Leeds Health & Care Partnership

NHS West Yorkshire Integrated Care Board

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

Tuesday 13th December 2022, 13:15 – 16:30
(Private pre-meet for members 13:00, public meeting 13:15)
Thackray Museum of Medicine, Beckett Street, Leeds LS9 7LN

AGENDA

No.	Item	Lead	Page	Time
LC 38/22	**Welcome, Introductions**	**Rebecca Charlwood** Independent Chair	-	13:15
LC 39/22	**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	4	
LC 40/22	**Minutes of the Previous Meeting** - To approve the minutes of the meeting held 22nd September 2022	**Rebecca Charlwood** Independent Chair	7	
LC 41/22	**Matters Arising** - To consider any outstanding matter arising from the minutes that is not covered elsewhere on the agenda	**Rebecca Charlwood** Independent Chair	-	
LC 42/22	**Action Tracker** - To receive the action tracker for review	**Rebecca Charlwood** Independent Chair	16	
LC 43/22	**People's Voice** - To share a lived experience of health and care services	**Hannah Davies** Chief Executive of Healthwatch Leeds	-	13:20
LC 44/22	**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	-	13:35
LC 45/22	**Place Lead Update** - To receive a report from the Place Lead	**Tim Ryley** Place Lead	18	13:45
ROUTINE REPORTS				
LC 46/22	**Quality & People's Experience Sub-Committee Update** - To receive an assurance report from the Chair of the sub-committee	**Rebecca Charlwood** Independent Chair & Chair of the Quality and People's Experience Sub-Committee	25	14:00
LC 47/22	**Delivery Sub-Committee Update** - To receive an assurance report from the Chair of the sub-committee	**Yasmin Khan** Independent Member & Chair of Delivery Sub-Committee	27	
LC 48/22	**Finance & Best Value Sub-Committee Update** - To receive an assurance report from the Chair of the sub-committee	**Cheryl Hobson** Independent Member & Chair of Finance & Best Value Sub-Committee	30	

No.	Item	Lead	Page	Time
LC 49/22	**Risk Management Report** - To receive and consider the risk management information provided	**Tim Ryley** Place Lead	32	14:15
FINANCE				
LC 50/22	**Finance Update at Month 7 (October) 2022-23** - To receive an update on the financial position update	**Visseh Pejhan-Sykes** Place Finance Lead	49	14:30
BREAK 14:45 – 14:55				
ITEMS FOR DECISION/ASSURANCE/STRATEGIC UPDATES				
LC 51/22	**Winter Plan 2022/23** - To receive a progress update on the Winter Plan for 2022/23	**Helen Lewis** Director of Pathway Integration	58	14:55
LC 52/22	**Refresh of the West Yorkshire Partnership's Five-Year Strategy - Working Draft** - To consider and provide feedback on the current draft of the strategy	**Jenny Cooke** Director of Population Health Planning	68	15:05
LC 53/22	**Leeds City Digital Strategy** - To receive and approve the strategy and publication	**Leonardo Tantari** Chief Digital and Information Officer	126	15:20
LC 54/22	**Clinical & Professional Leadership in the Leeds Health & Care Partnership** - To receive and comment on proposals for clinical leadership arrangements	**Dr Jason Broch** Chief Strategic Clinical Information and Innovation Officer	170	15:40
LC 55/22	**Practice Proposal: The Merger of Sunfield and Hillfoot Practices and subsequent closure of Sunfield Medical Centre** - To approve the merger and closure of practices	**Gaynor Connor** Director of Primary Care and Same Day Response	179	15:50
LC 56/22	**Leeds Joint Working Agreement (JWA) with Astra Zeneca for Improving Asthma Outcomes** - To agree the proposed Joint Working Agreement between the West Yorkshire ICB (Leeds Office) and Astra Zeneca	**Helen Lewis** Director of Pathway Integration	189	16:00
FORWARD PLANNING				
LC 57/22	**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	-	16:05
LC 58/22	**Forward Work Plan** - To consider the forward work plan	**Rebecca Charlwood** Independent Chair	198	
LC 59/22	**Any Other Business** - To discuss any other business raised and not on the agenda	**Rebecca Charlwood** Independent Chair	-	

No.	Item	Lead	Page	Time
LC 60/22	**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 14 March 2023, at HEART Headingley.	**Rebecca Charlwood** Independent Chair	-	-

The Board is recommended to make the following resolution:

"That the press and public be excluded from the meeting during the consideration of the remaining items of business as they contain confidential information as set out in the criteria published on the ICB's website (Freedom of Information Act 2000, Section 43.2) and the public interest in maintaining the confidentiality outweighs the public interest in disclosing the information."

No.	Item	Lead	Page	Time
LC 61/22	**Financial Planning for Improved Value in 2023/24** - To receive the report and agree the recommendations **Exempt under the provisions of the Freedom of Information Act 2000 (Section 43.2)**	**Jenny Cooke** Director of Population Health Planning	199	16:10

Leeds Committee of the West Yorkshire Integrated Care Board - Register of Interests, December 2022

Title	Name	Job Title (where applicable)	Declared Interest- (Name of the organisation and nature of business)	Type of Interest	Is the interest direct or indirect?	Interest From	Interest Until	Action Taken to Mitigate Risk
	Cath Roff	Director of Adults & Health, Leeds City Council	Director of Adults & Health, Leeds City Council	Financial Interests	Direct	01/04/2015	Ongoing	To declare at relevant meetings where appropriate.
	Cheryl Hobson	Independent member of the Leeds Committee of the WY ICB	Member of Joint Independent Audit Committee of South Yorkshire Police and Crime Commissioners Office	Financial Interests	Direct	01/12/2019	Ongoing	Declare any relevant potential or perceived interest at relevant meeting
			Nursing and Midwifery Council contracted as Lay Panel Member for Investigation Committee	Financial Interests	Direct	01/08/2021	Ongoing	Declare any relevant potential or perceived interest at relevant meeting
			Health Financial Managers Association (HFMA) Contracted as tutor on Level 7 NAPC diploma Finance module	Financial Interests	Direct	01/02/2019	31/10/2022	Declare any relevant potential or perceived interest at relevant meeting
			Wellspring Multi-Academy Trust Voluntary Trustee / Director and Vice-chair	Non-Financial Professional Interests	Direct	01/09/2015	Ongoing	Declare any relevant potential or perceived interest at relevant meeting
			Family member employed by PCN in Rotherham, south Yorkshire	Indirect Interests	Indirect	01/01/2019	Ongoing	Declare any relevant potential or perceived interest at relevant meeting
			Family member employed by Bradford Teaching Hospitals NHS FT	Indirect Interests	Indirect	01/01/2020	Ongoing	Declare any relevant potential or perceived interest at relevant meeting
Dr	Chris Mills	Chair, Leeds General Practice Confederation	GP Partner Aire Valley Surgery Leeds	Financial Interests	Direct	01/02/2006	Ongoing	Declare any potential or perceived conflict of interest at relevant meetings/workshops.
			Clinical Lead for ICB in Leeds (Leeds CCG)	Financial Interests	Direct	01/04/2013	Ongoing	Declare any potential or perceived conflict of interest at relevant meetings/workshops.
			Chair Leeds GP Confed	Financial Interests	Direct	01/01/2018	Ongoing	Declare any potential or perceived conflict of interest at relevant meetings/workshops.
			Wife is a GP Partner at Rockwell & Wrote Practice in Bradford	Indirect Interests	Indirect	01/01/2016	Ongoing	Declare any potential or perceived conflict of interest at relevant meetings/workshops.
Dr	Jason Broch	Chief Strategic Clinical Information & Innovation Officer, Leeds Office of the WYICB	Partner at Oakwood Lane Medical Practice	Financial Interests	Direct	01/01/2006	Ongoing	Declare any potential or perceived conflict of interest at relevant meetings/workshops.
			Director Jemjo Healthcare Ltd	Financial Interests	Direct	01/05/2022	Ongoing	Declare any potential or perceived conflict of interest at relevant meetings/workshops.
			Spouse business - Airtight International Ltd, Nails 17 Ltd	Indirect Interests	Indirect	10/05/2012	Ongoing	Declare any potential or perceived conflict of interest at relevant meetings/workshops.
			Director Governor, Leeds Jewish Free School	Non-Financial Personal Interests	Direct	16/01/2014	Ongoing	Declare any potential or perceived conflict of interest at relevant meetings/workshops.
			Chair of Governor's Brodetsky Primary School	Non-Financial Personal Interests	Direct	01/09/2012	Ongoing	Declare any potential or perceived conflict of interest at relevant meetings/workshops.

			Director, trustee Brodetsky Foundation Trust	Non-Financial Personal Interests	Direct	17/06/2014	Ongoing	Declare any potential or perceived conflict of interest at relevant meetings/workshops.
			Founding Fellow of the Faculty of Clinical Informatics	Non-Financial Professional Interests	Direct	01/05/2018	Ongoing	Declare any potential or perceived conflict of interest at relevant meetings/workshops.
			Calibre Care Partners Ltd OLMP is a member of this GP federation, which is part of Leeds GP Confederation	Financial Interests	Direct	01/06/2018	Ongoing	Declare any potential or perceived conflict of interest at relevant meetings/workshops.
			Gartner UK – Clinical Advisor	Financial Interests	Direct	01/06/2018	31/05/2020	Declare any potential or perceived conflict of interest at relevant meetings/workshops.
			Shareholder / Director Chapeloak Services Ltd	Financial Interests	Direct	01/01/2019	22/02/2022	Declare any potential or perceived conflict of interest at relevant meetings/workshops.
			Leeds Acupuncture Clinic - father's and brother's business	Indirect Interests	Indirect	10/05/2012	Ongoing	Declare any potential or perceived conflict of interest at relevant meetings/workshops.
			Clinical Lead - Yorkshire & Humber Local Health & Care record Exemplar, inc membership of NHSE Clinical Advisory Group	Financial Interests	Direct	01/11/2018	Ongoing	Declare any potential or perceived conflict of interest at relevant meetings/workshops.
	Joanne Harding	Director of Nursing and Quality, Leeds Office of the WYICB	My cousin's wife is a financial accountant with LTHT	Indirect Interests	Indirect	10/08/2022	Ongoing	Declare any potential or perceived conflict of interest at relevant meetings/workshops.
Dr	John Beal	Chair, Healthwatch Leeds	Board member (currently Chair) of Healthwatch Leeds	Non-Financial Professional Interests	Direct	01/01/2013	Ongoing	Declare any potential or perceived conflict of interest at relevant meetings/workshops.
			Member of Yorkshire Branch Council and West Yorkshire Committee of British Dental Association	Non-Financial Professional Interests	Direct	01/01/1990	Ongoing	Declare any potential or perceived conflict of interest at relevant meetings/workshops.
			Vice Chair of British Fluoridation Society	Non-Financial Professional Interests	Direct	01/01/1983	Ongoing	Declare any potential or perceived conflict of interest at relevant meetings/workshops.
			Family Member is a clinician in Leeds Community Health NHS Trust	Indirect Interests	Indirect	01/01/2008	Ongoing	Declare any potential or perceived conflict of interest at relevant meetings/workshops.
Sir	Julian Hartley	CEO, Leeds Teaching Hospitals Trust	Non-Executive Director DHSC	Non-Financial Professional Interests	Direct	01/10/2021	Ongoing	Declare any potential or perceived conflict of interest at relevant meetings/workshops.
	Rebecca Charlwood	Independent Chair, Leeds Committee of the WY ICB	Nil Declaration					
Dr	Sara Munro	CEO Leeds and York Partnership NHS Foundation Trust	CEO of LYPFT who will be impacted by decisions made by the Leeds Committee both financial and non financial	Financial Interests	Direct	01/07/2022	Ongoing	Declare any potential or perceived conflict of interest at relevant meetings/workshops.
			Sector representative for MHLDA on the ICB Board	Financial Interests	Direct	01/07/2022	Ongoing	Declare any potential or perceived conflict of interest at relevant meetings/workshops.
			Trustee on the board of the workforce development trust	Indirect Interests	Indirect	01/07/2022	Ongoing	Declare any potential or perceived conflict of interest at relevant meetings/workshops.

