an NHSE focus and a short time frame to allocate and approve. Within the report it outlined the engagement that had taken place in a short space of time and there was a focus on ensuring that schemes already in existence were considered. It was acknowledged that there was learning to take from the process and a future funding allocation would have a stronger sense of what should be taken forward. It had been a positive process highlighting integrated identified work rather than bids competing against each other. The Chair reflected how positive it was to see collaboration rather than competition and that the proposed projects included small pots of community-based funding.	

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	It was suggested that for a future cycle it would be useful to consider the top three or four priorities and also for the Committee to be made aware how the impact of spend will be measured. FW highlighted that it had been a fantastic opportunity to collaborate, and the third sector had been involved accelerating some of the work that was being considered through the Population Health Boards. Thanks were expressed to all colleagues involved in a positive process. It was agreed that the points would be reflected on and would feed back into future projects, and it was noted that an evaluation would return to the December Leeds Committee to update members on progress. **The Leeds Committee of the WY ICB:** a) **Ratified** the decision take by Accountable Officer of Leeds CCG in June 2022 to approve the use of the Leeds Health Inequalities Funding for 2022/23; b) **Noted** the suggestion that a further report, summarising the early evaluation of schemes funded through this pot is brought to the Leeds Committee of the WY ICB in December 2022; c) **Noted** the approach taken to allocation of the £3.1m of allocation of Health Inequalities funding to Leeds; and d) **Noted** the reflections, learning and recommendations for future years. *The Committee was adjourned for a break at 3.40pm and reconvened at 3.50pm*	
11/22	**Leeds Financial Plan Submission 22/23** The Chair outlined that due to timescales and given the CCG was still the statutory organisation when the plan submission was made, the plan was being brought to the Committee for ratification. Visseh Pejhan-Sykes provided an overview of the financial plan, informing members that there had been one submission at the end of April and then a further financial plan submission was made on 20 June 2022 based on revised allocations and national conditions. The overall submission moved to a balanced position in totality across all NHS organisations in the region. Members were informed that the revised plan for the Leeds CCG, now ICB in Leeds, shows an increase in the efficiency requirement to £18.5m. It was noted that the risks continue to be significant and include high levels of efficiency reduction at Leeds place, including across providers; operational pressures around discharge process and system flow issues and costs associated with Covid. The Committee were asked to consider the assurance process in terms of financial reporting moving forward. Cheryl Hobson recognised that the position had improved slightly and highlighted the important role of the Finance & Best Value sub-committee from an assurance	

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	perspective to the Leeds Committee of the ICB. The sub-committee will look into the financial plan and resources in more detail, constructively challenge and provide assurance to the Leeds Committee of the ICB. Clarification was sought on the risk of ESR funding potential loss and the figure that related to that. It was clarified that LTHT would incur the costs but they would not earn the money for the backlog if they did not meet the target. It was noted that it was a progressive target, but the risk was up to £45million with an increased risk given the latest position in terms of the increased Covid cases. It was recommended that this would be considered further at the Finance & Best-Value Sub-Committee. Members were informed that there were currently approximately 7 wards dedicated to Covid patients which limits what can be done in terms of elective activity. This was impacting on not being able to deliver the expected level of 104%, currently at 89% and it was acknowledged that the metric applied from NHSE was challenging and there was a significant amount of work ongoing. A concern was raised in relation to both pressing and immediate concerns financially and in the long term, and that financial difficulties could put third sector organisations at risk. It was suggested that the arrangements with the Population Boards would support this in considering third sector organisations. **The Leeds Committee of the WY ICB:** a) **Noted** the changes to the financial plan since 28 April 2022 submission; b) **Noted** and **discussed** the level of financial risk within these plans, and the context of overall place and wider West Yorkshire ICS positions; c) **Ratified** the 2022/23 financial plan submission of 20 June 2022 for Leeds CCG/Leeds Office of the West Yorkshire ICB, approved by AO/CFO under delegated authority (Leeds CCG column in Appendix 1); d) **Approved** the associated high-level budgets for Quarter 1 for Leeds CCG (Appendix 3); and e) **Clarified** the assurance process the Committee would like to see operating in terms of financial reporting.	
12/22	**Financial Business Case** The Chair introduced the item and welcomed Robert Hakin, Associate Director of Corporate Planning, LTHT, to the meeting. The Committee were asked to provide a letter of support following the presentation of the latest version of the Business case for the expansion of Chapel Allerton Hospital capacity. Background information was provided in relation to the Chapel Allerton Hospital Elective Care Hub expansion for spinal surgery and that the main focus had come from the NHS priorities in relation to increasing elective operating capacity away from acute sites. The Committee heard that as an organisation, LTHT were trying to build capacity away from the main acute site. Members were informed that the Chapel Allerton scheme was to develop two additional operating theatres and an additional inpatient ward opposite the existing	

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	ward. It was noted that the planned units would be joined to existing theatres and wards and outlined that additional car parking facilities would also be provided. The timetable was outlined highlighting approvals were being worked through over the next six months and then a focus on the design of new buildings and a two-phase construction. An overview of the strategic case was provided; given the current pressures in spinal surgery, this would provide a sustainable position for that service with increased protected operating capacity at Chapel Allerton which will have a significant impact on patient experience. The economic case was outlined, which identifies and evaluates the benefits for the organisation and the economy. Richard Noble, Associate Director for Estates Strategy, LTHT then presented the commercial case, highlighting that there were three main phases of the work, and that the procurement would be undertaken in two elements. It was highlighted that positive discussions had taken place to date with the planning department. Clare Gaunt, Assistant Director of Finance, LTHT proceeded to present the financial case outlining the financial highlights. It was noted there was a capital investment required of £26.7m which would be fully funded by the Targeted Investment Fund (TIF). In terms of revenue, there would be a staged approach and in total the anticipated revenue costs overall would be £10.6m. Members were informed that the staffing costs had been fully validated as the most efficient model. Key points in relation to the management case were provided to Committee members. NHSE guidance had been followed in the production of the business case and the project would be procured, managed, and executed in accordance with the Trust ways of working and internal governance arrangements. The workforce model was outlined with the view that the two-year timeline would provide the opportunity to explore different recruitment options to deliver the increased capacity. The ask of the Committee was a letter of support to go alongside the outline business case. Further information was available on request from the Committee. JH highlighted the rationale for the business case, particularly given what the Committee had discussion in relation to longer term pressures. It was acknowledged that there were skills, expertise and innovation in Leeds and the ambition was to develop that for the Leeds and the wider ICS and beyond. Members were reminded that this was a part of a national push on elective recovery. A query was raised in relation to recruitment of staff and the current vacancies and whether there was a realistic probably to recruit the staff to deliver the service. Members were assured that it was expected to recruit as the challenge had been theatre capacity rather than recruitment of consultants. There was a view that given	

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	the good reputation of Leeds, it was an attractive proposition for people coming in to work in Leeds and there would not be a problem in the workforce model. VPS raised a query in relation to the revenue and whether this was currently in the system or whether there was an expectation from more money from the system. Members were informed that there had been modelling complete in relation to anticipated growth and therefore the numbers assume a normal level of growth. BM emphasised the need for the Committee to consider the resources of the place and what the Committee was committed to as a system. In terms of growth, it was flagged that if that was taken into account for this development, it would then not be available elsewhere in the system. RH stated that it was clear that there was an immediate need to increase spinal surgery activity and it would take a period of time to deliver and that also aware that the pressures may be different along that timescale. Therefore, it had been taken into consideration that the development itself was required to be agile to respond to the system. TR expressed support for the business case given the immediate pressures but acknowledged there was further work to be done in relation to future revenue and could be built into medium term financial planning. A question was asked around whether any of the business case fell into the category of specialised commissioning. RH stated that there was approximately 50% in relation to specialised commissioning and therefore were engaging with specialised commissioning commissioners also around the activity. The assumptions around the balance of income assumptions for LTHT in the business case were debated by the Committee and it was agreed that the letter of support would include a caveat to highlight that. The Committee were of the view that how the Leeds system allocates its growth funding henceforth is a decision for the Committee to make collectively, and in the context of our priorities as a Place around our focus for (dis)investment, to address pressing issues like system flow and health inequalities. Therefore, LTHT would need to reflect this in their financial case more explicitly. YK expressed that the presentation had been useful and helpful information and recognised the importance and urgency of this. There was an ask to consider the infrastructure and whether there could potentially be an impact elsewhere and whether the infrastructure would be fit for purpose. Members were assured that as part of the planning application there would be a travel and transport plan in relation to accessing the site. The Chair summarised that the Committee had been asked to offer a letter of support. It was agreed that a letter would be drafted, and members delegated this to Visseh Pejhan-Sykes to draft with the suggested caveats discussed. With these caveats noted, the Committee agreed to support the business case submission. **<u>The Leeds Committee of the WY ICB:</u>**	

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	a) **Agreed** to provide a letter of support the Chapel Allerton Hospital Business Case, subject to the inclusion of the caveats discussed.	
13/22	**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 that they needed to be alerted on, assured on, action to be taken and any positive items to note. The Committee noted three areas to bring to the attention of the ICB Board: • System pressures and the challenging situation, both health and social care • Letter of Support to the Chapel Allerton Business Case • Positive discussion in relation to the approach to 'We Start with People' In terms of reflections, it was acknowledged that there was development work in relation to the NHS finance allocations and reports from members of the Committee, specifically those who sit outside the NHS. The Director of Public Health reflected on the new arrangements and how they will work with the join up to the local public health system and felt an opportunity. Members were informed that there was an expectation for a White Paper on Health Disparity, however this had been postponed due to parliamentary changes. It was noted that there would be themes within the White Paper for discussion at the Committee.	
14/22	**Forward Work Plan** The forward work plan was presented for review and comment, noting that it was in development and would be an iterative document. Members of the Committee were invited to consider and add agenda items. These would be discussion with the Governance team to ensure the Committee was the most appropriate forum. A suggestion was made to include overall system pressures on the forward plan for September to provide assurance on overall plans to the Committee.	
15/22	**Summary and reflections** This agenda item was covered under 13/22. It was agreed that members could reflect following the meeting and feedback to Sam Ramsey.	
16/22	**Any Other Business** Sam Ramsey raised that in relation to agenda item 17/22, Memorandum of Understanding, this was currently being presented across partner organisations for approval and sign up. An omission had been made within the document for Healthwatch approval, but this had now been added and would be taken to the Healthwatch Board on 21 July 2022. VPS brought to the Committees attention, that in relation to system flow and pressures at LTHT, a system wide piece of work had been undertaken to gain consultancy support. The first phase had taken place and did not cost over the threshold, however in order to implement the three phases, the consultancy work required NHSE approval. A business case would be submitted to NHSE and given	

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	the cost was between £50k and £250k, the Committee was required to approve. It was noted that support had been provided from the Chief Executives of the NHS organisations in advance of the business case being submitted to NHSE. It was agreed that the business case would be shared following the meeting and the Committee supported this important system wide piece of work.	
ITEMS FOR INFORMATION		
17/22	**Memorandum of Understanding** The Memorandum of Understanding for the Leeds Health and Care Partnership was included within the paper pack for information.	
18/22	**Date and Time of Next Meeting** The next meeting of the Leeds Committee of the WY ICB will be held at 1.00 pm on Thursday 22 September, at a venue to be confirmed.	