Dr	Sarah Forbes	Medical Director, Leeds Office of the WYICB	Calibre Care Partners Ltd OLMP is a member of this GP federation, which is part of Leeds GP Confederation	Financial Interests	Direct	01/06/2018	Ongoing	Declare any potential or perceived conflict of interest at relevant meetings/workshops.
			Honorary contract with LTHT NHS Trust	Non-Financial Professional Interests	Direct	01/01/2021	Ongoing	Declare any potential or perceived conflict of interest at relevant meetings/workshops.
			GP Partner, Oakwood Lane Medical Practice	Financial Interests	Direct	01/01/2014	Ongoing	Declare any potential or perceived conflict of interest at relevant meetings/workshops.
			Husband – Director, Craggs Shoe Repairs – has some contracts with fire and ambulance services	Indirect Interests	Indirect	01/01/2003	Ongoing	Declare any potential or perceived conflict of interest at relevant meetings/workshops.
			Aunt – financial interest in SPARC which is an autism assessment service in Birmingham. Autism West Midlands – Trustee. Autism Education Trust – Board Member	Indirect Interests	Indirect	01/01/2014	Ongoing	Declare any potential or perceived conflict of interest at relevant meetings/workshops.
			Director, Craggs Wetherby Limited – this is a shoe repair shop in Wetherby	Financial Interests	Direct	01/11/2018	Ongoing	Declare any potential or perceived conflict of interest at relevant meetings/workshops.
	Shanaz Gul	Third Sector Representative	Director of Hamara, seeks to do business re Health and Social Care	Financial Interests	Direct	01/01/2019	Ongoing	Declare any potential or perceived conflict of interest at relevant meetings/workshops
			Voluntary Rep for Forum Central and Third Sector Leeds Leadership group	Non-Financial Professional Interests	Direct	01/11/2021	Ongoing	Declare any potential or perceived conflict of interest at relevant meetings/workshops
	Thea Stein	Chief Executive – Leeds Community Healthcare NHS Trust	Trustee of Nuffield Trust	Financial Interests	Direct	06/12/2019	Ongoing	No action required N.B. Role not remunerated
			CQC Executive Reviewer	Non-Financial Professional Interests	Direct	01/01/2018	Ongoing	Declare any potential or perceived conflict of interest at relevant meetings/workshops.
	Tim Ryley	Accountable Officer - Leeds	Nil Declaration					
	Victoria Eaton	Director of Public Health	Nil Declaration					
	Visseh Pejhan-Sykes	Chief Finance Lead, Leeds Office of the WY ICB	Parent Governor – Penistone Grammar School	Non-Financial Personal Interests	Direct	04/04/2022	03/04/2026	Declare any potential or perceived conflict of interest at relevant meetings/workshops
			Related to Officer working in the CCG's Digital Communications Officer – Niece by marriage	Indirect Interests	Indirect	11/12/2017	Ongoing	Declare any potential or perceived conflict of interest at relevant meetings/workshops
	Yasmin Khan	Independent member of the Leeds Committee of the WY ICB	Nil Declaration					

Draft Minutes

Leeds Committee of the West Yorkshire Integrated Care Board

Thursday 22 September 2022, 1.00pm – 4.00pm

New Wortley Community Centre, 40 Tong Road, Leeds, LS12 1LZ

Members	Initials	Role	Present	Apologies
Rebecca Charlwood	**RC**	Independent Chair, Leeds Committee of the WY ICB	✓	
Tim Ryley	**TR**	Place Leeds, ICB in Leeds	✓	
Visseh Pejhan-Sykes	**VPS**	Place Finance Lead, 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 NHS Trust (LCH)	✓	
Sara Munro	**SMu**	Chief Executive, Leeds & York Partnership Foundation NHS Trust (LYPFT)	✓	
Julian Hartley	**JuH**	Chief Executive, Leeds Teaching Hospital NHS Trust (LTHT)	✓	
Dr Chris Mills	**CM**	Chair, Leeds GP Confederation	✓	
Cath Roff	**CR**	Director of Adults & Health, Leeds City Council		✓
Shona McFarlane	**SMc**	Deputy 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	**FW**	Third Sector Development Lead	✓	
Dr John Beal	**JBe**	Chair, Healthwatch Leeds	✓	
Dr Jason Broch	**JBr**	Chief Strategic Clinical Information & Innovation Officer, ICB in Leeds	✓	
Jo Harding	**JoH**	Director of Nursing and Quality, ICB in Leeds	✓	
Additional Attendees				
Sam Ramsey	**SR**	Head of Corporate Governance & Risk, ICB in Leeds	✓	
Manraj Khela	**MK**	Head of Health Partnerships	✓	
Harriet Speight	**HS**	Corporate Governance Manager, ICB in Leeds	✓	
Karen Lambe	**KL**	Corporate Governance Senior Support Officer, ICB in Leeds	✓	
Gaynor Connor (Item 30)	**GC**	Director of Primary Care and Same Day Response, ICB in Leeds	✓	
Stuart Morrison (Item 23)	**SM**	Team Leader, Healthwatch Leeds	✓	

Members of public/staff observing – 2

No.	Agenda Item	Action
19/22	**Welcome and Introductions** The Chair opened the meeting of the Leeds Committee of the West Yorkshire Integrated Care Board (WY ICB) and invited all members to introduce themselves. It was noted that the Committee meeting was being live streamed to the Leeds Health and Care Partnership YouTube channel. The Chair thanked the venue, New Wortley Community Centre, for hosting the meeting and for the fantastic work that they do to support the local community, including skill-building classes, youth groups, ex-offender support, food and hygiene banks, and counselling services.	
20/22	**Apologies and Declarations of Interest** Apologies had been received from Cath Roff and Shanaz Gul. Shona McFarlane was deputising for Cath Roff 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 at this stage in the meeting, however specific interests were declared at the outset of Item 30/22 (please refer to Minute 30/22).	
21/22	**Minutes of the Previous Meeting – 14 July 2022** It was noted that Jo Harding attended the meeting and that this will be reflected in the final published version of the minutes. The minutes were otherwise approved as an accurate record.	
22/22	**Action tracker** The Committee noted the completed actions set out in the action tracker.	
23/22	**People's Voice** The Chair introduced Stuart Morrison from Healthwatch Leeds, who provided a summary of the key themes from the recently published Healthwatch Insight Report *'What people across West Yorkshire are telling us about their experience of health and care services'.* SM highlighted that a significant amount of contributors to the report were from Leeds. GP access was noted as a central theme to overall patient experience in the region in the last 12 to 18 months, following significant changes made to the way people can access GP appointments as a result of the covid 19 pandemic. Patients	

No.	Agenda Item	Action
	reported difficulties with booking appointments, lack of opportunities for face-to-face appointments and variation in approach between different practices. NHS dentistry was also identified as a key theme, with patients reporting that they cannot find NHS dentists that have capacity to take on new patients, as well as significant issues around a lack of support for young people with their mental health. SM highlighted that many of the issues raised were exacerbated by the cost of living crisis and created additional challenges to those with the greatest health inequalities, those with additional communication needs and people living in poverty. The report included several recommendations to the West Yorkshire Health and Care Partnership, centred around communication, compassion and coordination. JuH reiterated the capacity issues across the system and recognised the detrimental impact that this was having on patient experiences, along with assurance that there is substantial work taking place to address flow of patients through from hospital and into the community. JuH also commented that it was surprising that patient wait times did not come through as a key theme in the report, as a significant national issue and a particular challenge for LTHT currently. However, JuH also reflected that Leeds waiting times are lower than other core cities in the UK. Some members reflected on their own experiences of variations between GP practices as well as long processes of referral and diagnosis. The Place Lead highlighted several schemes and opportunities to tackle the key themes raised in the report in addition to the system flow programme JuH referred to, including the ongoing reform of community mental health services. It was also suggested that an item be added to the forward work plan of the either the Delivery Sub-Committee or Quality and People's Experiences Sub-Committee to conduct a 'deep dive' into the variation across primary care services. **ACTION – To determine appropriate sub-committee for variation across primary care services to be considered and add to the relevant forward work plan.** **ACTION – To add an item to the forward work plan to understand how the Better Care Fund is currently utilised to support system flow.** GC gave assurance that the Primary Care Board and its working groups work closely with Healthwatch Leeds. GC also confirmed that a quality improvement module specifically focused on access and experience is being undertaken at all 92 GP practices in Leeds, which will provide a greater understanding of the level of variation across the system.	**SR/HS** **SR/HS**
24/22	**Questions from Members of the Public** The Chair advised that the Leeds Office of the ICB were unable to widely publicise the opportunity to submit questions on this occasion, due to the sad passing of Her Majesty Queen Elizabeth II and the period of national mourning.	

No.	Agenda Item	Action
	There were no questions received from members of the public either prior to the meeting or from members of the public present.	
25/22	**Place Lead Update** The Place Lead provided an overview of the report, highlighting the period of change at national level, with the appointment of the new Prime Minister and Secretary of State for Health and Social Care, as well as ongoing challenges associated with the cost-of-living crisis and winter planning. Members were also provided with updates in regard to three plans / programmes that the Partnership Executive Group (PEG) are focusing on currently - System Flow and Intermediate Care Improvements, the Integrated Winter Plan, and Plan C - in Extremis (Emergency Planning). The Place Lead also sought members views on information that should be included in future Place Lead Update reports. TS welcomed the report, however noted that some pressures experienced across the system in Leeds were not reflected, such as child and adolescent mental health services (CAMHS) and digital / data sharing. It was suggested that all partners collectively feed into the report through the Partnership Executive Group (PEG) to ensure that the content represents the experiences across the entire Leeds health and care system. Members were supportive of a more integrated approach to reporting. **ACTION – Future Place Lead Update reports to include input from PEG.** Members noted that the agenda setting process for the Leeds Committee is in the early stages of development and discussed potential future items. The Chair suggested that a regular item be added to the agenda which focuses on a specific system pressure and the work each partner is undertaking to alleviate. JuH suggested that a combined report on workforce issues be added to the future work plan. YK queried whether the shared mandate / common narrative work to articulate the assets of the partnership, priorities and key building blocks to progress delivering the Health & Wellbeing Strategy and Vision with a small group of Chief Officers, as detailed in the report, adequately reflects the diversity of the health and care system in Leeds. TR assured members that although the work had been led by the Chief Officer group, it had been considered widely with a range of groups and forums, continually involved in the process. **<u>The Leeds Committee of the WY ICB:</u>** **a) Considered** and **noted** the contents of the report; and **b) Advised** on the content of future Place Lead Updates.	**TR/MK**
26/22	**Quality and People's Experience Sub-Committee Update**	

No.	Agenda Item	Action
	The Chair provided a brief overview of the assurance report included in the agenda pack and highlighted the following item to 'alert' the Committee to: - 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. **<u>The Leeds Committee of the WY ICB:</u>** a) **Received** the update.	
27/22	**Delivery Sub-Committee Update** The Chair of the Sub-Committee, Yasmin Khan, provided a brief overview of the assurance report included in the agenda pack and highlighted the following items to 'alert' the Committee to: - 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. **<u>The Leeds Committee of the WY ICB:</u>** a) **Received** the update.	
28/22	**Finance and Best Value Sub-Committee Update** The Chair of the Sub-Committee, Cheryl Hobson, provided a brief overview of the assurance report included in the agenda pack and highlighted the following items to 'alert' the Committee to: - The sub-committee received a presentation outlining the draft submission of the 22/23 business case for Community Diagnostics Centres (CDC) at three Leeds sites, plus an overview of 23/24 & 24/25 business case requirements and timescales. - Members were advised that a short form business case (SFBC) was submitted in July 2022 for £4.48m capital/ £642,000 revenue funding for 22/23 implementation of CDC model. It was advised that the 23/24 and 24/25 submissions had been requested to be postponed until December 2022 to align with place base governance processes and to reflect the 8-week feedback process following submission of 22/23 business case.	

No.	Agenda Item	Action
	- Members agreed that the Leeds community diagnostic centre model will support improved access to community based diagnostic services and reduce numbers of people coming into an acute setting and were supportive of proceeding with implementation for 22/23. A discussion took place regarding the potential for proceeding with the scheme prior to formal approval of the bid in order to ensure that resources allocated for 22/23 can be spent within the required timeframe. - The finalised combined 23/24 & 24/25 business case will be submitted to the Leeds Committee meeting scheduled for 13th December 2022 for approval prior to final submission. **<u>The Leeds Committee of the WY ICB:</u>** **a) Received** the update. ***The meeting adjourned for a comfort break at 2:20 p.m. until 2:30 p.m.***	
29/22	**Risk Management Report** The Place Lead provided an overview of the report, highlighting that all previous Leeds CCG risks were reviewed and aligned to relevant sub-committees at Leeds Place, however, are all categorised as 'new' risks due to the change of organisation. As mentioned in the previous items, all risks had also been considered by the sub-committees at the most recent meetings. TR also noted the importance of ensuring that risks assigned at partnership level do not duplicate the risks managed by individual partners. TR highlighted the importance of ensuring that discussions around risk are focused on action taken to mitigate the risk, not simply identifying the issue. TS queried whether the risk relating to mental health (risk no. 2018) represented children as well as adults and this was confirmed by TR. JB queried the impact of risk 2006 and the potential impact of risk of harm to patients associated with reduced numbers of hospital beds. It was confirmed that the partnership work closely with all providers, to ensure safe capacity in the system. Members agreed that an additional risk should be added to the risk register around workforce issues, as a substantial risk experienced across partner organisations. SM emphasised that the addition of a workforce risk must not blur the first line of accountability, which remains with each partner organisation and the substantial work undertaken through the One Workforce Board. **ACTION – To add a system-wide workforce risk to the risk register.** CM highlighted that sharing of data must be a priority across all organisations to alleviate risk. TR noted that the Leeds Digital Strategy will be considered at the next meeting in December, which will provide an opportunity to discuss any barriers and actions for partners to take.	**SR**

No.	Agenda Item	Action
	Members highlighted the need to articulate the process for adding risks to the risk register, and the role of partner organisations in the process. It was also requested that the presentation of the risk register at Appendix 1 be considered for future reports. **ACTION – To include the process for adding to / amending the risk register in future reports.** **ACTION – To amend formatting of future risk reports for clarity / ease of reading.** **<u>The Leeds Committee of the WY ICB:</u>** **a) Received** and **noted** 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) Agreed assurance** in respect of the effective management of the risks aligned to the Committee and the controls and assurances in place. *SM left the meeting at 2:55 p.m. during discussion of this item.*	**SR/HS** **SR**
30/22	**Primary Care Network – Enhanced Access Service** *At the outset of the item, JBr and CM both declared a financial professional interest as practicing GPs, with CM additionally noting his role as Chair of the Leeds GP Confederation. It was agreed that both members would not take part in a vote but could contribute to the discussion.* Gaynor Connor, Director of Primary Care and Same Day Response, provided an overview of the current arrangements for enhanced access, along with the proposals for the new service following national policy changes. GC assured the Committee that the current level of activity will be maintained, if not improved with more local services available. JB commented that urgent care across the system is not a uniformed approach in terms of location of services and requires communication. GC recognised the confusion and highlighted that care navigation at the first point of contact for patients is crucial. GC confirmed that plans are in development for public communications alongside the new enhanced access service. FW requested that the third sector be engaged with any future communications plans, so that they can help disseminate messages to communities through trusted channels. YK commented that it is key to ensure that marginalised groups are consulted to ensure that their needs are reflected in plans for the new services. TR added that addressing health inequalities must key play a key role in schemes that enable additional services and capacity. **<u>The Leeds Committee of the WY ICB:</u>**	

No.	Agenda Item	Action
	a) **Approved** the Enhanced Access plans for Leeds place; and b) **Noted** the minimal impact on the wider health and care service	
31/22	**Medium Term Financial Plan** Visseh Pejhan-Sykes, Place Finance Lead, delivered a PowerPoint presentation that set out the medium-term financial plan and timescales for implementation. As part of the presentation, VPS set out the underlying positions of each NHS trust in Leeds and Leeds City Council, and the efficiencies required. VPS highlighted the need for a collaborative approach across populations and the review of impact and value throughout financial planning in this challenging period. VPS also advised the Committee of the emerging role of Population Boards, which have become increasingly responsible for assessing value of services, pathways and interventions, and therefore have a crucial advisory role in financial planning. TS reiterated that the primary role of the Leeds Committee is the effective allocation of resources, and therefore consideration and approval of the plan is key. FW commented that the behavioural change required through the work of the Population Boards should not be underestimated. TR noted that the advisory and strategic role of Population Boards will become more distinguished with time, but that it is important to note that they currently do not have any decision-making power as a Board. Decision making functions sits with the Leeds Committee. VPS added that the five year plan is really important for setting the strategic direction of the health and care partnership in Leeds, and supporting all of the forums that feed into decision-making to ensure that there is a shared aspiration around embedding preventative approaches. It was noted that the finalised plan would be submitted to the Committee in advance of the final deadline, although not confirmed, likely to be March 2023. *TS left the meeting at 3:35 p.m. during discussion of this item.*	
32/22	**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 flow and variation between primary care services – a common theme which will inform forward work plan • Workforce challenges identified as a key system-wide issue, to be added to the risk register • Positive discussion in relation to the draft Medium Term Financial Plan, to return for formal approval before the end of the financial year	

No.	Agenda Item	Action
	In terms of reflections, it was acknowledged that the People's Voice item set the tone for the remainder of the meeting and will be a valuable regular item to begin each meeting with.	
33/22	**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. Proposed items would be discussed with the Governance team to ensure the Committee was the most appropriate forum. The Chair reflected on several discussions throughout the meeting relating to the work plan and the various actions detailed in previous minute items (23/22 and 25/22 refer).	
34/22	**Any Other Business** There were no matters raised on this occasion.	
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 2022, at a venue to be confirmed.	

Action Tracker

NHS West Yorkshire Integrated Care Board

Leeds Health & Care Partnership

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**	**People's Voice**	To determine appropriate sub-committee for variation across primary care services to be considered and add to the relevant forward work plan	**Sam Ramsey / Harriet Speight**	**LCICB**		**Complete** The Delivery Sub-Committee (17 Nov) considered a comprehensive report detailing the data, insight and work programmes associated with improving access to primary medical services
6	**22/09/2022**	**People's Voice**	To add an item to the forward work plan of the to understand how the Better Care Fund is currently utilised to support system flow	**Sam Ramsey / Harriet Speight**	**LCICB**		**Complete** Better Care Fund Update incorporated into Place Lead Update at Item 45/22
7	**22/09/2022**	**Place Lead Update**	Future Place Lead Update reports to include input from PEG	**Tim Ryley / Manraj Khela**	**LCICB / PEG**		**Ongoing** Place Lead Update at Item 45/22 includes local context and priorities. Further feedback to be sought through agenda item
8	**22/09/2022**	**Risk Management Report**	To add a system-wide workforce risk to the risk register	**Sam Ramsey**	**LCICB**		**Complete** Update included in the report at Item 49/22

Action No.	Meeting Date	Item Title	Actions agreed	Lead(s)	Accountable body / board / committee	Status	Update
9	**22/09/2022**	**Risk Management Report**	To include the process for adding to / amending the risk register in future reports	**Sam Ramsey**	**LCICB**		**Complete** Included in the report at Item 49/22
10	**22/09/2022**	**Risk Management Report**	To amend formatting of future risk reports for clarity / ease of reading	**Sam Ramsey**	**LCICB**		**Complete** Included in the report at Item 49/22
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

Meeting name:	Leeds Committee of the West Yorkshire Integrated Care Board (ICB)
Agenda item no.	LC 45/22
Meeting date:	13 December 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)

<u>The Leeds Committee of the West Yorkshire Integrated Care Board is asked to:</u>

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

b) **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. Purpose

1.1 This report provides an update on significant national and local developments that affect the context within which we operate. This report will help shape the conversation at the Committee.

2. National Context

2.1 Since the last meeting a new Prime Minister and Secretary of State have changed. As of 25 October 2022, Rishi Sunak replaced Liz Truss as the leader of the Conservative and Unionist Party, and became Prime Minister, and Steve Barclay replaced Therese Coffey as Secretary of State for Health and Social Care. There has also been a change in the rest of the ministerial team in the Department of Health and Social Care (DHSC).

2.2 The priorities for the health service remain similar to those previously announced:

- Reduction of back-log in elective waiting times
- Improving GP Access
- Ambulance handovers
- No Reason to Reside and system flow.
- It has also been announced that the A&E measure (4 hour waiting time) that was due to be replaced is now being retained.

2.3 The Autumn Financial Statement allocated an additional £3.3bn to the NHS over the next two years. Whilst a considerable improvement on what had been expected, it still falls someway short of the £7bn that was generally felt to be needed. We will need to wait for the NHS planning guidance, due later this month, to understand what this will mean in detail. At the same time councils have been given flexibility to increase council taxes beyond the previous limit of 3%.

2.4 Also, within the autumn statement it was announced that the Chancellor had asked Patricia Hewitt to undertake a review of ICBs. There is an expectation that whilst undertaken fairly quickly this could result in some far-reaching recommendations with a particular emphasis on reducing the bureaucratic burden on the NHS.

2.5 Health Education England (HEE) and NHS Digital are being merged into NHS England (NHSE). The future merged NHSE is expected to reduce its running costs / headcount by up to 40%. This reflects the phase of the COVID-19 pandemic we are now in and the new operating framework that has been agreed which pushes more responsibility to systems and organisations.

2.6 Understandably, there is a strong emphasis on winter preparedness at a national and regional level. All ICBs have had to submit winter plans and establish from the 1st December Winter System Control Centres which operate 24/7 365 days per year. In the Northeast and Yorkshire, the ICBs and places with them, along with the Ambulance Service have worked together to create the necessary infrastructure.

2.7 As a Leeds Place we have developed our Winter Plan with an emphasis on prevention (Vaccination, warmth etc.), increased capacity within hospital and in the community, and increases in flow and effectiveness. The separate paper on winter planning on the agenda discusses this in more detail.

2.8 The £500m Winter Discharge Fund has been announced. 40% will go directly to Local Councils and 60% to ICBs. The expectation is that this is managed collectively through the Better Care Fund. This equates to £7.85m for Leeds. This will be essential for a number of elements of our agreed plans with much of the funding pre-committed as partners have gone at risk ahead of hearing the details.