Action Tracker

Leeds Committee of the WY ICB

Action No.	Meeting Date	Item Title	Actions agreed	Lead(s)	Accountable body / board / committee	Status	Update
5	**22/09/2022**						
Completed Actions							
1	**14/07/2022**	**Sub-Committee Terms of Reference**	Amendment to be made in relation to quoracy and full membership.	**Sam Ramsey**	**LCICB**		**Complete** Amended. All terms of reference will be published on the Leeds Health & Care Partnership website.
2	**14/07/2022**	**Place Lead Update**	Leeds Prospectus Update & Leeds Place Pilot to be added to forward work plan for September 2022.	**Sam Ramsey**	**LCICB**		**Complete** Added to forward work plan.
3	**14/07/2022**	**Financial Business Case**	Letter of support to be drafted and circulated to Committee members for comment.	**Visseh Pejhan-Sykes**	**LCICB**		**Complete** Circulated for comments and final letter sent to LTHT on 22/07/22.
4	**14/07/2022**	**Summary & Reflections**	Email to be circulated to Committee members for reflections on the Committee meeting and any items for the forward work plan.	**Sam Ramsey**	**LCICB**		**Complete** Email circulated with action tracker on 22/07/22.

Updated: 9 September 2022

Meeting name:	Leeds Committee of the West Yorkshire Integrated Care Board (ICB)
Agenda item no.	LC 25/22
Meeting date:	22 September 2022
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:

This report provides an overview of key developments across the health and care system nationally, regionally, and locally.

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. **Consider and note** the contents of the report
2. **Advise** on the content of future Place Lead Updates

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

N/A
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. CVD - Cardiovascular Disease

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	Paragraph 4 sets out the stakeholder engagement that has taken place to date for developments relating to stroke services.

1. National Context

1.1 There have been significant constitutional and governmental changes since the committee last met. The death of Her Majesty, Queen Elizabeth II has been a profound and historically significant event in the life of our nation. His Majesty, King Charles III has ascended to the throne and with the nation we wish him well.

1.2 The new Prime Minister in her inaugural address made it clear that the health service was one of her top three priorities. We have in place the 3rd Secretary of State for Health & Social Care within a few months, Thérèse Coffey.

1.3 We are expecting from an NHS perspective the national focus to be on four areas: GP Access, Dental Access, Recovery of Cancer and Elective waiting times and Ambulance Services including turnaround times. Whilst primary dental services are currently not part of this committee's responsibilities, I would expect this to change during next year. As partners in Leeds, we will have significant responsibilities in ensuring improvements in all of the other three priorities. Our work on improvements in system flow are critical to both elective recovery and ambulance waiting times.

1.4 We are also hearing that there is to be a national focus on excess mortality rates post covid. In part this is being understood nationally to be driven by delays in urgent care and through late presentation and diagnosis. There is therefore, in addition to the areas above which are pertinent, likely to be work expected particularly around health checks. Clearly as a partnership we would also consider issues beyond direct health care being factors and with the cost-of-living pressures increased risks. We will continue to work in Leeds on these wider issues.

2. Cost of Living Crisis and Winter Planning

2.1. Inflation is running at c10% and expected to rise further, and there are significant increases in energy prices compared to last winter. We anticipate significant implications arising for the NHS and Care system. Public Health experts have predicted an increase in mortality **and** associated hospital admissions due to both cold and poor nutrition. In addition, it is likely there will be strike action of some kind affecting the public services including within the NHS and Social Care.

2.2. At the time of writing, covid pressures have fallen and have flat-lined. However, we are being warned to expect further spikes during the autumn and winter and a challenging flu season. Member of the Leeds Committee will be aware that this is on top of a very real continuing difficulties with the flow of patients out of

hospital once their hospital treatment is complete in both the acute and mental health sectors.

2.3. Taken together these present us with the likelihood of an extremely difficult winter. The city Partnership Executive Group are focussing on three specific plans:

1: System Flow and Intermediate Care Improvements: We have in place a detailed three phased programme to improve system flow. We have put in place a Programme Director and programme office to oversee a complex set of changes and improvements. This is starting to bear some fruit at the time of writing. Phase 1 is focussed on immediate tactical improvements including the strengthening of the Transfer of Care Hub, Bed Brokerage, and options for people with Complex Dementia as well as improvements in each of the four discharge pathways themselves. Phase 2 which started in August is focussed on Intermediate Care and we have brought-in an external partner with expertise in this area, Newton Europe.

2: Integrated Winter Plan: Each Winter we have Winter Plans. These include options around additional bed capacity, a focus on flu and covid vaccinations for example. We are giving particular attention to this plan this year and ensuring its fully connected to wider council led plans to address economic hardship and fuel poverty. We are looking, as large anchor institutions, at ways to support our staff personally and to provide them with the right support to enable them to help individuals in their care with the practicalities of life as well as the usual high standards of clinical and social care.

3: Plan C - in Extremis: Rightly the focus of our energy is making sure that the two programmes of work above deliver maximum benefit and ensure that we sustain service provision through this winter. However, given the combination of factors described earlier it would be remiss of us not to plan for a worse-case scenario where normal provision has to be suspended. We are therefore testing our Emergency Planning approach both within organisations and across the partnership. We are also testing a number of worse case scenarios and developing potential actions to enable us to retain focus on life critical services. These plans and progress are monitored on a weekly basis by the Partnership Executive Group in one forum or another.

3. Development of the Leeds Health and Care Partnership

3.1 The Leeds Health & Care Partnership continues to evolve. Whilst the introduction in statute of Integrated Care Systems and the Integrated Care Board has brought

about some significant changes, in Leeds and West Yorkshire the partnerships were already highly developed and continuing to evolve. I would like to draw attention to 5 areas of ongoing work:

- The three sub-committees of the Leeds Committee of the ICB have now all met at least once and membership of the committee itself is in place. The Sub-committees (Delivery and Inequalities, Finance and Best Value and Quality & People's Experience) are responsible for seeking assurance on behalf of the committee that in each area of the Triple-Aim of Outcomes, Experience and Finance the partnership is sustaining good care and financial balance and making progress in areas of improvement. Finance and Best Value will also have the task of reviewing major business cases and financial plans. All partner organisations are represented on each and each has an independent chair.

- Within the city we already have a range of Population and Care Boards alongside the Partnership Executive Group. Without increasing the number of meetings and where possible rationalising them we have over the last year been clarifying and strengthening the role of these with a particular emphasis on how they interact with each other (and local care partnerships) to prioritise and deliver improvements in care and outcomes for and with the population. Clinical and professional review of data and insights from the public is creating a strong person centred and population health focus to their work. This will continue to evolve.

- Leeds was selected as one of the national NHS England Place Based Partnership pilot sights for testing population health. This has enabled us to look with the support of external expertise at our leadership and Governance, our Financial Stewardship approach, and the use of data to empower change. All partner organisations have been involved. The national team saw Leeds as already having a strong population health management approach and at the same time there were areas where we needed to improve, in particular around data and intelligence. The Partnership Executive Group reviewed the work and recommendations at its last meeting in early September.

- A small group of Chief Officers have been working together to produce a shared mandate/common narrative articulating the assets of the partnership, our priorities and key building blocks if we are to progress delivering our part of the Health & Wellbeing Strategy and Vision. This is currently going through its final review with a wider group of colleagues before sign-off at the start of October. We will be sharing with the Committee at that point. It pulls together much of what we have already

been doing and the way we work. Its purpose is to both provide a strong articulation of the Leeds Health & Care Partnership externally and provide a mandate and articulation to our own city leadership and colleagues. The city communication colleagues are developing the accompanying products and communication plans.

- In a similar vein since the last formal meeting of the Committee the creation of Leeds Health & Care Hub has been published. This is in-effect a memorandum of understanding between the Department of Health & Social Care and Leeds and the wider West Yorkshire system to look at areas where we might work together in a new way in areas of workforce, technology and policy. This is a huge opportunity for Leeds to both shape national thinking and also benefit from national expertise.

4. Leeds Stroke priorities and the redesign of community neurological rehabilitation services

4.1. The Long-Term Conditions Population Board and its workstreams are progressing two key areas of work:

- The development of a stroke vision and priorities for the city for publication
- The redesign of community neurological rehabilitation services

4.2. In October 2021, NHS Leeds CCG (now Leeds ICB), LTHT and LCH all committed to developing a vision for stroke services for the next five years. Development of the vision was due to commence in October 2021, via the formation of a 'Stroke Vision Task Group' which would meet monthly. Our intention back in October was to publish a first draft of the Stroke Vision by April 2022.

4.3. The Stroke Task Group is in place and has been meeting monthly since October. The task group includes good stakeholder representation.