2.9 The Care Quality Commission (CQC) published its annual CQC State of Care Report last month. This highlighted that the health and care system is in 'gridlock' as flow across the system is affected by a mixture of COVID-19 pressures, staffing pressures and increased demand for some services. This is an accurate description of what we see in elements of our system and emphasises the need for whole system planning and delivery.

2.10 The Royal College of Nursing (RCN) have received a mandate for industrial action in many trusts across the United Kingdom and have announced the 15th and 20th December as the first strike dates. The West Yorkshire ICB, Leeds Teaching Hospitals Trust and Leeds Community Health trust are all impacted. At the time of writing the exact details are to be confirmed. We are also expecting to hear whether other unions including Unison will also be mandated to call strike action by their members.

3. Leeds System

3.1. As the performance report notes the Leeds system remains under considerable pressure in a number of areas. We should note continued good performance and progress in some key areas such as Ambulance Handovers and clearing the backlog of 78-week waiters. Clearly there are still significant pressures in system flow, urgent and unplanned care and also in Mental Health. The mental health performance figures can be mis-leading, and we know that services for young

people are still difficult to access and that out of area placements for adult services remain higher than we would like.

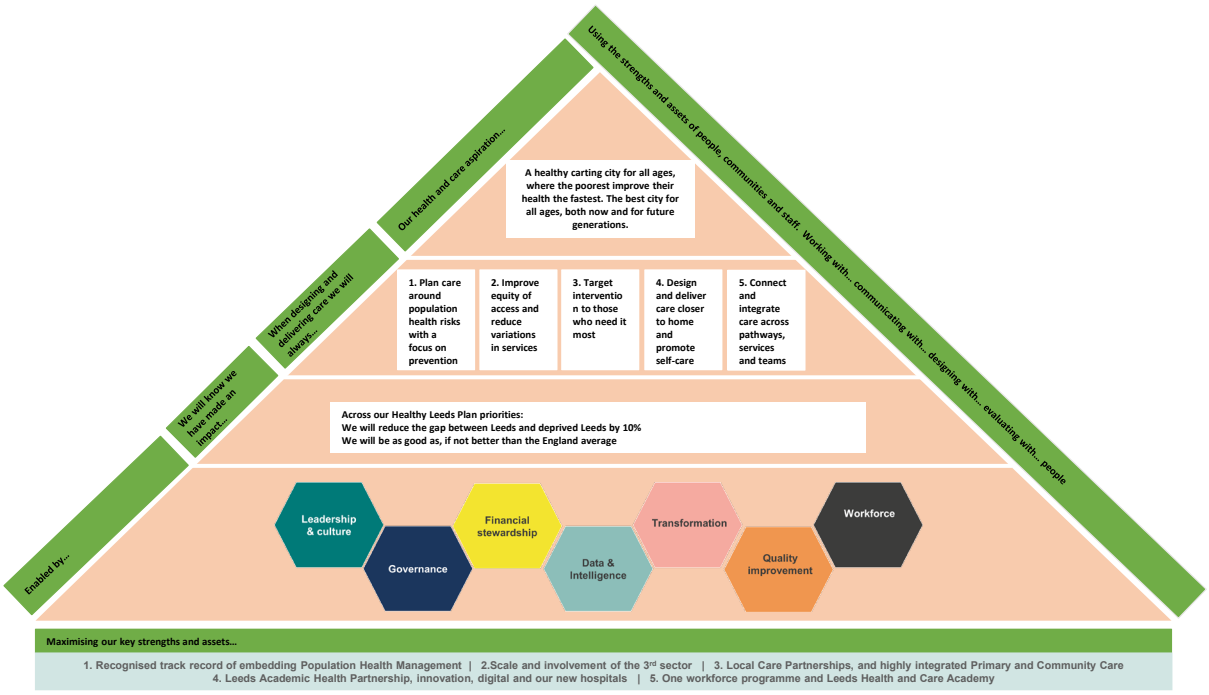
3.2. The Partnership and its members remain focussed on addressing these challenges. One of the significant barriers to progress remains workforce availability in many areas. The One Workforce Board and individual providers are working hard to ameliorate this risk, but the position remains challenging and will do for the foreseeable future.

3.3. As partners, given the challenges we face as a system particularly around system flow, we have since the last meeting of the committee, initiated system conversations with the CQC and wider regional partners to share our approach. Coming out of that meeting are a number of pieces of work that have been undertaken, most notably work to look at how we share risk across the partnership, and to understand the next steps for our Transfer of Care Hub.

3.4. Whilst there are a number of important pieces of work we are undertaking now to improve performance and feature in our Winter plans, we recognise the need for a more fundamental review of our intermediate tier system. From late August through to November we have been undertaking an in-depth diagnostic with the support of Newton Europe. Clinicians, professionals, and others have undertaken in-depth reviews of 90plus cases. This has identified significant opportunities. The next steps are to deliver any quick wins whilst at the same time designing the major transformation programme ahead of testing and delivery next year.

3.5. Since we last met, we have had announcements that two key members of our Leeds Health & Care Partnership are leaving in February 2023. Cath Roff, Director of Adult Social Care and Sir Julian Hartley, Chief Executive of Leeds Teaching Hospitals Trust. Each has made a significant contribution to the Leeds partnership and to the city and will be sorely missed. We wish them both well in the next part of their journey and look forward to welcoming and working with their successors.

3.6. The Chief Officers in the Leeds system have been meeting regularly over the last six months to further develop the common narrative that underpins the partnership and articulates concisely who we are, what we are about and what our ambition is. This initial work is now with Communications colleagues to develop some products we can use to share more widely. The purpose and audience is very much in the first instance for external audiences and our senior leadership across the system. The diagram below is a summary of the work to date.



3.7. As part of this work to stretch our thinking and move us to the next level of integration and shared endeavour we are in conversation with the Staten Island performing Provider system in New York. In 2014, Staten Island PPS (SI PPS) created an integrated network of providers to improve population health outcomes, reduce costs for its Medicaid and uninsured populations, and reduce avoidable hospital use by 25% over five years. It is comprised of more than 75 provider organisations covering mental health, social care, and community services; 22 population health practices; 20+ community organisations, and 3,600 primary care practitioners. It uses a strong population health management approach underpinned by excellent data analysis and digital infrastructure. As the relationship develops, we will update the ICB Committee in Leeds on the learning.

3.8. One of the key features of advanced health care systems is excellent analytical capability. In Leeds we are in the fortunate position of having the Leeds Office of Data Analytics (LODA) which is a joint venture between Leeds City Council and the NHS. After a couple of years of investment, gestation, and development this is now moving to the position of offering us some of the capability that we will require. The LODA board which oversees the work will ensure the partnership including the ICB committee is kept up to date on progress.

4. 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.

Agenda item LC 46/22

Committee Escalation and Assurance Report – Alert, Advise, Assure

Report from: Leeds Quality and People's Experience Subcommittee

Date of meeting: 24th November 2022

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

Date of meeting reported to: 13th December 2022

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

Key escalation and discussion points from the meeting
Alert:
• **System flow**: Following Care Quality Commission (CQC) concerns around the time people spent in Leeds Teaching Hospitals NHS Trust (LTHT) Emergency Department (ED), leaders were working collectively to provide a system response, recognising this represented a system risk. Leaders had met with CQC representatives to assure them of actions being taken to mitigate risk to ED. • **Summary Hospital Level Mortality Indicator (SHMI)**: An increase and return to 'higher than expected' banding in LTHT's SHMI data between June 2021 and May 2022 was highlighted in the QPEC Quality Report. LTHT's role as a tertiary centre in treating the most complex cases in the region was noted and the work ongoing in LTHT to understand the reasons for the increase continue. Analysis by diagnostic category continues to show that no single diagnostic group lies significantly outside the range and neither of the two main acute sites at LTHT has a SHMI that exceeds expected. • **Emerging risks**: Members highlighted emerging risks caused by the cost of living crisis and its impact on increasing health inequalities. Concern was expressed that by focussing on individual services, risks to groups such as carers could be overlooked.
Advise:
People's Voice The Quality and Peoples Experience Subcommittee (QPEC) reflected on the positive progress made in developing a city-wide approach to hearing the People's Voice as a system. This had entailed the introduction of *How Does It Feel For Me?*(HDIFFM), a balanced scorecard to gain insight into people's experiences and how joined-up healthcare services felt to them. From the insight, the Three Cs were identified as key themes: communication; compassion; and coordination.

Members discussed how the insight being gathered from HDIFFM could be used by the QPEC and how it would manifest in quality improvement. It was agreed the role of the subcommittee was to be assured that: the People's Voice was being heard at Population Health and Care Boards; people were involved across the system; and a quality approach was being applied. The Three Cs approach was recognised as an approach that aligned with person-centred integrated care.

The subcommittee agreed to develop a People's Experience report for future QPEC meetings to demonstrate the depth and breadth of people's experience of care across Leeds.

Assure:

Risk Report

Members received the risk register aligned to the QPEC. Seven risks were aligned to the Subcommittee with five high scoring open risks scoring 12 or above; all seven had retained a static risk score since September 2022.

The following key areas were discussed:

- *R2019 Risk of Harm - System Flow* was highlighted due to the amended number of community beds from 120 to 96 and the average occupancy being updated to 80. Assurance was given that reprovision of 90 beds had been arranged, resulting in 113% of the utilised bed capacity at the start of October 2022. The number of patients with *no reason to reside* in hospital beds was increasing in Leeds. Work was ongoing with system partners to deliver a winter plan to mitigate the risk and a longer term plan for intermediate care.
- Members were assured that Leeds City Council social care services were fully involved in work to mitigate system flow risk.
- Issues regarding recruitment and retention for critical posts were being picked up and tracked by the Leeds One Workforce Board.

Quality Highlight Report

The subcommittee received the Quality Highlight Report which had been revised following the first iteration and feedback from QPEC members. A discussion was held regarding the triangulation of information for inclusion in the report. Additional issues were raised for inclusion in the highlight report including delays in mental health services providing care and lack of pre-diagnosis support for young people awaiting autism assessment. Members agreed to develop a fully integrated quality highlight report; its focus would need to stretch beyond CQC registered services and include data from dashboards currently in development.

West Yorkshire Quality Committee Update

The subcommittee was updated on the recent West Yorkshire Quality Committee (WYQC) meeting. In terms of governance, members agreed the subcommittee's AAA report to the Leeds Committee of the WY Integrated Care Board would be the route to highlight any issues to the WYQC.

Agenda item LC 47/22

Committee Escalation and Assurance Report – Alert, Advise, Assure

Report from: Leeds Delivery Sub-Committee

Date of meeting: 17th November 2022

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

Date of meeting reported to: 13th December 2022

Report completed by: Harriet Speight, Corporate Governance Manager, 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:
Performance The Sub-Committee received the Delivery Performance Report, within which the following key areas were flagged: • The challenges of the winter period and upcoming industrial action are expected to significantly impact service delivery and potentially widened inequalities – several actions taking place to address pressures were highlighted in the report • Cancer waiting times remains a significant challenge, with limited understanding of the level of underlying demand, however referral numbers are higher than pre-pandemic levels, which is encouraging in terms of identifying cancer that may have been missed during the periods of lockdown • Waiting times for planned care are improving in some areas in line with pre-pandemic levels, however the challenges associated with the Winter period is expected to significantly impact the rate of referrals to treatment • Children's mental health continues to report high demand and urgency, although performance for urgent demand to eating disorder services is above target • Significant demand on adult mental health services, particularly challenging around out of area placements
Advise:
People's Voices The Sub-Committee discussed the format of future People's Voice items at each Sub-Committee meeting. Members recognised the importance of understanding

people's experiences of how effectively services are delivered in Leeds, and the crucial insight this provides to the Sub-Committee.

Members considered the 'insight reports' coordinated by the Communications Team to be helpful content to consider for future People's Voice items. The Sub-Committee received the Primary Care Access - Insight Review Report for information, and Members reflected that the report detailed people's varied experiences, particularly for people with disabilities, language barriers, or digital poverty, which showed the importance of messaging and support available to be tailored to the needs of individual communities.

Assure:

Performance

The Sub-Committee highlighted the importance of the data presented to show a breakdown by inequalities, which was taken as an action to explore for the next reporting cycle.

The Sub-Committee noted reasonable assurance that performance has been improving and that there are plans in place to address gaps, however, limited assurance that progress will be maintained through the challenging Winter period and limited assurance in relation to sufficient understanding of the impact on health inequalities.

Access to Primary Medical Services

At the Leeds Committee of the WY ICB meeting held on 22 Sept 2022, it was requested that a deep dive into access to primary care services be conducted by one of the sub-committees. Members received a comprehensive report detailing the data, insight and work programmes associated with improving access to primary medical services.

Members discussed a number of matters, including:

- Leeds has a stable GP workforce and is not experiencing challenges to the extent of other core cities, with more appointments available at each GP practice than pre-pandemic
- The impact of the fast transition to digital services on health inequalities and the need for more hyper-local communications to convey the benefits and options available
- More data analysis to be undertaken to measure patient journey and unmet demand

The Sub-Committee noted reasonable assurance around current capacity within primary care services, however expressed concerns for future sustainability of the current model and sufficient understanding of the demand for services.

Risk Management

The Sub-Committee received the risk register and an update on the risk levels for the eight risks aligned to it. It was agreed that future reports would provide further detail regarding impact of each risk to provide a further level of assurance to members. The Sub-Committee reflected on the winter pressures and upcoming industrial action and the impact this could have on the risks across the system leading to limited assurance.

Agenda item LC 48/22

Committee Escalation and Assurance Report – Alert, Advise, Assure

Report from: Leeds Finance and Best Value Sub-Committee

Date of meeting: 1st December 2022

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

Date of meeting reported to: 13th December 2022

Report completed by: Harriet Speight, Corporate Governance Manager, ICB in Leeds on behalf of Cheryl Hobson, Independent Member and Chair of Finance and Best Value Sub-Committee

Key escalation and discussion points from the meeting
Alert:

Finance Update at Month 7 (October) 2022-23

The Sub-Committee received the finance update, and the following key areas were flagged:

- Leeds Place was asked to deliver a £16.1m surplus to West Yorkshire by the end of the financial year and signalled at the end of Month 6 that LTHT and the Leeds Office of the ICB would not be able to deliver the levels of services required whilst making that level of surplus, leaving a £13.2m gap. However, following improvements in other parts of WY, that reduce commissioning commitments for the ICB, and clarification on the ability for ICBs to be able to retain National Insurance refunds from Providers as a benefit, the ICB in Leeds position has improved as we approach Month 8 and we are now planning to be less than £1.5m off the plan position. This position can improve further if system flow commitments made at risk by the ICB in Leeds can be badged against the social care and system flow monies being allocated by NHSE in December and January this financial year. The Provider trusts in Leeds have agreed to distribute their share of Depreciation funding from the ICB to LTHT improving their reported by £1.5m in Month 8. The Leeds Place is now circa £5m off plan and this gap is likely to close to around £3- £3.5m. It would appear that across WY there is enough flexibility to cover this residual gap from plan.
- There are still significant further cost pressure risks associated with prescriptions, energy costs, inflation, and supply chain disruption across the system, which have impacted the financial position at Leeds Place and may continue to impact adversely on our projected outturn position if they crystallise.
- Members were assured by the next steps highlighted within the report to mitigate the risk of not delivering the surplus required

Advise:

The Role of the Sub-Committee

A key theme of discussion during the meeting was the Sub-Committee's role in the financial planning process, and members agreed that the Sub-Committee has a clear role in considering whether the processes of financial planning are effective and assuring the Leeds Committee on this basis.

Financial Planning for Improved Value in 2023/24

The Sub-Committee received a summary report of the six proposals for service change and transformation that aim to drive improved value for Leeds. The Sub-Committee were supportive of the proposals and encouraged by the transformative approach taken respond to the financial challenges experienced within the system. It was agreed that the matter be referred to the Leeds Committee for further consideration. Members highlighted that further detail was required for consideration by the Leeds Committee that distinguishes actual cash savings from future projected savings against future cost increases based on successful implementation, for each of the six proposals.

Assure

Risk Management Report

The Sub-Committee received a report providing an update on the Risk Register and the risks aligned to the Finance and Best Value Sub-Committee and agreed that although it was assured that the processes were in place to mitigate against the financial risks for 2023/24, it had limited assurance in relation to mitigation plans for the medium to longer term financial risks. Discussion took place on the value of a medium-term financial plan and commencing planning for future years early in the new financial year 2023 / 24. Given the potential financial risks across the Leeds system in future years, this approach was supported.

Meeting name:	Leeds Committee of the West Yorkshire Integrated Care Board
Agenda item no.	LC 49/22
Meeting date:	13 December 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) – 21 October 2022 (email)

Delivery Sub-Committee – 17 November 2022

Quality and People's Experience Sub-Committee – 24 November 2022

Finance and Best Value Sub-Committee – 01 December 2022

Executive summary and points for discussion:

This report presents the Leeds Place High-Scoring Risk Report (all risks scoring 15+) as at the end of the current risk review cycle (Cycle 2 2022/23). The report also shows risks directly aligned to the Leeds Committee of the ICB and highlights any scoring 12 and above.

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 Executive Management Team (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, and those risks scoring 12 and above that are aligned to the Leeds Committee of the ICB are presented in this report for review.

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)
<u>The Leeds Committee of the Integrated Care Board is asked to:</u> a) **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; b) **Receive** and **note** the risks directly aligned to the Leeds Committee of the ICB scoring 12 and above; and c) **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 15 November 2022 2. Appendix 2: West Yorkshire ICB Common Risks as of 15 November 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 2 of 2022/23) which commenced on 08 September and ended on 16 November following the West Yorkshire Integrated Care Board meeting.

1.2 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 The ICB risk management arrangements categorise risks as follows:

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

2.2 Following the first risk reporting cycle, as described in the West Yorkshire Risk Management Policy and Framework, the WY ICB Audit Committee requested that all high scoring place risks and all risks common to more than one place should be visible to the ICB Board. This includes all risks scoring 15 and above and any common risks falling under (but not limited to) the following themes:

- System Flow
- Risk of Harm / Quality
- Infrastructure – digital, estates, non ICB workforce risks
- Finance

The ICB Risk Operational Group, which includes risk leads from all places and the core team, meet fortnightly to discuss emerging risks, categorisation of risks as place, common and corporate risks and to moderate the assessment of risks.

An extract from the ICB Risk report showing the common risks is attached at Appendix 2.

2.3 Risks scoring 15 and above and common risks have been presented to the relevant ICB committee and to the ICB Board on the following dates:

- West Yorkshire ICB Quality Committee – 25 October 2022
- West Yorkshire ICB Finance, Investment & Performance

Committee – 25 October 2022

- West Yorkshire ICB – 15 November 2022

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

The Place Risk Register will not capture risks which are owned by ICS System Partners, that they are accountable for via their individual statutory organisations.

2.5 Risk management arrangements for the Population and Care Delivery Boards are being developed. It is proposed that there will be a single risk register where all risks associated with the objectives to the boards can be recorded and aligned to the relevant board enabling a view to be taken of both the overall risk position and the risk position of individual boards. The interaction between team and project risk registers (RAID logs), partner organisation risk registers and the Place risk register will also be explored as part of this work.

2.6 There are currently 32 risks on the Leeds Place Risk Register, one of which is marked for closure, leaving a total of 31 open risks.

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

IMPACT	LIKELIHOOD				
	1 - Rare	2 - Unlikely	3 - Possible	4 - Likely	5 - Almost Certain
5 - Catastrophic	0	0	0	0	0
4 - Major	1	0	2	2	2
3 - Serious	0	2	12	5	2
2 - Moderate	0	1	2	1	0
1 - Insignificant	0	0	0	0	0

TOTALS		
Low Risks (White)	:	0
Moderate Risks (Green)	:	6
High Risks (Yellow)	:	20
Serious Risks (Red)	:	4
Critical Risks (Black)	:	2

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

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 21 October 2022.

a) All aligned delivery risks were reviewed by the Delivery Sub-Committee on 17 November 2022.

b) All aligned quality risks were reviewed by the Quality and People's Experience Sub-Committee on 24 November 2022.
c) All aligned finance risks were reviewed by the Finance and Best Value Sub-Committee on 01 December 2022.
d) All risks directly aligned to the Leeds Committee scoring 12 and above are presented to the Committee in this report.

2.9 **High Scoring Risks**

There are two open risks rated as Critical (scoring 20 or 25), one more than the last risk cycle.

There are three open risks rated as Serious (scoring 15 or 16), one less than the last risk cycle as a result of two risks being merged.

Details of the risks are provided in Appendix 1.

All of these risks are marked as common risks, common to more than one place but not a corporate risk.

Risk Number and Risk Title	**Lead EMT Member**	**Current Position**	**Current score**	**Previous score**	**Target score**
2019 Risk of Harm - System Flow	Helen Lewis	Key controls in place responding to high levels of demand. Current controls are still not sufficient to reduce the risks. The contract for one of the community bed bases has had notice served to close on 23rd November (120 beds). Re-provision of this capacity is a priority. Further update at time of writing - 113% of bed occupancy has been re-provisioned. No reason to reside numbers remain high. Work is underway with system partners to deliver a winter plan that mitigates this risk.	20	20	12

Risk Number and Risk Title	Lead EMT Member	Current Position	Current score	Previous score	Target score
2014 Leeds System Financial Position	Visseh Pejhan Sykes	The QIPP risk has been reviewed and updated to reflect the overall financial position of the Leeds system. The risk score has increased from 9 to 20 due to the combination of undelivered QIPP and new cost pressures in 2022 – 23.	20	9	6
2016 Risk of Harm – Elective / Cancer Waiting Lists	Helen Lewis	Numbers of long waiters are reducing but remain high. Additional actions since the last risk report include; • Development of data dashboard using Power BI to understand health inequalities across Leeds Teaching Hospital Trust (LTHT) waiting lists. • LTHT implementation of clinical harm reviews of patients awaiting treatment longer than 52 weeks.	16	16	12
2018 Risk of Harm – Mental Health access	Helen Lewis	Whilst Leeds Mental Wellbeing Service (LMWS) /IAPT continue to consistently achieve access targets, access to step 3 therapy for more complex needs is reported by LMWS as 14 months as of August 22, and IAPT recovery performance remains below target at 38.0% (target of 50%). Actions are progressing but not yet having the required impact. Work is required to map these actions to an agreed improvement trajectory.	15	15	12
2017 Risk of Harm – Long Term Conditions/ frailty/ mental health conditions	Helen Lewis	IQPR Performance demonstrating improvement. There are a number of actions and schemes in place to manage this risk, a gap in assurance, however, is the impact on the health and wellbeing of all staff across teams and recruitment plans at individual GP Practice level.	15	15	9

2.10 **Risks Aligned to the Leeds Committee**

There are five risks aligned to the Leeds Committee, which comprise 16% of total risks currently on the ICB Risk Register.

a) No risks are marked for closure; and
b) There is one open risk scoring 12 or above (see below).