4.4. Whilst several immediate stroke priorities have been taken forward/are progressing, the work on writing the stroke vision/priorities document for publication and agreeing / progressing future priorities has been delayed due to the impact of Covid.

4.5. Immediate priorities have continued to be progressed and have been implemented, including:

- The Chapel Allerton Hospital rehabilitation ward move in November 2021
- Continued delivery and initiation of new projects focusing on stroke prevention via our LTCs CVD work programme
- Plans for patient and public involvement

4.6. This focused work and commitment as a system to a stroke vision and priorities is allowing us the time to place a spotlight on emerging data and health inequalities, enabling us to understand need and where to focus our efforts. The next steps and timeline for developing and publishing our vision/priorities are:

- Continued development via the Stroke Task Group
- A draft of our vision/priorities document to be shared with the Leeds Long Term Conditions Population Board in November 2022 following review and agreement by partners; LTHT, LCH and Leeds City Council.
- The development of an implementation plan, detailing current and future priorities (and ownership) to accompany the vision/priorities document; this will also conclude continuous engagement plans once developed
- Any further revisions/updates to be made in December prior to publication in January 2023

5. Future Nature of Report

5.1 The members of the committee are invited to comment on what they would find helpful in the report of the ICB Accountable Officer (Leeds) going forward. Most Boards and Committees would have a report of this kind and there are numerous ways such a report can be fashioned. Members will note that this covers something on:

- The national picture
- Local and immediate system priorities
- Key developments in the partnership, and
- A focus one or more areas of partnership level service improvement

5.2 Further thoughts are welcome. One area that doesn't feel reflected in the paper or broader agenda is the importance and success of the individual statutory bodies (and groups of other organisations) that constitute the partnership. Another consideration is a focus on work underway at a West Yorkshire level.

6. Recommendations

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

a) **Consider** and **note** the contents of the report; and

b) **Advise** on the content of future Place Lead Updates

Leeds Health & Care Partnership

NHS West Yorkshire Integrated Care Board

Committee Escalation and Assurance Report – Alert, Advise, Assure

Report from: Leeds Quality & People's Experience Sub-Committee

Date of meeting: 7th September 2022

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

Report completed by: Rebecca Charlwood, Independent Chair, Leeds Quality & People's Experience Sub-Committee

Date: September 2022

Key escalation and discussion points from the meeting
Alert:
• The sub-committee expressed overarching concerns regarding system pressures and workforce challenges. It was noted that a place-based programme of work was in progress.
Advise:
• The sub-committee received an update on the new Patient Safety Incident Response Framework (PSIRF) which would enable a shift from specific incidences to thematic reporting. It was noted that all providers would be required to implement the framework by September 2023, with Leeds Teaching Hospitals Trust being an early adopter. • Members received the risk register aligned to the Leeds Quality & People's Experience Sub-Committee (QPEC). The sub-committee were informed that there were seven risks aligned to the sub-committee with five high scoring open risks scoring 12 or above. Members queried current processes around risk management and discussed a number of system risks. It was acknowledged that individual organisations continued to hold their own organisational risk registers. • The sub-committee noted the draft Quality Highlight Report which would be used as an initial approach until national guidance was issued. The report incorporated an overview of areas where issues or concerns had been highlighted including those on the national agenda, as well as specific provider concerns. Patient experience data received from the Leeds ICB team was also included, with 184 contacts having been made since 1 April 2022. Key themes had been identified across the system including difficulty accessing prescriptions and appointments from GP practices and concerns regarding the number of IVF cycles funded.

- With regards to the Quality Highlight Report, members emphasised the need to consider the system more widely, for instance, the implications of Ockenden Report recommendations on third sector organisations.

Assure:

- An update was provided on the Leeds Quality Architecture. Members noted that a range of Quality Improvement (QI) techniques were being utilised; there was a need to develop a clear understanding of how QI was approached as a system. Key drivers for this change included: the formation of ICBs; development of health and care partnerships; Population Health Management approaches; changes to CQC regulation; and National Quality Board refreshed guidance. With regards to the CQC new regulations, the new approach was illustrated with an example of the recent inspection of Urgent Care in West Yorkshire, which provided a system picture as opposed to an inspection of an individual service.

- Members held a positive discussion regarding embedding the People's Voice in future meetings. Population Health Board representatives would feed through to the sub-committee, sharing their insights. Discussion focussed on the People's Voices Partnership and how insight could be shared to ensure members stayed connected into communities.

- Key findings from the *Measuring Person Centred Outcomes in Leeds Report: A Baseline Survey of the adult population of Leeds* were shared at the meeting. The survey had been commissioned by Leeds Health & Care Partnership for Ipsos to measure how adults' self-rate their health and wellbeing and experience of person-centred integrated care. Key findings from users' voices indicated people valued: good communication with service users; good communication between professionals; a compassionate approach; person-centred co-ordinated care; enablement of independent living; and involvement of carers. In terms of multi-agency working, complexity of jargon was identified as one barrier to person-centred integrated care.

Committee Escalation and Assurance Report – Alert, Advise, Assure

Report from: Leeds Delivery Sub-Committee

Date of meeting: 5th September 2022

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

Date of meeting reported to: 22nd September 2022

Report completed by: Sam Ramsey, Head of Governance & Risk, ICB in Leeds on behalf of Yasmin Khan, Independent Member and Chair of Delivery Sub-Committee

Key escalation and discussion points from the meeting
Alert:
• The sub-committee received the delivery performance report, which has been appended to this report, and the following areas were flagged: - Although cancer performance is improving overall, there are specific areas where cancer improvement is not to the level we would want it to be. - The demand and pressures on colleagues in mental health services were acknowledged despite the indicators displaying the right direction. - In terms of appointments for GP access, it was demonstrated that they were growing, however it was important to note that people's experience had fallen. - The biggest challenge and major area of concern was in relation to acute and emergency pressures and the consequences in discharge. A Programme Director and programme office has been put in place to oversee a complex set of changes and improvements.
Advise:
• The sub-committee reviewed the terms of reference and the purpose outlining that the role was to provide assurance to the Leeds Committee with respect to progress being made with plans to improve outcomes, tackle health inequalities and improve the effectiveness and efficiency of services. Members discussed that the sub-committee would seek assurance relating to the performance of delivery against NHS constitutional standards and more broadly as a Leeds Health and Care Partnership. The importance of the membership was discussed in recognising joint ownership across the system to address health inequalities. • Members received an update in relation to the Healthy Leeds Plan Strategic Indicator Remeasurement 2022. The report provided a high-level review of the data for each of the strategic indicators including, where possible, a Leeds average and deprived Leeds position, a comparison to regional and national average as well as Leeds position against the core city data.

- The sub-committee agreed to receive future updates recognising the need to be realistic in terms of what can be contributed to in making the difference and considering investment and disinvestment. There was a suggestion for a future report to focus on three top priorities to consider.
- A proposal was presented to the sub-committee on the format, process and content for which health inequality information would be gathered and reported to the sub-committee, given its remit around health inequalities. The specification is based around the national Core20Plus5 approach; however it was noted that the focus in Leeds would be the 10% most deprived population given the significant proportion of the population who live in the most deprived 10%.
- Members were informed that the report would be annual and would be reviewed by the Leeds Tackling Health Inequalities Group (THIG). It would also be used to steer the Population and Care Delivery Boards.
- Members were supportive of the approach and acknowledged the assurance role of the sub-committee.

Assure:

- The sub-committee received the delivery performance report, as highlighted under the 'Alert' section, within which the performance dashboard was included, containing four groups of performance measures and indicators:
  - Access and waiting times as set out in the **NHS Constitution**
  - Measures described within the **NHS Standard Contract**
  - Measures described within the **2022/23 Priorities and Operational Planning Guidance**
  - Indicators and measures as described in the **Healthy Leeds Plan**
- Members acknowledged that reporting of performance was not simple, and feedback was welcome on the content and structure of the report. It was also important to note that the indicators do not inform of the whole story.
- The sub-committee was asked to agree a level of assurance. It was agreed that given the information presented, a level of limited assurance would be appropriate, *'performance/quality is not in line with agreed targets/trajectories but there is reasonable mitigation for this and an action plan needs to be developed to rectify issues'.*
- Members challenged themselves as to what they would need to see as a sub-committee in order to move to being reasonably assured. It was agreed that further detail would be included within the report in relation to qualitative information to provide context to the hard data. This would be received at the next meeting.
- Members received the risk register aligned to the Delivery sub-committee and were informed that there were seven risks aligned to the sub-committee, five of which were reported as high scoring open risks. The discussion focused on the plans in place to reduce the risk and holding each other to account for system risks through mutual accountability.
- It was agreed that future reports would provide further detail regarding mitigation and how the risks are being addressed and managed within the system to provide a further level of assurance to members.

Leeds Health & Care Partnership

Item Lead(s): Tim Ryley
Author(s): Andrew Baines

Report of: Tim Ryley, Place-based lead for Leeds Health and Care Partnership

Report to: **Delivery Sub-Committee**

Date: **5th September 2022**

Report title: **DC 05/22(a) – Revised Delivery Performance Report**

1 Purpose of this report

1.1 This report is intended to support the Delivery Sub-Committee by providing an overview of reported performance in Leeds against national and local measures and metrics.

1.2 The report consists of a summary of performance areas of specific note, taken from a wider performance dashboard.

1.3 One role of the subcommittee (taken from the terms of reference) is to *"seek assurance relating to the reported performance and improvement in health outcomes being achieved…"*. This report is intended support the subcommittee to consider the assurance level.

2 Context and Background information

2.1 Process Background: The performance dashboard this report is based upon contains 4 groups of performance measures and indicators;

- Access and waiting times as set out in the **NHS Constitution**
- Measures described within the **NHS Standard Contract**
- Measures described within the **2022/23 Priorities and Operational Planning Guidance**
- Indicators and measures as described in the **Healthy Leeds Plan**

2.2 The first three groups of measures are often referred to as the NHS 'must do's' and in many instances overlap as might be expected, and with minimal variance year to year. Some measures are also reflected in the Operational Planning Guidance, however often these do change year to year, and in line with key national operational targets set by NHS England.

2.3 The Healthy Leeds Plan measures have been developed from the Left-Shift Blueprint indicators and measures that are aimed at improving health outcomes and in support of the Health and Wellbeing strategy *'where people who are the poorest, improve their health the fastest.'*.

2.4 All the measures in the dashboard have been assigned broadly in line with the Population and Care Delivery Board structure; Frailty, End of Life, Long Term Conditions, Healthy etc.. Each board will, in due course, have a section of the dashboard that details the national and local measures most relevant for their populations.

2.5 The performance dashboard is updated monthly using nationally published data sets and as a consequence, the reported position may be subject to a reporting lag.

2.6 Leeds Performance Context: The Health and Care system remains very challenged having relatively recently recovered from the Spring Covid wave and currently experiencing the tail of the sixth Covid wave, alongside high demand across services, coupled with staffing challenges.

2.7 Nationally there is a '*Living with Covid*' approach that saw the lowering of the national incident level to 3 in March, but there are significant pressures across the national system still.

2.8 Although pressures directly related to covid-inpatient numbers and outbreaks are currently reducing, bed occupancy and acuity for both mental health and general beds remains high, and flow through to home care and care homes remains challenging. This is a factor in significant pressures across urgent and emergency care.

2.9 These ongoing challenges as well as the initial pausing of services in the very first Covid wave, are still adversely affecting performance against many measures.

3 Key Points

3.1 Cancer: Cancer 2-week-wait performance has been improving and reported at 80.2% (for May against a target of 93%). Referrals numbers are remaining high with increases in some areas, and this demand trend likely to continue. The greatest demand remains consistent in skin, breast and lower GI specialties. Recovery plans remain in place supporting improvement that include additional capacity.

3.2 31-day decision to treat performance has also improved to 92.7% (May against a 94% target), from a more challenged position at the start of the year, reflecting increasing planned activity levels, and fewer covid-related and wider pressures related disruption. Action plans to support improvement are in place that include working with Primary Care (in relation to skin referrals as the greatest number by specialty), as well as internal reset groups, with improvement expected to continue.

3.3 Reported performance of 62-day referral (48.4% in May against a target of 85%) reduced slightly, although the broad trend has been improving in 2022. Support plans include clinical prioritisation of cancer patients, increases in capacity and a focus on backlog reductions.

3.4 Planned Care: Diagnostic wait lists have started to reduce again (dropping below 17,000) and performance has shown improvement in May and June (80% towards a target of 99% of people having their test within 6 weeks of referral) with some benefits from improved CT capacity now being realised.

3.5 Referral to Treatment performance remains around 70% of people being seen within 18 weeks of referral (69% in May against a target of 92%) with wait list sizes continuing to increase monthly. However, progress continues to be positive in relation to the management and reduction of very long waits (72 and 104 weeks).

3.6 Long Term Conditions: NHS Health Check invites and completed check figures are positive (for the latest data available, Q4, 8246 invites) and approaching a return to pre-pandemic levels. A restart and recovery plan including additional capacity is in place to support improvement.

3.7 Adult Mental Health: EIP (Psychosis treated within 2 weeks of referral) data continues to show performance at or around the 60% target (Q4).

3.8 Improving Access to Psychological Therapies (IAPT) wait time performance is above target (at 99% within 18 weeks, 87% within 6 weeks) despite increasing demand. However there are onward waits for step 3 (intensive CBT) wait times which causes a particular pressure.

3.9 Learning Disability and Neurodivergence: 84% of the eligible population for Learning Disability eligible population had had their Annual Health checks at year end. 2022/23 numbers have started initially slow as is the normal profile.

3.10 The complex needs/inpatient position at 22 patients (Q1) remains above target for ICB commissioned beds. However, there are plans for further discharges by the end of September.

3.11 Children and Young People: Children's mental health continues to report high demand and urgency although performance for urgent demand to eating disorder services is being delivered at 95%. There are plans to improve performance for routine demand including additional investment and additional triage capacity available is indicating an improvement.

3.12 Frailty: Locally set Frailty measures have been reviewed by the population board and will move to include at least quarterly measures once finalised. High utilisation of the virtual ward for frailty is reported across recent months, and positive performance (comparatively and against targets) is reported for urgent community response.

3.13 End of Life: Advanced care planning performance recorded locally is starting to improve and is not far from periods before the pandemic. There has also been year on year increases in the total number of plans recorded as completed. Additional staff training continues that will further increase the number of care plans.

3.14 Same Day Response: High levels of GP appointments continue to be offered (+12% May 2022 compared to May 2021) with total activity higher than 2019 levels and face to face appointment levels very similar. Wider access improvement plans are in place to continue this trend, and additional same day capacity has been introduced.

3.15 Current system wide pressures are evident in A&E measures. For July the Emergency Care Standard (4-hour wait in A&E) was on average around 70% (for all attendances against a target of 95%), with increasing numbers of patients waiting over 12 hours from arrival to leaving. Ambulance handovers performance continues to be positive compared to other places, with average times near target (15mins) at both ED sites.

4 Next steps

4.1 The scope, format, presentation, and mechanisms of the system performance reporting will continue to be developed in line with any feedback from the committee, and subject to future developments from NHSE and ICB reporting requirements.

4.2 Committee members will be provided direct access to the performance dashboard.

Meeting name:	Leeds Committee of the West Yorkshire Integrated Care Board
Agenda item no.	LC 29/22
Meeting date:	22 September 2022
Report title:	Risk Management Report
Report presented by:	Tim Ryley, Place Lead, ICB in Leeds
Report approved by:	Sabrina Armstrong, Director of Organisational Effectiveness, ICB in Leeds
Report prepared by:	Anne Ellis, Risk Manager, ICB in Leeds

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

Previous considerations:

ICB in Leeds Executive Management Team (EMT) – 17 August 2022

Delivery Sub-Committee – 05 September 2022

Quality and People's Experience Sub-Committee – 07 September 2022

Finance and Best Value Sub-Committee – 14 September 2022

Executive summary and points for discussion:

This paper presents the ICB in Leeds High-Scoring Risk Report (scoring 15+) as at the end of the current risk review cycle (Cycle 1 2022/23).

Following review of individual risks by the Risk Owner and the allocated Senior Manager, all risks on the Leeds Place Risk Register were reviewed by the EMT of the ICB in Leeds and then by either the Delivery Sub-Committee, Quality and People's Experience Sub-Committee or the Finance and Best Value Sub-Committee. A number of risks are directly aligned to the Leeds Committee of the ICB, these risks are presented in this report for review by the Committee, risks scoring 12 and above 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 ICB is asked to receive and note 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. The Leeds Committee is also asked to 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
1. Appendix 1: Risk Register extract (High Scoring risks and risks aligned to the Leeds Committee) as of 18 August 2022
Acronyms and Abbreviations explained
1. ICB – Integrated Care Board

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	Any implications relating to individual risks are outlined in the Risk Register.
Transformation and Innovation	
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 the current review cycle (Cycle 1 of 2022/23) which commenced on 01 July and ends after the Leeds Committee meeting.

1.2 As this is a new risk register, all risks are marked as new, future risk reports will show the numbers of risks which are marked for closure, new, increasing or decreasing in score.

1.3 The report shows all high-scoring risks (scoring 15 and above) recorded on the Leeds Place risk register. The report also shows all risks aligned to the Leeds Committee and highlights any scoring 12 and above. Details of the risks are provided in Appendix 1.

2. Leeds Place Risk Register

2.1 There are currently 28 risks on the Leeds Place Risk Register. These are all categorised as new risks as the risks have been added during the review cycle. The majority of the risks have been reviewed and transferred from the former NHS Leeds CCG Risk Register.

2.2 An overview of the Leeds Place risk exposure is provided below:

LIKELIHOOD

IMPACT	1 - Rare	2 - Unlikely	3 - Possible	4 - Likely	5 - Almost Certain
5 - Catastrophic	0	0	0	0	0
4 - Major	1	1	1	2	1
3 - Moderate	0	4	11	3	2
2 - Minor	0	0	2	0	0
1 - Insignificant	0	0	0	0	0

TOTALS

Low Risks (White)	:	0
Moderate Risks (Green)	:	7
High Risks (Yellow)	:	16
Serious Risks (Red)	:	4
Critical Risks (Black)	:	1

2.3 The process for the update and review of the Risk Register has been as follows:

2.2.1 Review of the former CCG Risk Register to determine whether risks should be:

a) Transferred to the Leeds Place Risk Register;
b) Transferred to the ICB Corporate Risk Register; or
c) Closed.

2.2.2 Following an update of the Risk Register by Risk Owners and review of individual risks by the allocated Senior Manager, all risks were reviewed by the EMT of the ICB in Leeds on 17 August 2022.

a) All aligned delivery risks were reviewed by the Delivery Sub-Committee on 05 September 2022.
b) All aligned quality risks were reviewed by the Quality and People's Experience Sub-Committee on 07 September 2022.
c) All aligned finance risks were reviewed by the Finance and Best Value Sub-Committee on 14 September 2022.
d) All risks aligned to the Leeds Committee are presented to the Committee in this report.

The committees reflected on possible additions/amendments which would be required in the next cycle (due to begin on 22 September).

2.4 Work is in progress to develop how partnership risks are identified, logged and managed. This includes work with:

- The Population Health Boards;
- Clinical Executive Group; and
- Leeds Health and Care Governance Leads

2.5 Members are asked to note that all organisations will continue to hold their own organisational risk registers.

2.6 **High Scoring Risks**

There is one open risk rated as Critical (scoring 20 or 25).

There are four open risks rated as Serious (scoring 15 or 16).