Risk Number and Risk Title	**Lead EMT Member**	**Current Position**	**Current score**	**Previous score**	**Target score**
2013 Availability of Programme Management Resource	Sabrina Armstrong	Recent leavers have sought and secured a higher banded job aligned to their long-term career goals. An external factor is the level of market competition across the city of Leeds. Actions to address include: • Building relationships with external agencies to understand market conditions and develop responsiveness in the event of external expertise being required; • Working with the Health and Care Partnership to agree the deployment of resources to manage system requirements; and • Supporting staff to develop capabilities (PRINCE 2 accreditation)	12	12	6

2.11 **Leeds System Workforce**

The Leeds system workforce risk was discussed by the sub-committees and the Leeds Committee of the WY ICB during the previous governance cycle. Detail in relation to the risks around the Leeds system workforce was sought from the Director of Leeds Strategic Workforce & Health and Care Academy and the oversight of the Leeds One Workforce Strategic Board (LOWSB).

Workforce risk sits with organisational boards, and the LOWSB have oversight of the Leeds workforce risk profile. This is not a city risk register but allows visibility on the 'system' risks associated with workforce and ensures the insight provided informs the priorities of the LOWSB and shapes the interventions. The risk profile includes the following:

- Capacity risk - Recruitment, Retention & Mobility (Leeds City Resourcing Group)
- Skill-mix risk - Education & Development (Academy Steering Group)
- Wellbeing risk - Absence & Employee Engagement (Wellbeing Community of Practice)

The risk profile feeds into the LOWSB under the One Workforce Programme (co-ordinated by the Leeds Health and Care Academy) and the board comes together to provide strategic direction and support joint mitigations. In addition to this the HR Directors (including the Director of the Leeds Health and Care Academy) meet as a professional group to monitor and escalate risk as it might impact the system (e.g. industrial action) and the Director of Leeds Health and Care Academy attends City Silver with the Chief Operating Officers to link workforce risk with operational issues.

The Academy is currently developing a model which allows the risk profile to be tracked more systematically to improve visibility for partners. This update is to provide assurance to the Leeds ICB Committee that workforce risk is appropriately managed across the system with oversight from the LOWSB.

2.12 **ICB Board Assurance Framework (BAF)**

The ICB Board meeting held on 20 September 2022 approved the proposed strategic risks for inclusion on the BAF; approved the proposed strategic risk appetite statement and its application to the strategic risks; and noted that a Task and Finish Group would be

established to support the next stage of development of the BAF.

Work is underway to schedule the first meeting of the Task and Finish Group, with a view to submitting an initial draft BAF to the Audit Committee in mid- December, and the WY ICB Board in January.

3. Next Steps

3.1 Subsequent to the Leeds Committee meeting, the risks will be carried forward to the next risk review cycle which started on 16 November 2022.

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

4. Recommendations

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

a) **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;
b) **Receive** and **note** the risks directly aligned to the Leeds Committee of the ICB scoring 12 and above; and
c) **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 15 November 2022

Appendix 2: West Yorkshire ICB Common Risks as of 15 November 2022

Appendix 1

High Scoring Risks

Risk ID	Date Created	Risk Type	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
2019	30/06/2022	Both Delivery and Quality and People's Experience	20	(4x5)	12	(4x5)	Nicola Nicolson	Helen Lewis	There is a risk of harm to patients in the Leeds system due to people spending too long in Emergency Departments (ED) due to high demand for ED, the numbers and acuity of inpatients and the numbers 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 4 Additional wards open at LTHT Transfer of Care hub almost completely staffed and working 7 days 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 refreshed and additional capacity commissioned from November onwards including 30 additional community beds and additional community staff System Escalation Actions and Processes revised continuously OPEL & System Pressures Reporting Regime Communications work with Public to suggest alternatives to ED Intermediate Care Redesign programme up and running with diagnostic phase due for completion by November to identify improvements for short and medium term Active Recovery programme - bring Reablement and Neighbourhood teams together to develop a single waiting list for allocation of care with an aim to improve access and deliver a home first model.	Key controls in place responding to high levels of demand. Current controls are still not sufficient to reduce the risks Contract for one of the community bed bases has had notice served to close on 23rd November (120 beds). No firm agreement has been identified as to how this capacity will be re provided.	Health & Social Care Command & Control Groups: System Resilience Operational Group (Bronze), Stabilisation and Reset (Silver) and System Resilience and Reset Assurance Board (Gold) Integrated Commissioning Executive Partnership Executive Group Quality and Performance Committee	Weekly meeting in place for services to report on capacity /demand Reviewed Silver Action cards Monthly reporting to SRrAB to update on System flow action plan fortnightly 'check in' meetings with System flow programme director to report on actions plan, overseen by Accountable officer as SRO and Chief Execs	Opel reporting system under development for ASC but not yet finalised or shared .	Static - 1 Cycle
2014	29/06/2022	Finance and Best Value Committee	20	(4x5)	6	(4x5)	Judith Williams	Visseh Pejhan-Sykes	There is a risk that the financial position across the Leeds system will not achieve financial balance due to the combination of undelivered QIPP and new cost pressures in 2022 – 23. This could result in the system as a whole not meeting the statutory duties.	Budgetary reporting and control stepped up to weekly EMT meetings as part of a turnaround approach across the Leeds ICB and the wider WY ICB. Weekly Senior team meetings every Thursday morning to generate and review short and longer term QIPP schemes. Greater involvement of PHBs and their chairs in the process. Development of benchmarking and data modelling tools BI and Finance led to help with QIPP assessments. Business cases to be presented to December Leeds Committee as a first wave of save to invest initiatives aimed to be transformational to the system. CCB Board to review effective commissioning of intermediate care beds from 22-23	Active turnaround approach adopted across the ICB in Leeds and the wider WY ICB since October means that all parts of the WY system are actively looking at opportunities to ensure that the ICB finance balance by the end of 22-23. However, these are pitched against new cost pressures emerging and many measures are only non-recurrent whereas the cost pressures are recurrent. This means that our exit position from 22-23 to 23-24 is developing a growing financial gap all the time. The 22-23 position across WY is getting closer to balance but not recurrently	Policies and Procedures Audit of Procedures Weekly assessment and reporting to EMT Weekly meetings with senior leads Leeds NHS DoFs liaising every two weeks re Leeds position	Q1 on track against the QIPP profile, however the expectation is that the majority of efficiencies will not be realised until later in the year.	The ICB in Leeds has now informed the ICB that the combination of undelivered QIPP and new cost pressures in 22-23 will now mean that it will only be able to meet £2.6m of its surplus plan target of £6.4m. LTHT is also only able to meet £2m of its planned £7.6m plan. LYPFT and LCH have been able to increase their forecast to above plan but overall Leeds is still short of its target plan collectively by circa £9m.	Increasing
2016	29/06/2022	Both Delivery and Quality and People's Experience	16	(4x4)	12	(4x4)	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) Development of data dashboard using Power BI to understand health inequalities across LTHT waiting lists. LTHT implementation of clinical harm reviews of patients awaiting treatment longer than 52 weeks.	Implementation of actions enabled through TIF/ERF monies Implementation of initiatives funded through Cancer Recovery funding	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. 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 analysis and actions agreed at place. Cancer Care Delivery Board will take a lead role in developing solutions at a system wide cancer level, supported by the Leeds Integrated Cancer Strategy Partnership Group which will continue to meet quarterly. Ongoing meetings with ICB at Leeds/ LTHT cancer team and wider partners. Clinical harm review process, first update report awaited and agreeing ICB Quality team links with LTHT.	Numbers of long waiters continue to reduce.	tbc	Static - 1 Cycle
2006	29/06/2022	Delivery Committee	16	(4x4)	12	(4x4)	Michelle Van Toop	Visseh Pejhan-Sykes	There is a risk that 109 Assessment and Rehabilitation Beds provided by Villa Care are closed, due to Co-Formation giving early notice to terminate primary care support to the Discharge to Assess Service, resulting in reduction in discharge from hospital and impacting system flow and patient safety, experience and quality.	Contractual notice period (Co-Formation) Contractual levers (Villa Care) - breach of contract Six month notice period - Co-Formation raised issues and possible will withdraw notice if resolution to issues found (CCG to respond in 14 days).	Quality improvement plan - breach of contract notice issued to Villa Care. Improvement plan due by 7/7/22, now overdue. Leeds ICB Quality Team working with Villa Care on improvement plan. Looking at alternative bed provision. Expression of interest deadline (15/08/22)	Further action required in relation to breach of contract and bed provision.	None	Separate risk added in relation to quality of care, if this does not improve Co-Formation will not withdraw notice. Quality improvement plan - breach of contract notice issued to Villa Care. Improvement plan due by 7/7/22, now overdue. CQC issued report - requires improvement, Safe Domain is inadequate (link to quality risk)	Closed - Merged with risk 2019

2018	29/06/2022	Both Delivery and Quality and People's Experience	15	(I3xL5)	12	(I3xL5)	Eddie Devine	Helen Lewis	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.	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. 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 (30/06/22) ARRS Roles (30/09/22) Expansion of crisis resources (30/09/22) Targeted investment into LMWS/IAPT to meet increasing demands (30/09/22)	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	Whilst a full mobilisation plan is still in development to finalise by end of Oct, the Community Mental Health Transformation Mobilisation Planning meeting with wider partners 3/10/22 identified the workstreams to take forward key components of implementation, and agreed timelines for phased mobilisation and implementation of a new model to commence Q4 22/23 in early implementer PCN sites, Q2 23/24 phase 2 sites, and remainder Q3 23/24. A mobilisation lead to coordinate and take forward the plan has been successfully recruited. In context of workforce challenges, some key access performance metrics are being maintained; Adult CMHT consistently achieved performance target for access across Q2 22/23 (most recent available data- 82.4% accessing within 15 days of referral in August 2022 against target of 80%), Access to Early Intervention in psychosis services in Leeds has made significant improvements and achieved access above target	Whilst LMWS/IAPT continue to consistently achieve access targets, access to step 3 therapy for more complex needs is reported by LMWS as 14 months as of August 22, and IAPT recovery performance remains below target at 38.0% (target of 50%). Whilst a number of improvement actions relating to workforce planning and skill mix, significant recruitment to trainees to internally grow CBT workforce, developing integrated psychologically informed group provision between primary care mental health and secondary care, and review/evaluation of algorithm screening tool to ensure right people are being added to step 3 waiting list - further work is required to map these actions to an agreed improvement trajectory. Access to crisis assessment within 4 hours for urgent needs performance has remained consistently below target through Q2 22/23, achieving 28.8% in Aug 22 against a target of 50%	Static - 1 Cycle
2017	29/06/2022	Both Delivery and Quality and People's Experience	15	(I3xL5)	9	(I3xL5)	Lindsay Mcfarlane	Helen Lewis	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.	Risk of harm / impacts of Covid assessed by each LTC Steering Group with individual projects agreed as required Health Check working group in place to agree recovery approach into 22/23. Future model for health checks is currently being designed and consulted on 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 and evolving - good rate of referrals Increased focus on same day access through local winter resilience resource to support increase in demand Quality and Outcomes Framework restarted on 1st April 2022 and the local QIS has been refreshed to continue to support recovery, prioritising those at greatest risk and priority areas such as Heart Failure, Mental Health etc Plans for MH ARRS role expansion in 22/23 are being reviewed in context of updated national guidance that enable more deliverable recruitment plans that incorporate a wider range of non-registered MH roles to build capacity for MH support.	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 6 x LTC Health Inequalities projects funded and being implemented	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	Impact on the health and wellbeing of all staff across teams and recruitment plans at individual GP Practice level .	Static - 1 Cycle