Risk Number	Risk Wording	Risk Score	Risk Movement
2019	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 and the numbers in hospital beds with no reason to reside, resulting in poor patient quality and experience, failed constitutional targets and reputational risk.	20	New.
2016	As a result of the longer waits being faced by patients, 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.	16	New
2017	There is a risk of harm to patients with LTC/frailty/mental health conditions due to the inability to proactively manage patients with LTC/frailty/mental health and optimise their treatments due to the impact of covid on capacity and access resulting in increased morbidity, mortality and widening of health inequalities and increased need for specialist services.	15	New
2018	There is a risk of harm to patients with mental health conditions due to sustained increased demand impacting capacity to support a more responsive access to specialist mental health services, resulting in increased morbidity and widening of health inequalities.	15	New

2.7 Risks Aligned to the Leeds Committee

There are four risks aligned to the Leeds Committee, which comprise 14% of total risks currently on the ICB Risk Register.

a) All are classified as new risks, added in the first risk cycle of the new organisation (see Appendix 1);
b) No risks are marked for closure; and
c) There is one open risk scoring 12 or above (see below).

Risk Number	Risk Wording	Risk Score	Risk Movement
2013	There is a risk of insufficient project and programme management resource due to the capacity and capabilities of staff trained and available to support new system wide initiatives resulting in late delivery of initiatives / reduced service quality.	12	New.

3. Next Steps

3.1 Subsequent to the Leeds Committee meeting, the risks will be carried forward to the next risk review cycle which starts on 22 September 2022.

3.2 Work will continue to develop partnership and system risk management arrangements.

4. Recommendations

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

a) **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 committees; and

b) **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.

5. Appendices

Appendix 1: Risk Register extract (High Scoring risks and risks aligned to the Leeds Committee) as of 18 August 2022.

Risk ID	Date Created	Risk Type	Strategic Objective	Risk Rating	Risk Score Components	Target Risk Rating	Target Score Components	Risk Owner	Senior Manager	Principal Risk	Key Controls	Key Control Gaps	Assurance Controls	Positive Assurance	Assurance Gaps	Risk Status
High-level Risks																
2019	30/06/2022	Quality and People's Experience Committee Delivery Committee	Improve healthcare outcomes for residents	20	(I4xL5)	12	(I3xL4)	Christine Beck	Helen Lewis	There is a risk of harm to patients in the Leeds system due to people spending too long in Emergency Departments and in hospital beds with no reason to reside, resulting in poor patient quality and experience, failed constitutional targets and reputational risk.	Palliative and End of Life working group working to maximise flow 3 Additional wards open at LTHT Transfer of Care hub in development (operating as daily MDT for discharge placement) Daily System Huddle in place to identify capacity and demand System Flow action plan refreshed and overseen by Accountable Officer System Resilience Operational Group (SROG) & System Resilience and Reset Assurance Board (SRaRAB) dashboards informed by LTHT short-term COVID modelling Seasonal Activity Planning System Escalation Actions and Processes OPEL & System Pressures Reporting Regime Winter/Seasonal Resilience Planning Programme: Winter Plan and System Action development and Easter System action plans Communications work with Public to suggest alternatives to ED Project Lead recruited for the intermediate reablement/NT programme	Key controls in place responding to high levels of demand.	Health & Social Care Command & Control Groups: System Resilience Operational Group (Bronze), Stabilisation and Rest (Silver) and System Resilience and Reset Assurance Board (Gold) Integrated Commissioning Executive Partnership Executive Group Governing Body Quality and Performance Committee	Weekly meting in place for services to report on capacity /demand Reviewed Silver Action cards Monthly reporting to SRrAB to update on System flow action plan established fortnightly 'check in' meetings with System flow programme director to report on actions plan	No robust Opel reporting system in place for ASC .	New - Open
2016	29/06/2022	Quality and People's Experience Committee Delivery Committee	Tackle inequalities in access, experience, outcome	16	(I4xL4)	12	(I4xL3)	Joanna Bayton-Smith	Helen Lewis	As a result of the longer waits being faced by patients, 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. Revising the priority for patients who have waited over 80 weeks for treatment to a P3 category. Consistent messaging to patients re waiting times. Implementation of initiatives funded through Cancer Recovery funding, circa £350k Greater use of advice and guidance to help manage patients pre-referral / whilst waiting for appointments Implementation of patient initiated follow up (PIFU) LTHT developing methodologies to account for learning disability and deprivation in assessing clinical priority (as part of Healthy Hospitals Network)	Implementation of actions enabled through TIF/ERF monies Implementation of initiatives funded through Cancer Recovery funding Planned Care Delivery Board	Frequent dialogue with ICB at Leeds and providers (LTHT/ LCH and community /IS providers) to identify and maximise opportunities to support with waiting lists. Development and implementation of roll-out plans for advice and guidance and PIFU are reviewed at LTHT Outpatient Board attended by ICB at Leeds Pathway Integration Lead. Monthly review / focus on elective recovery/ waiting list position update shared through SRaRAB. IQPR monthly reporting process in place. Planned Care Delivery Board has oversight and co-ordination function Set up of 2 x T&F groups, reporting to the Planned Care Board around Communications with Patients and Understanding our waiting lists - projects/ activities currently include focused project to support people attending at A&E who are on a Planned Care waiting list and also focus on supporting people who are on multiple waiting lists across providers Cancer - data driven discussion at WY&H Cancer Alliance Board levels and follow up	tbc	tbc	New - Open
2017	29/06/2022	Quality and People's Experience Committee Delivery Committee	Tackle inequalities in access, experience, outcome	15	(I3xL5)	9	(I3xL3)	Lindsay Mcfarlane	Helen Lewis	There is a risk of harm to patients with LTC/frailty/mental health due to the inability to proactively manage patients with LTC/frailty/mental health and optimise their treatments s due to the impact of covid on capacity and access resulting in increased morbidity, mortality and widening of health inequalities and increased need for specialist services.	Risk of harm / impacts of Covid assessed by each LTC Steering Group with individual projects agreed as required ARRS roles have been expanded in 21/22 with an associated increase in funding, PCNs encouraged to utilise roles to support complex cohort, frail cohort. Further work planned to ensure full utilisation of the funding allocation Health Check working group in place to agree recovery approach into 21/22. Contract extension currently being considered Projects underway to promote rehabilitation/self-management offers available to primary care and that new interventions including digital offers are evaluating well to encourage increases in referrals Self-management strategies being developed; for example digital equipment to support patients with LTCs/@Home monitoring Digital technology to support access to mainstream general practice being evaluated due to its rapid expansion of online and video consultations Risk Stratification prioritisation continues to be supported in primary care through the refreshed Quality Improvement Scheme and by all services, Long-Covid Pathway established Increased focus on same day access through local winter resilience resource to support increase in demand	Work programme 22/23 implementation focusing on enhancing improved integrated care Recovery to pre-pandemic levels of performance; i.e. CCSP reviews in primary care and key waiting time trajectories Health Inequalities project delivery	Continue to use PQI to monitor progress. Primary care quality visits underway reviewing outcomes in PQI. Alignment of some contract measures to support a focus in key areas i.e. QoF Continued engagement of CDs, PMs and LMC to respond to feedback and address any concerns. Discussion and review at LTC Board and relevant pathway steering groups. Tracking of PCN ARR workforce plan and aligned funding Quality and Outcomes framework has re-commenced with effect from 1 April 2022. Alignment of IIF indicators to population boards to ensure consistency of approach	IQPR Performance demonstrating improvement; i.e. number of CCSPs review undertaken	The impact of the national shortage of blood tubes in delaying monitoring presented a further complication to proactively manage patients with LTC (now rectified) Impact on the health and wellbeing of all staff across teams and recruitment plans at individual GP Practice level .	New - Open

2018	29/06/2022	Quality and People's Experience Committee Delivery Committee	Tackle inequalities in access, experience, outcome	15	(I3xL5)	12	(I3xL4)	Eddie Devine	Helen Lewis	There is a risk of harm to patients with mental health due to sustained increased demand outstripping capacity that supports a more responsive access to specialist mental health services, resulting in increased morbidity and widening of health inequalities.	Restoring Normative Function scoping proposal being taken forward by commissioners to respond to service gaps around MUS, Chronic fatigue and long COVID. Targeted increased investment into Leeds Mental Wellbeing Service in response to identified increased demand on IAPT referrals, and to bolster primary care mental health resources. Work completed with PCNs to progress plans for joint funded MH ARRS roles. Planned MH investment into early implementer PCN sites in developing new integrated models of care for MH. New commissioned crisis house provision in Leeds operational from August 2021 Increased funding into CYPED identified and communicated to providers. The service has now recruited to all vacant posts and are now undertaking the recruitment process to secure the additional posts. MUS regional service bid being taken forward by commissioners to seek regional funding solution. Secured national funding to extend our Mental Health Support Teams across primary and secondary schools. 6 new teams will be launched between Jan 22 and Jan 24.	Planned mental health investment into early implementer PCN sites for developing new integrated models of MH care (30/09/22) ARRS Roles (30/09/22) Expansion of crisis resources (30/09/22) Targeted investment into LMWS/IAPT to meet increasing demands (30/09/22) Establishing system Psychology sub-group to MH Board (30/09/22)	Waiting and access times to services monitored through KPIs Close monitoring of mental health demand through system calls. COVID demand modelling to forecast MH demand , at risk populations/ and demand impacts in particular settings to support effective planning	Paper to EMT Delivering Value - whilst pressures still remain- particularly access to IAPT step 3 (high intensity) waiting times - assurance in providing detail of progress made against the action plan to address this. Paper reported actions being taken forward following Leeds wider system wider multiagency review event of the needs of people on the current step 3 IAPT waiting list, that would likely benefit from alternative therapy interventions, and options for providing this- progress and impact on waiting times will be overseen by MH Care Delivery Board	IAPT recovery performance as of Q1 22/23 remains below target at 38.5% (target of 50%). This is impacted by increasing waiting times for high intensity intervention (CBT) at step 3- this is 13.5 months for the same reporting period.	New - Open
Risks Aligned to the Leeds Committee																
2013	29/06/2022	Leeds Committee of the WY ICB	Enhance productivity and value for money	12	(I3xL4)	6	(I2xL3)	James Hirst	Sabrina Armstrong	There is a risk of insufficient project and programme management resource due to the capacity and capabilities of staff trained and available to support new system wide initiatives resulting in late delivery of initiatives / reduced service quality.	Re-prioritisation of priorities each time a new request is made. Ongoing skills development work with staff within the PII BU.	Budget under spend used to support system wide priorities where a capability or capacity issue has been experienced (30/8/22) Recruitment in place for all gaps (30/9/22) Informal lunch and learn type training for members of the PII to support upskilling in Project disciplines (30/10/22) Head of PII building relationships with external agencies to understand market conditions and develop responsiveness in the event of external expertise being required (30/10/22) Deeper relations with the Health Care Partnership to agree the deployment of system resource to manage system priorities (30/10/22) Formal training through PRINCE 2 for member of the PII team who are not professionally accredited (30/10/22)	All leavers are interviewed to understand their reasons for leaving the BU.	All leavers have sought and secured a higher banding job aligned to their long term career goals.	A external factor is the level of market competition across the city of Leeds. We face competition across the city from other industry sectors who offer better packages for project and programme managers.	New - Open
2024	30/06/2022	Leeds Committee of the WY ICB	Improve healthcare outcomes for residents	9	(I3xL3)	1	(I1xL1)	Penny Mcsorley	Jo Harding	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.	Monthly meetings held with Health Case Management managers to monitor current position, plan LPS and maintain numbers. Monitored through the quarterly ICB Leeds safeguarding committee Prioritise cases based on complexity and risk of challenge Assessments completed in line with availability of court time to ensure they do not go out of date. MCA Lead is working in collaboration with 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 reviewing moved to Continuing Care Service to free up HCM capacity	Liberty Protection Safeguards legislation is being implemented in October 2020, there is a possibility this may be delayed to 2022. The ICB Leeds is preparing for the changes in responsibility and is awaiting the Code of Practice. (31/03/23) Development of Health Case Management Service and staff within Continuing Care to deliver LPS effectively.(31/03/23) Development of systems and processes within the Continuing Care Service to deliver LPS efficiently and minimise impact on ICB Leeds assessments (31/03/23).	LCH provide performance reports, highlighting current position. The ICB Leeds Mental Capacity Act Lead meets with LCH quality Leads and Beachcroft solicitors quarterly to track progress and unpick any delays or performance issues	tbc	tbc	New - Open
2025	30/06/2022	Leeds Committee of the WY ICB	Tackle inequalities in access, experience, outcome	9	(I3xL3)	1	(I1xL1)	Penny Mcsorley	Jo Harding	There is a risk that when the new Liberty Protection Safeguard (LPS) Framework is implemented possible by April 202 as per MCA Amendment Act 2019 there will not be the necessary resources and processes in place to fulfil the new ICB statutory responsibilities due to the delay in publication of the draft MCA Code of practice, its regulations and updated impact assessment by the DHSC primarily resulting in unlawful deprivations of liberty and breach of human rights for those who meet the criteria for deprivation of liberty and receive Continuing Health Care, resulting additionally in both financial and reputational damage to the ICB.	1. In anticipation of this significant change the MCA Lead has drafted and disseminated the Mental Capacity Act Policy which will inform staff of key Mica principles relevant to LPS 2. MCA Lead has reviewed current training material to embrace the principles highlighted in the LPS framework and has also commenced a programme of training which introduces LPS to ICB staff and the staff we have commissioned to LPS 3. NHSE are generating LPS training materials for all staff groups and for citizens which will be disseminated by the ICB once they are ready. We are still waiting for them at the moment, we will get some but more when final draft is completed 4. NHSE have confirmed the employment of LPS regional Leads to support the health fraternity with implementation of LPS. LPS regional lead in place 5. Scoping exercise to fully understand the Cases that will fall under the LPS framework has commenced and continues to be updated as data emerges from the key teams 6. A process mapping exercise to breakdown the process and inform resource planning was completed in 2021 and will inform resource planning 7. There is monthly ICB LPS implementation group which is overseen by Penny Mcsorley the Deputy director of Nursing and Quality. This group involves key stakeholders within the ICB Leeds and suggest plans to and action to prepare for LPS implementation. This continues to run monthly with clinical leads from CHC 8. There is a citywide LPS readiness group which also looks at key action plans and pushes the	We will continue to feedback to DHSC via NHSE and SANN the need to have the final code to be published and clarity on what constitutes a deprivation of liberty	1. The ICB and Leeds LPS readiness keep a log of minutes and action plans and these are pursued. 2. There is clear governance for the LPS project implementation within the ICB. 3. The MCA lead works collaboratively with the head of CHC and reports to the director of nursing and quality. 4. Commissioned services i.e. Local authority Learning disability team and the LCH case managers prepare quarterly reports that provide information on progress and highlight barriers that need actioning. 5. The CHC and MCA lead are working collaboratively with colleagues in HCM / LA to identify patients who meet the LPS criterion and to monitor progress with assessments that could be transferred to LPS 6. MCA Lead has created a project action	5. The CHC and MCA lead are working collaboratively with colleagues in HCM / LA to identify patients who meet the LPS criterion and to monitor progress with assessments that could be transferred to LPS	No Gaps	New - Open
2021	30/06/2022	Leeds Committee of the WY ICB	Enhance productivity and value for money	6	(I3xL2)	6	(I3xL2)	Sam Ramsey	Sabrina Armstrong	There is a risk of conflicts of interests in decision making due to insufficient and/or ineffective controls, resulting in decisions being challenged/overturned and reputational damage to the WY ICB at Leeds.	Declarations of interest and potential conflicts of interest policy has been updated to a single West Yorkshire Conflicts of Interest Policy in line with national guidance and is reviewed on an annual basis. Register of interests in place for members of the Leeds Committee of the ICB, sub-committee members, member practices, and staff and is updated regularly and published on the website. Declarations of interest is a standing item at Leeds Committee of the ICB and sub-committee meetings, and individuals are excluded from discussions if appropriate. The Head of Corporate Governance remains up to date on guidance and appropriate training relating to conflicts of interest Single West Yorkshire Standards of Business Conduct Policy to be disseminated in place which iterates the need to be aware of and declare conflicts and potential conflicts Mandatory training on conflicts of interest is undertaken by all staff	Conflicts of Interest working group to continue to develop arrangements post 1st July 2022.	Internal auditors have reviewed previous CCG arrangements and have provided a rating of high assurance. Leeds Committee of the ICB and sub-committee meeting minutes to demonstrate how conflicts have been addressed	Rating of High assurance on the operation of arrangements to manage conflicts of interest at the CCG, arrangements going forward into the ICB will be based on this.	tbc	New - Open

Meeting name:	Leeds Committee of the West Yorkshire Integrated Care Board
Agenda item no.	LC 30/22
Meeting date:	22 September 2022
Report title:	Primary Care Network Directed Enhanced Service Enhanced Access Arrangements from 1 October 2022
Report presented by:	Gaynor Connor, Director of Primary Care and Same Day Response, ICB in Leeds
Report approved by:	Gaynor Connor, Director of Primary Care and Same Day Response, ICB in Leeds
Report prepared by:	Kirsty Turner, Associate Director Primary Care, ICB in Leeds Vicky Annakin, Senior Primary Care Manager, ICB in Leeds Jane Sadler, Head of Operations, Leeds GP Confederation

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

Previous considerations:

Initial consideration at the Primary Care Board on 4 August 2022.
Final report and recommendation for approval agreed at Primary Care Board on 1 September 2022.

Executive summary and points for discussion:

Currently, extended access services are delivered at evenings and weekends via an APMS Contract with the Leeds GP Confederation. As part of the contract negotiations for 2022/23 the national GP Contract transferred responsibility for delivering evening and weekend appointments to Primary Care Networks (PCNs) with effect from 1 October 2022.

This paper will set out the contractual requirements and provide assurance of the Leeds place adherence to the contract including any impact on the wider health and care system.

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 Enhanced Access plans for Leeds place; and
2.	**NOTE** the minimal impact on the wider health and care service

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.	Themes from patient insight

Acronyms and Abbreviations explained	
1.	PCNs – Primary Care Networks
2.	EA – Enhanced Access
3.	DES – Directed Enhanced Services
4.	CPWY – Community Pharmacy West Yorkshire

What are the implications for?

Residents and Communities	Improved access to communities with a review of communications to ensure clarity of offer
Quality and Safety	Continued access to quality services with appropriate clinical governance
Equality, Diversity and Inclusion	Patient engagement to target specific populations to look at access issues.
Finances and Use of Resources	Utilises existing resources. Improved review of value for money. Risk identified for recurrent revenue for Same Day Response service.
Regulation and Legal Requirements	None identified
Conflicts of Interest	None identified
Data Protection	None identified
Transformation and Innovation	Improved skill mix and continued commitment to look at innovative models
Environmental and Climate Change	None identified (some improved local access which will prevent need for travel across Leeds)
Future Decisions and Policy Making	None identified
Citizen and Stakeholder Engagement	Further patient engagement planned

1. Background

1.1 Access to GP services continues to be a specific focus for the Leeds Health and Care System, with a programme of work established as part of the Same Day Response Care Delivery Board.

1.2 There are on average over 18,500 appointments delivered each day in Leeds by our 92 individual GP practices and during July 2022, 71% of all appointments were face to face.

1.3 In March 2022 NHS England and Improvement announced a number of amendments to the GP Contract which included some specific changes with regard to the provision of access to services outside of core hours.

1.4 In summary, the new arrangements brought together two existing funding streams which support extended access, outlined as follows:

1.4.1 £1.44 per head from the Network Contract DES extended hours funding
1.4.2 £6 per head CCG-commissioned extended access services

1.5 The intention is to reduce variability across the Country so that there is a national consistent offer and therefore improve patient understanding of the services.

1.6 The new arrangements would make it a contractual requirement for Primary Care Networks (PCNs) to deliver the new service.