Risks Aligned to the Leeds Committee of the WYICB

Risk ID	Date Created	Risk Type	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
2013	29/06/2022	Leeds Committee of the WY ICB	12	(I3x14)	6	(I3x14)	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.	Static - 1 Cycle

NHS West Yorkshire
Integrated Care Board

Appendix 2

Identification of Common Risks and Potential Corporate Risks – 2nd risk cycle

Common Risks

Place	Risk	I	L	Score	
Leeds	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.	4	5	20	Common risk – A&E targets
Kirklees	There is a risk that the system will see an unprecedented volume of patients attending A&E, potentially higher than the pre-C19 levels of demand and therefore will not deliver the NHS Constitution 4-hour A&E target due to pressures associated with unavoidable demand, capacity and flow out.	4	3	12	
Calderdale	That the system will return to the pre-C19 levels of demand and will not deliver the NHS Constitution 4-hour A&E target for the next quarter, due to pressures associated with; avoidable demand, implications of social distancing measures and capacity and flow out - resulting in harm to patients and patient experience being compromised.	4	4	16	
Calderdale	There is a risk that children and young people (CYP) will be unable to access timely mental health services (in particular complex 'at risk' cases and autism spectrum disorder/Attention Deficit Hypertension Disorder (ASD/DHD)). This is due to a) waiting times for ASD (approx. 14 months) b) lack of workforce locally and nationally to recruit into this service and c) appropriate services not being available for CYP as identified in SEND. Resulting in potential harm to patients and their families.	4	3	12	Common Risk – ASD / ADHD / SEND / CAMHs
Wakefield	There is a risk of 0–19-year-olds waiting up to 52 weeks for autism assessment due to availability of workforce to manage the volume of referrals, resulting in poor patient experience and delays to accessing treatment	4	5	20	
Kirklees	There is a risk of non-compliance with the Children & Families Act 2014 and the Health and Care Act 2022 relating to ICB responsibilities with regard to Children with Special Educational Needs and Disabilities (SEND).	2	2	4	
BDC	Child autism and/or adhd assessment and diagnosis There is a risk of further deterioration in the statutory duty service offer for children waiting for assessment, diagnosis and immediate post diagnostic support. This results in non-compliance with the NICS (non-mandatory) standard for first appointment by three months from referral which was highlighted as an area for a remedial Written Statement of Action in the Ofsted/CQC local area SEND inspection held in March 2022.	4	4	16	

Calderdale	There is a risk that people with complex mental health needs will not receive the right level of support that they require to meet their needs This is due to current capacity within community mental health services both health and social care resulting in escalating crisis situations for people in the community and requests for out of area locked rehabilitation hospital placements; and delays in discharge for people who are ready to leave out of area locked rehabilitation hospital placements. This leads to an increased pressure upon the CCG Specialist Care/CHC team and to potentially increased costs for the CCG.	3	4	12	Common risk – mental health capacity
Leeds	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.	3	5	15	
Kirklees	The numbers of children and young people who are being referred or self-referring to CAMHs SWYPFT has continued to increase, the CYP who are presenting have greater acuity and risk than before the pandemic and often they are requiring support from the ReACH team and Intensive Home Based Treatment Team.	3	4	12	
Leeds	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 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.	3	5	15	Common risk – LTC / frailty
Calderdale	There is a risk of harm to patients with LTC/frailty due to a delay in proactive management of patients during the Covid pandemic resulting in increased morbidity, mortality and widening of health inequalities.	3	3	9	
Kirklees	There is a risk that Kirklees Health and Care Partnership will fail to achieve both local and the national performance standards (set out in the NHS constitution), due to the impact of the national covid-19 pandemic, the increased demand on urgent and emergency services & the safe restart of elective activity	1	4	4	Common risk - performance standards
Kirklees	There is a risk that Kirklees and Wakefield place will fail to meet the required cancer standards for 62-day cancer waiting time targets due to operational performance and increased referrals for 2ww at Mid Yorkshire Hospitals NHS Trust (MYHT).	3	4	12	
Wakefield	There is a risk of people waiting more than 52 weeks for treatment due to demand and prioritisation of COVID during the pandemic, resulting in poor patient experience/outcomes and non-compliance with the constitutional RTT standard	4	5	20	
Wakefield	There is a risk that MYHT will fail to meet the required standard for referral to treatment within 18 weeks which will result in not achieving the constitutional target and poor patient experience	4	5	20	

Leeds	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.	4	4	16	
Bradford	System performance against national requirements There is a risk that poor performance against national requirements (key constitutional standards, operational planning targets and recovery) will impact upon our place-based contribution to the annual ICB performance assessment. This may lead to both financial and reputational impact alongside reduced patient care."	4	4	16	
Kirklees	There is a risk that elective care services will not be able to meet the required level of activity identified in the 22/23 elective recovery plan, (surgery, day case and out-patient).	4	3	12	Common risk – elective care
Calderdale	There is a risk that reduced access to elective care services in both the surgical and medical divisions at CHFT will result in; long waits, harm to patients, poor patient experience and non-delivery of patients' rights under the NHS Constitution	4	4	16	
Kirklees	There is the risk of delays to Continuing Care administration processes and workflows due to a staff shortage in the business support team.	3	4	12	Common risk – Continuing Healthcare staffing
Calderdale	The Continuing Healthcare team is currently significantly short staffed with eight (8) live vacancies. This is at a time where the team is experiencing high volumes of complex case management and increased scrutiny and requests for information coming from NHSE. There is a risk with regard to the organisational effectiveness in the delivery and quality of the service provided, patient/carer dissatisfaction and increase in complaints leading to reputation damage to the organisation, non-compliance in meeting national assurance targets set by NHSE, and with regard to financial efficacy. Due to the reallocation of work over fewer staffing numbers, there is a risk of staff burnout, leading to increased sickness levels and difficulty in staff retention resulting in high staff turnover within the team. Staff have alerted Over the past 12 months five staff within the learning and disability and mental health fraction of the team only, have left the team citing excessive caseload as the reasons for leaving. Recruitment to these positions in particular and within Children's Continuing Care has proven to be challenging despite going out to recruitment for these positions on multiple occasions. There are also several projects relating to service improvement occurring across the Calderdale footprint that various staff within the team are contributing to. All these projects aim to provide a more joined up approach and economical delivery model for the people of Calderdale. The current level of staffing shortage within the team risks a delay to the progress of these projects as staff focus on ensuring statutory functions are prioritised.	3	3	9	

Leeds	There is a risk of an inability to attract, develop and retain people to work in general practice roles due to local and national workforce shortages resulting in the quality of and access to general practice services in Leeds are compromised.	3	3	9	Common risk – general practice workforce
Calderdale	There is a risk that the quality of and access to commissioned primary medical services in Calderdale is compromised due to local and national workforce shortages, resulting in the inability to attract, develop and retain people to work in general practice roles.	4	2	8	
Calderdale	There is a risk to the ability of care homes to be able to provide a safe, high quality, person centered quality lifestyle due to staffing capacity and gaps in knowledge.	3	3	9	Common risk – care homes workforce
Kirklees	There is a risk to the ability of care homes to be able to provide a safe, high quality, person-centred quality life due to staffing capacity and gaps in knowledge.	3	3	9	
Leeds	There is a risk that when the new Liberty Protection Safeguard (LPS) Framework is implemented 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 legally contentious interpretation of what constitutes a dol in the draft MCA Code of practice which is at odds with current law. This has led to uncertainty as to the numbers of people who will be within scope of what constitutes a Deprivation of Liberty and need to be subject to the LPS making it challenging to accurately estimate and plan for the resources that will be needed for LPS prior to the publication of the final MCA Code of practice, impact assessment and its regulations. This will potentially result 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.	3	3	9	Common risk – Liberty Protection Safeguards (under consideration as a corporate risk)
Kirklees	There is a risk that when the new Liberty Protection Safeguard (LPS) legislation is implemented, there will not be the necessary resources and processes in place to fulfil the new Kirklees Health and Care Partnership (KHCP) responsibilities.	4	3	12	
Calderdale	There remains a risk that when the new Liberty Protection Safeguard (LPS) legislation is implemented, there will not be the necessary resources and processes in place to fulfil the new responsibilities of the WYICB across Calderdale Cares Partnership (CCP), CHFT and SWYFT as “Responsible Bodies” as a result of uncertainty as to the numbers of people who will be within scope of what constitutes a Deprivation of Liberty and need to be subject to the LPS, resulting in people who are Continuing Healthcare (CHC) funded or residing in a hospital are of deprived of their liberty without the required legal authorisation safeguards. This makes it extremely challenging to identify the numbers of patients who will fall into scope for the LPS and therefore the amount of resource required to administer the process. This will result potentially in both financial and reputational damage to the WYICB Calderdale Cares Partnership (CCP) and NHS trusts. Alongside this the implementation LPS will	3	4	12	

	likely result in an increased staffing costs and there is a lack of clarity regarding any national financial support to support delivery of the extra requirements.				
BDC	DOLS in PCD funded cases Risk of legal challenge against the HCP and potential harm to patients due to unauthorised Deprivation of Liberty (DoL) in PCD funded community cases resulting in reputational and financial damage. Where people are deprived of their liberty in their own homes as a result of PCD funded packages of care, the CCG is responsible for seeking authorisation from the court, however the court has a large backlog and these cases are outside the scope of the existing Deprivation of Liberty Safeguards (DoLS). This is a nationally recognised problem and Local Authorities and HCPs across the country are taking a risk management approach to prioritise only the most contested cases. The planned Liberty Protection Safeguards (LPS) aim to provide a statutory process for CCGs to authorise CHC funded cases, without the need for court proceedings, however, there have been repeated delays to publication and implementation of the LPS scheme.	3	3	9	
Leeds	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.	3	3	9	
Kirklees	There is a risk to patient safety, experience, the quality of care delivered by Local Care Direct (LCD) - Out of Hours GP Services via the West Yorkshire Urgent Care (WYUC) contract due to increased demand for the service.	3	3	9	Common risk – Local Care Direct Out of Hours GP Service
Calderdale	There is a risk to patient safety, experience, the quality of care delivered by Local Care Direct (LCD) - the provider of Out of Hours GP Services via the West Yorkshire Urgent Care (WYUC) contract due to increasing demand for the service.	3	3	9	
Kirklees	There is a risk that the allocated Full Business Case funding for Huddersfield Royal Infirmary (HRI) is not released by the secretary of state (Her Majesty's Treasury), due to current political changes, within the required timescales.	4	3	12	Common risk – Full Business Case
Kirklees	There is a risk that the allocated Full Business Case funding for Huddersfield Royal Infirmary (HRI) is not released by the secretary of state (Her Majesty's Treasury).	4	3	12	
Calderdale	There is a risk that the allocated funding is not secured due to the Full Business Case (FBC) not being approved by Her Majesty's Treasury, resulting in an inability to implement the transformational changes required to address the Financial and Quality and Safety case for change and failure to deliver improved patient experience, better clinical outcomes and overall system financial sustainability	4	2	8	

Leeds	There is a risk that QIPP will not achieve financially due to the failure to identify and implement a QIPP programme that reduces spend and mitigates growth pressures. This could result in the CCG failing to meet its statutory duties	4	3	12	Common risk – QIPP / financial deficit
Calderdale	The risk is that WYICB-Calderdale Place will fail to deliver our 2022/23 planned deficit of £0.2m for the year. This is due to 22/23 financial plan submitted to the WYICB including a number of pressures/risks which have been articulated in the plan approval process.. These risks include activity pressures on independent sector acute contracts, prescribing and under-delivery of QIPP. The QIPP challenge for 22/23 is significant at £4.5m. The result of failure to deliver the plan in Calderdale will be a risk to the overall WYICB achievement of its financial plan and financial statutory duties.	4	2	8	
Bradford	Underlying financial deficit There is a risk that we do not address the underlying financial deficit and establish a financially sustainable position over the medium term as we exit the pandemic	4	4	16	

Meeting name:	Leeds Committee of the West Yorkshire Integrated Care Board
Agenda item no.	LC 50/22
Meeting date:	13 December 2022
Report title:	Finance Update at Month 7 (October) 2022-23
Report presented by:	Visseh Pejhan-Sykes, Finance Director, Leeds Health and Care Partnership
Report approved by:	Visseh Pejhan-Sykes, Finance Director, Leeds Health and Care Partnership
Report prepared by:	Gareth Winter, Head of Financial Resource Integration – Intelligence & Planning

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

Previous considerations:

This report follows the financial presentation at the first meeting of this Committee in September 2022 which set the scene for the Leeds system and also looked forward to the 2023-24 financial planning landscape. This report was also considered at the Finance and Best Value Sub Committee meeting held 1st December 2022.