1.7 Currently, access to primary medical services (outside of core hours) is provided by:

1.7.1 Leeds GP Confederation – provide arrangements for accessing evening and weekend appointments 365 days per year via a (time limited) APMS contract
1.7.2 Leeds GP Confederation – provide additional access to 'Same Day' appointments as part of non-recurrent funding
1.7.3 Local Care Direct – out of hours general practice services (for issues which cannot wait until the practice is open)
1.7.4 One Medical Ltd – Shakespeare Walk-in-Centre provides a walk in service for the Leeds population at Burmantofts Health Centre
1.7.5 A number of practices provide 'extended hours' to their population as part of the current DES arrangements (some practices sub-contract this to the Leeds GP Confederation)

2. Current Provision

2.1 Leeds was one of the early adopters of extended access arrangements with West Leeds CCG successful as part of the Prime Ministers Challenge Fund.

2.2 All CCGs were required to provide extended access to general practice for their whole population by 1 October 2018. This included ensuring access during peak

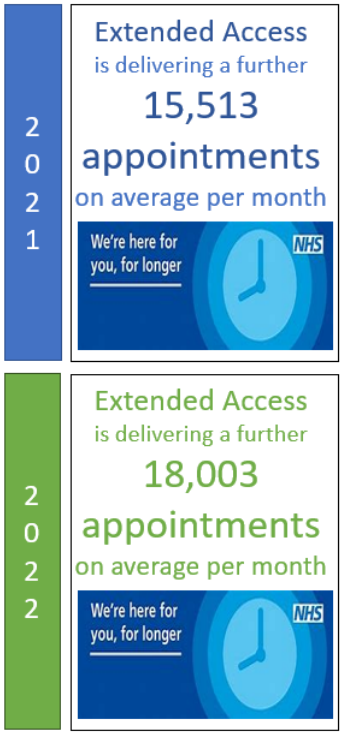
times of demand, including bank holidays and across the Easter, Christmas and New Year periods.

2.3 Services were commissioned to meet seven national criteria which included:

a) weekday provision of access to pre-bookable and same day appointments to general practice services in evenings (after 6:30pm)
b) weekend provision of access to pre-bookable and same day appointments on both Saturdays and Sundays to meet local population needs
c) a minimum additional 30 minutes consultation capacity per 1000 population, rising to 45 minutes per 1000 population
d) the requirement to advertise and promote ease of access
e) Use of digital approaches to support new models of care in general practice.
f) issues of inequalities in patients' experience of accessing general practice identified by local evidence and actions to resolve in place
g) Effective connection to other system services enabling patients to receive the right care from the right professional, including access from and to other primary care and general practice services such as urgent care services

2.4 The extended access service has continued to develop over the years and as a primary care service we have been keen to ensure that the wider connection with urgent care services is made. The Leeds GP Confederation have been successful in recent years in developing integrated arrangements with other services such as 111 and out of hours to manage peak demand.

2.5 The current extended access services provides on average 18,000 appointments per month. The service is delivered from 20 locations and includes a provision of a virtual pharmacy, healthy minds and physiotherapy service.



2.6 As part of the winter access fund arrangements for last year, the Leeds GP Confederation developed a Same Day Response service to provide additional capacity on the day, reflecting the increase in demand. This service has become an essential part of GP resilience and whilst non-recurrent funding has been identified to support this service during 22/23, longer term funding to support this service will need to be identified.

2.7 The Same Day Response service provides access to GP and ACP appointments which are either virtual or face to face at two locations across the City, dependent on patient need. The service delivers on average 2,000 appointments per month.

3. New PCN Enhanced Access Requirements

3.1 The new arrangement comes into effect from 1 October 2022 and a detailed specification setting out the core requirements for the service has been made available.

3.2 Key components of the specification can be identified as:

a) 6.30pm and 8pm Mondays to Fridays and between 9am and 5pm on Saturdays (network standard hours)
b) A minimum of 60 minutes of appointments per 1,000 PCN adjusted populations per week
c) GP cover during the network standard hours
d) Appointments must be bookable in advance and same day
e) Must deliver a mixture of in person face to face and remote
f) PCNs must deliver general practice services, including appointments for planned care like screening, vaccinations (including COVID-19 vaccinations and boosters) and immunisations, health checks and PCN services

g) Appointments must be delivered by a multi-disciplinary team of healthcare professionals
h) Must make available to NHS 111 any unused on the day slots during the Network Standard Hours
i) PCNs must actively communicate availability of enhanced access appointments to patients
j) Sites at which face-to-face services are to be provided must be at locations convenient to access for patients

3.3 Full details of the specification can be found at NHS England Report Template 7 - no photo on cover

3.4 PCNs were required to submit a plan to the commissioner by 31st July 2022. The plan set out how the PCN plans to deliver the service including:

- How the PCN will engage or has engaged with its patient population and will or has considered patient preferences, including considerations of capacity and demand.
- The mix of services that will be provided during the Enhanced Access period.
- The appointment types and channels that will be available to patients, including how the PCN will meet the requirement to ensure that a reasonable number of in-person face to face consultations are available.
- The proposed site location(s) for patients to access face-to-face appointments
- Any planned sub-contracting arrangements

4. Arrangements in Leeds

4.1 Improving access to primary care is a key workstream for the primary care team in Leeds. A dedicated group (under the governance of the Same Day Response Care Delivery Board) has been established and enhanced access is one aspect of that workstream.

4.2 Early discussions indicated that the majority of PCNs would be sub-contracting the provision to the Leeds GP Confederation. Sub-contracting arrangements are permitted, and this was widely recognised as a positive step in maintaining consistency of approach across Leeds place, whilst also ensuring a population focus with PCNs actively involved in the development of plans and services as part of the offer, which reflects the model already adopted in Leeds.

4.3 All plans were submitted to the ICB in Leeds by the deadline of 31 July 2022.

4.4 An initial review of the plan against the core requirements was undertaken by a focussed group. An overview of the arrangements compared with the requirements can be found below:

Meets full compliance of the DES requirements A PCN must provide bookable clinical appointments during the Network Standard Hours that satisfy all of the requirements set out below:	**Assured.** We are assured on the overall requirements.

a. are available to all PCN Patients; b. are for any general practice services and services pursuant to the Network Contract DES that are provided to patients; c. are for bookable appointments, that may be made in advance or on the same day, by the PCN's Core Network Practices, regardless of the access route via which patients contact their practice, and the PCN must: i. make the appointments available a minimum of two weeks in advance, with the PCN's Core Network Practices utilising appropriate triage and/or navigation as required to book and/or offer patients available appointments; ii. make the Network Standard Hours appointment book accessible to the Core Network Practices to enable efficient patient bookings into slots following patient contact; iii. make same day online booking for available routine appointments where no triage is required up until as close to the slot time as possible; iv. operate a system of enhanced access appointment reminders; v. provide patients with a simple way of cancelling enhanced access appointments at all times; vi. in line with published guidance, make available to NHS111 any unused on the day slots during the Network Standard Hours from 6.30pm on weekday evenings and between 9am-5pm on Saturdays, unless it is agreed with the commissioner that the timing for when these unused slots are made available is outside of these hours; and vii. have in place appropriate data sharing and, where required data processing arrangements to support the delivery of Enhanced Access between the PCN's Core Network Practices and where applicable a sub-contractor. d. are delivered by a multi-disciplinary team of healthcare professionals employed or engaged by the PCN's Core Network Practices, including GPs, nurses and Additional Roles and other persons employed or engaged by the PCN to assist the healthcare professional in the provision of health services; e. are within Network Standard Hours: i. a mixture of in person face to face and remote (telephone, video or online) appointments, provided that the PCN ensures a reasonable number of appointments are available for in person face-to-face consultations to meet the needs of their patient population, ensuring that the mixture of appointments	A number of individual discussions have been needed to obtain clarity on some plans but a summary of arrangements includes: All models deliver a minimum of 60 minutes per 1000 patients across M-Sat. There is additional provision on a Sunday within all PCN's and in some cases early morning to deliver above the required minutes. Also in some PCN's there is some 'in hours' provision of additional services such as Healthy Minds. These are included in hours as there is data that shows this is the time patients access these services. A proportion of appointments (circa 80%) are available to book in advance. There are also same day appointments available to book All plans are delivered by a range of professionals (some individuals plans require further discussion). Hub locations are at 21 different venues across the City including increasing physical location in Wetherby.

seeks to minimises inequalities in access across the patient population; ii. in locations that are convenient for the PCN's patients to access in person face-to-face services; iii. ensuring that the premises from which Enhanced Access is delivered is as a minimum equivalent to the number of sites within the PCN's geographical area from which the CCG Extended Access Service was delivered; f. are providing a minimum of 60 minutes of appointments per 1,000 PCN adjusted patients per week during the Network Standard Hours, g. not restrict access to Enhanced Access for any patients of the PCN's Core Network Practices whose primary medical services contracts require appointments to be provided during the Network Standard Hours.	
Ensured no pause in Extended Access and Enhanced access. Confirmation that all PCNs have planned for service commencement from 1st October with no pause in Service.	**Assured** No pause in service.
Clear transitional arrangements in place between current and future service model providers	**Assured** Clear transitional arrangements in place.
Overall PCN plans reflect a range of service and workforce models considered best for the patient population needs, balancing both urgent and planned care access	**Assured** Clear balance of pro-active care in some areas to support with specific population needs.
Place has assessed any potential disruption and impact on wider services such as UEC, (i.e. no longer delivering Sunday service) along with mitigating actions if possible and shared this at place and system level.	**Assured** Discussed at 24/7 Integrated Primary Care support to continue Sunday arrangements given potential reduction would have on the wider system.
Places have agreed local approach where issues with IT interoperability	**Assured Locally –** Regional/National conversations taking place to address some elements of the spec in relation to IT interoperability
PCN plans will be approved based on PCN assurance of their review of local appointment data and other intelligence such as, how and where patients usually access services which will inform their local service model and location which will determine a	**Partial Assurance** Further review of plans to be undertaken on this specific point. Patient

proportionate level of local engagement with patients and key stakeholders. This should as a minimum include local engagement with CP colleagues on service delivery times and Healthwatch	engagement to be undertaken to inform service developments. To meet with Healthwatch (Healthwatch now part of 24/7 group). Discuss with CPWY.
Worked with ICB and ensured a consistent/cohesive approach at place and system level to avoid confusion for the patient regarding the appropriate service offer. Confirm that each practice within PCN has appropriately advertised EA and how patients can access services	**Assured (plan in place)** Refresh standard website information once models go 'live'
Confirmed level of f2f appointments v digital is based on clear rationale, for example the review of data and population health needs and does not inadvertently result in widening of health inequalities or negatively impact on patient access. In addition appointments reflect a reasonable level of variation such as a proportionate number of apps for immunisation, screening and GP routine.	**Partial Assurance** Utilising patient surveys to demonstrate ratio of appointments. Reviewing data on utilisation. DNA rate low for virtual appointments.
Wherever possible, and supported by patient need, developed services that go beyond minimum Network contract DES requirements within the funding envelope	**Assured** Majority of PCNs are delivering in excess of the minimum standards (from a minutes point of view)
Undertaken an appropriate level of due diligence ensuring the best possible service for patients and best value for the public purse	**Assured**
Considered any TUPE implications	**Assured**

4.5 Where partial assurance is identified, this is where further work is planned. Specifically, with regard to patient engagement where meaningful engagement has not been able to happen prior to the submission of the plans and therefore this will be undertaken following 'launch' as part of the ongoing review of plans and improvements of the service. An insight report has been shared with PCNs which summarises existing feedback from patients on themes relating to access, a copy of those themes can be found at Appendix A.

4.6 We are assured the current level of activity will be maintained, if not improved with more local services available.

5. ICB Collaborative Approach and common principles

5.1 As a newly formed ICB, representatives from each of the five West Yorkshire places have been coming together to agree a consistent approach to EA transition and share examples of good practice.

5.2 As part of working consistently in West Yorkshire, each place has been asked to check that core components and risks have been considered and a consistent sign off through place committees.

6. Risks

6.1 The key risk emerging from the arrangements was the provision of Sunday appointments. This has been historically provided in Leeds and reducing that amount of activity would add further pressure to the Leeds system. As a City, we have been able to continue to secure this provision but longer-term funding to maintain this will need to be factored into budget planning for 23/24.

6.2 Additionally, as previously mentioned the Same Day Response service is currently funded non-recurrently from funding that is outside the scope of the Enhanced Access arrangements. This service has become integral to supporting the resilience of general practice and therefore the longer-term funding of this service is a risk.

7. Next Steps

7.1 Following approval at the Committee of the ICB in Leeds, the PCN plans will be mobilised. We are assured that all plans will be 'live' from 1 October 2022.

7.2 A key action is to develop standardised wording to ensure the consistent offer across PCNs, ensuring that it is clear for patients how services are accessed.

7.3 A review of the Directory of Service will be undertaken to ensure the integration with other services continues i.e. patients able to be booked into appointments if they call 111.

7.4 We will ensure that appropriate contract arrangements are put in place with regular reviews and a continuous improvement cycle.

8. Recommendations

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

a) **Approve** the Enhanced Access plans for Leeds place; and
b) **Note** the minimal impact on the wider health and care service

Appendix 1

Themes from patient insight

Theme (reoccurring issues throughout the insight)	**Description** (what is this theme about?)	**Summary** (summary of feedback)	**Feedback** (what people have told us in the past or recently)

Booking an appointment	Actual or perceived difficulties booking an appointment with a healthcare professional	Many people find it hard to book an appointment with their GP	• Significant numbers of people report difficulty making an appointment at their GP practice.
			• However, 71% of people in the National GP survey in Leeds report that their experience of booking an appointment is 'good'
			• People who struggle to make an appointment tell that this is because:
			  ○ They have to wait a long time on hold
			  ○ They are cut off after a period of time
			  ○ Appointments are not available when they get through
			  ○ There are not any or enough online appointments available
			• Over a third of people who call the practice want an appointment on the same day
			• A third of people who called the practice did not get an appointment on the day they wanted

Use of technology	The use of technology (including telephone) to make or hold an appointment	People have different preferences regarding digital and non-digital access	• Some people want to make an appointment online but report that these are often not available • Many people value being able to access appointments by telephone or online as this is convenient to them • Some people are not confident that a diagnosis can be made over the phone or online • Some people prefer face-to-face appointments perhaps because this is historically how services were offered and because they are more comfortable with this approach • People who need interpreting services find appointments difficulty when the interpreter is on the phone.

Joint working	Health and care services working together	People want to see health and care services working better together	• Some people report that services often don't appear to work together, and they are passed between different services such as primary care, hospitals and 111.
			• Some people were concerned that joint working might have a negative impact on consistency of care, because patients end up seeing different clinicians.
			• Many people presenting in emergency departments report trying to access primary care services first. People said that:
			  ○ there were not appointments left that day,
			  ○ that they could not get through on the phone
			  ○ that they simply assumed the service would be closed
			  ○ that they assume the service would be too busy to see them
			• People are more likely to travel to an appointment if they are seen sooner

Inequalities	Health inequalities due to differences	Some communities face specific barriers to	• Some people from some communities prefer face-to-face appointments. This is particularly the case for people who are deaf or hard of hearing and people whose first language is not English

	in demographics	accessing services	• Some people report that they are not confident that all primary care professionals understand the diverse needs of local communities, in particular the accessible information standard • The experience of people who are deaf or hard of hearing was worse than that of the general population • People from deprived backgrounds, non-English speakers and those with learning disabilities were amongst the groups who said that available health information was difficult to understand and did not help them make the right choices. • People with hearing and sight difficulties want to be offered a choice between digital and face-to-face appointments • People whose first language is not English want information in a range of languages and formats • Some staff feel that they are seeing fewer older people in clinic since the start of the pandemic • Staff report concerns that people who are less likely to use digital technology are less likely to make an appointment • Parking close to the practice, reliable and frequent public transport and opening times outside traditional working hours are particularly important to people with disabilities. • For people with long term conditions, continuity of care and seeing the same professional is particularly important.

Health information	Information provided to patients about services and health advice	People want better information about health service in a range of formats, that helps them make decisions about their care	• Some people report confusion about which service is most suitable for them
			• Some people report that they are unsure what times and where services are available. This can be particularly confusing when different GP practices offer different services at different times.
			• A third of people who used the GP practice website said this was not easy to use to find the information they wanted.
			• Many people see their GP as a trusted source of information
			• Some people want better quality information about mental health services from their GP
			• People felt that much of the health information they received from their GP was too complicated and difficult to understand. They told us that information should:
			  ○ Have simple messages with images and limited text
			  ○ Be in video format with voice overs and subtitles.
			  ○ be delivered verbally
			  ○ be translated into community languages
			  ○ be delivered consistently and across multiple channels
			  ○ use Whatsapp
			• Many people felt that using personal stories and case studies is a helpful way of helping people understand how to use health and care services. Personal stories elicit more empathy and understanding that pure statistics.

Care navigation	Practice based staff who triage patients and help direct them to the right healthcare professional	Many people are not confident in this approach	• Many people are generally supportive of a triage system that helps them see the right person at the right time • Some people are not confident in the care navigation system and are reluctant to share personal information with 'receptionists'.
Workforce	The range of professionals who provide primary care and their skills and competences	People value a range of professionals but need more information about the wider team	• People report that they are generally satisfied with the care they receive from primary care. • Some staff feel that significant numbers of people they see in clinic could have self-cared • Friend reception staff was seen as very important to most people • Most staff report a significant increase in work pressure • Many staff report an increase in abuse from patients • People from communities that have communication challenges report that staff need a better awareness of people's differing needs and a more patient approach.
Travel and transport	The ways people travel to their appointment	People value parking close to the practice and regular and reliable public transport. People will travel further if they understand how this will improve their care.	• Some people had concerns that joint working sometimes meant that they have to travel to a location further away. • Parking close to the practice was seen as important to most people • People are more likely to travel to an appointment if they can be seen sooner • People are more likely to travel to an appointment if they know they are being seen by the right professional • Regular and reliable public transport is seen by many people as important when accessing primary care services
Waiting times	The time people wait get an appointment (not the time waiting in clinic)	Being seen quickly is important to most people	• Many people feel that low waiting times for primary care services is very important • Some staff feel that patients are more reluctant to wait for an appointment and are keen to be seen the same day
Opening times	The times of the day and days of the week services are open	People support longer opening times but need better information about when their practice is open	• Most people are keen to have access to services outside of traditional working hours • Longer opening times are important to people with disabilities • People often don't know when their GP is open

LEEDS COMMITTEE OF THE WEST YORKSHIRE INTEGRATED CARE BOARD WORK PROGRAMME 2022-23

ITEM	Sept 22	Dec 22	Mar 23	Lead
STANDING ITEMS				
Welcome & Introductions	X	X	X	Chair
Apologies & Declarations of Interest	X	X	X	Chair
Minutes of previous meeting	X	X	X	Chair
Matters Arising	X	X	X	Chair
Action Tracker	X	X	X	Chair
Questions from Members of the Public	X	X	X	Chair
Summary & Reflections	X	X	X	Chair
People's Voice	X	X	X	
Place Lead Update	X	X	X	TR
Forward Work Plan	X	X	X	Chair
Items for the Attention of the ICB	X	X	X	Chair
GOVERNANCE ITEMS				
Sub-Committee Assurance Reports	X	X	X	Relevant Chairs
Committee Effectiveness			X	Chair
Risk Management Report	X	X	X	TR
ITEMS FOR DECISION				
Clinical Leadership Arrangements		X		JB/SF
Leeds City Digital Strategy		X		LT
Primary Care – Enhanced Access Service	X			GC
Medium Term Financial Plan	X			VPS
Community Diagnostics Centre Business Case		X		VPS
Joint Working Arrangements		X		TR
Primary Care Priorities		X		GC
Practice Proposal		X		GC
Operational Plan Update			X	VPS
Health and Wellbeing Strategy Refresh			X	MK/TC
ITEMS FOR 2023/34	May 23			
Terms of Reference	X			