Executive summary and points for discussion:

The 2023-24 financial planning guidance is unlikely to be issued before January 2023. This report is therefore focussed on the 22-23 financial position and provides a first glance at the underlying financial gap with which we are ending the 2022-23 financial year. The 2022-23 position is experiencing a number of significant risks that are now crystallising and the Leeds NHS system has been able to mitigate using extensive non-recurrent technical flexibilities. These options will not be available in future financial years.

The Leeds and West Yorkshire system as a whole is still forecasting financial balance for 2022-23 as we feel there are enough potential mitigations across the wider footprint to ensure that this will be the case.

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 WY ICB is asked to:

a) **Note** the month 7 year to date and forecast financial position;

b) **Note** the additional key risks that may crystallise later in the year; and
c) **Discuss** the next steps as we close the 2022-23 financial year and prepare for the 2023-24 planning round in the new calendar year.

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

The report reflects the financial risk element of the corporate risk register that is now scored at 20 for the Leeds system.

Appendices

1. Summary Position at Month 7
2. Running Costs as at Month 7

Acronyms and Abbreviations explained

1. WY ICB - West Yorkshire Integrated Care Board
2. EMT - Executive Management Team
3. MH Mental Health
4. D2A – Discharge to Assess
5. DHSC – Department of Health and Social Care
6. BI - Business Intelligence
7. LTHT – Leeds Teaching Hospitals NHS Trust
8. QIPP – Quality, Improvement, Productivity, Prevention (efficiency initiatives)
9. HR – Human Resources

What are the implications for?

Residents and Communities	N/A
Quality and Safety	N/A
Equality, Diversity and Inclusion	N/A
Finances and Use of Resources	Risks (mitigations) to achieving financial balance across Leeds
Regulation and Legal Requirements	N/A
Conflicts of Interest	N/A
Data Protection	N/A
Transformation and Innovation	N/A
Environmental and Climate Change	N/A
Future Decisions and Policy Making	N/A
Citizen and Stakeholder Engagement	N/A

1 Purpose of this report

1.1 To inform the committee of the current Financial Position of the ICB in Leeds and an overview of partner organisations. The paper provides details of current and future actions to ensure the city has a sustainable financial position.

2 Context and Background information

2.1 This paper provides and update to financial position for the Leeds Place of the West Yorkshire Integrated Care Board and in the context of the wider WY ICB financial position.

2.2 It also provides an overview of the financial projections for the 3 NHS Providers across Leeds that form part of the overall WY Integrated Care system in terms of financial resources and delivery.

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

2.4 The Leeds Place collectively (Leeds Place of the ICB plus 3 NHS Providers) are currently forecasting not to meet their original planned surplus of £16.1m. Our likely collective outturn position is at risk of falling short of that surplus position unless further allocations are made later in the year, further mitigations found or resources redistributed across WY.

2.5 The baseline position as we enter 2023-24 financial year is still projecting a significant and recurrent shortfall of £120m across NHS organisations in Leeds alone. Leeds City Council is signalling a gap of c£65m+ for 2023-24.

3 Key Points

3.1 The Leeds NHS system has a collective financial target delivery plan of £16.1m surplus for 2022-23 distributed as follows:

	Planned Surplus £m	**Emerging (Risks) / Improvements £m**
ICB In Leeds	6.4	(3.8)
LTHT	7.6	(5.6)
LYPFT	1.1	0.5
LCH	1.0	0.0
Leeds Total	**16.1**	**(8.9)**

3.2 As at month 7, the Leeds Place and West Yorkshire are still planning to meet their forecast plan but there are now some risks that are crystallising for LTHT and the Leeds Office of the ICB which are unlikely to be fully mitigated. LTHT and the

Leeds Office of the ICB have now initiated a turnaround / recovery programme to review all discretionary spend and use slippage on programmes not started and any technical balance sheet flexibilities to improve our position for 2022-23.

3.3 We are also pursuing all possible avenues to seek financial cover for risks that have emerged since the planning stage.

3.4 The unforeseen cost pressures, including QIPP still to be identified, are as follows:

Summary	**£'000**
Planned Surplus	**£6,413**
Unidentified QIPP	£5,000
New Pressures Since Plan:	
Unfunded Pressures - System Flow	£600
Retention of YAS CAS and Independent Sector activity Referral Pressures	£600
MH Section 117 more complex packages	£1,700
D2A (Former HDP) – Out of Hospital Beds	£2,000
Prescribing – DHSC Price concessions and volume	£1,700
Revised Position	**(£5,187)**
Total Mitigations Identified *	£7,758
Revised Surplus Post Schemes	**£2, 571**
Potential Gap to Original Plan	**(£3,829)**

*** Summary of Mitigations**	**£'000**
Balance sheet and technical flexibilities – Non Recurrent	£2,607
Service line reviews - Recurrent	£760
Service line reviews – Non Recurrent	£4,016
Recharges	£375

3.5 The majority of the mitigations in 2022-23 are non-recurrent. The underlying baseline funding gap that ensues from non-recurrent measures forms the basis of the underlying system deficit plan for 2023-24 financial plans.

3.6 Prescribing costs risks continue to rise and NHS England has been notified and lobbied on this particular aspect of our cost pressures.

4 Next steps

4.1 Many Business Units from across the organisation are involved in the financial planning and efficiency process. As this has been an area where it has been difficult to gain traction since the work commenced in July, a contracting document has been developed and agreed to specify the outcomes, process and behaviours required from the team, and the specific business unit contributions.

4.2 There are two meetings in place to support this internal work:

- **Weekly financial efficiency meeting:** This meeting includes all Heads of Pathway Integration, Population Health Planning, Medicines Optimisation, Finance, and Organisational Effectiveness. EMT have been asked to nominate other colleagues to attend this meeting, in particular Digital. This meeting is to identify, track and review potential saving opportunities. The PHP team are running thematic reviews of different areas to help people with this.

- **Bi-weekly financial planning meeting**: this is a small meeting with representatives from Population Health Planning, Finance, Partner Relations Management, and BI, Governance and Medicines Optimisation. This groups' focus is on delivering the necessary processes, guidance, and technical products to enable the efficiency plan.

5 Recommendations

The Leeds Committee of the WY ICB is asked to:

a) **Note** the month 7 year to date and forecast financial position;
b) **Note** the additional key risks that may crystallise later in the year; and
c) **Discuss** the next steps as we close the 2022-23 financial year and prepare for the 2023-24 planning round in the new calendar year.

Appendix 1 – Summary Position at Month 7

	YTD Plan £000	YTD Spend £000	YTD variance £000	Annual Plan £000	Forecast Spend £000	Annual Variance £000
RESOURCE						
Allocation - Programme	833,896		-833,896	1,419,737		-1,419,737
Allocation - Primary Care Co-Commissioning	83,440		-83,440	143,937		-143,937
Allocation - Running Costs	7,922		-7,922	13,706		-13,706
TOTAL RESOURCE for Leeds	**925,258**	**0**	**-925,258**	**1,577,380**	**0**	**-1,577,380**
Expenditure						
Acute	461,333	461,977	644	786,865	788,138	1,273
Mental Health	117,223	116,890	-332	201,256	200,036	-1,220
Community	118,870	120,056	1,187	204,729	206,942	2,214
Continuing Care Services	35,844	34,831	-1,014	61,473	60,083	-1,390
Prescribing and Primary Care	93,961	93,997	36	158,965	159,480	514
Primary Care Co-Commissioning	83,878	84,256	377	145,714	151,249	5,535
Other	7,744	7,713	-31	13,212	13,474	262
Programme Reserves	-3,134	-2,038	1,097	-14,953	-16,838	-1,885
Sub total programme spend	**915,719**	**917,683**	**1,964**	**1,557,261**	**1,562,563**	**5,303**
Running Costs	8,370	7,436	-934	13,706	13,561	-145
Additional Central Adjustment for ARRS					-5,157	-5,157
TOTAL SPEND for ICB in Leeds	**924,089**	**925,119**	**1,030**	**1,570,967**	**1,570,967**	**-**
Planned position	**1,169**		**-1,169**	**6,413**		**-6,413**

Appendix 2 – Running Costs as at month 7

WY ICB - Leeds
Finance Report - Running Costs 22/23
As at 31st October Month 7

Leeds Place description	CCG Cost centre	ICB Cost centre	Budget Holder	Note	Q1 Leeds CCG YTD Plan £'000	Q1 Leeds CCG YTD Spend £'000	Q1 Leeds CCG YTD Variance £'000	Q2-4 Leeds as part of ICB YTD Plan £'000	Q2-4 Leeds as part of ICB YTD Spend £'000	Q2-4 Leeds as part of ICB YTD Variance £'000	Q2-4 Leeds as part of ICB Annual Plan £000	Q2-4 Leeds as part of ICB Forecast Spend £000	Q2-4 Leeds as part of ICB Annual Variance £000	Full year YTD Plan £'000	Full year YTD Spend £'000	Full year YTD Variance £'000	Full year Annual Plan £000	Full year Forecast Spend £000	Full year Annual Variance £000
													96370						
Programme, Improvement & Integration	440261	945561	Sabrina Armstrong		329	267	-62	497	430	-67	1,094	1,045	-49	826	697	-129	1,423	1,312	-111
Office of Data Analytics	440266	945564	Leonardo Tantari	5	409	388	-21	571	633	62	1,267	1,154	-113	980	1,021	41	1,676	1,542	-134
CEO/ICB in Leeds Exec Team	440271	945565	was Tim Ryley		268	254	-14							268	254	-14	268	254	-14
ICB in Leeds Lay Members	440276	945566	was Jason Broch		79	78	-2							79	78	-2	79	78	-2
Clinical Leadership	440291	945569	Sarah Forbes		52	25	-27	70	70	0	156	163	7	122	95	-27	208	188	-20
Primary Care Integration	440292	945570	Gaynor Connor		198	152	-45	276	206	-70	612	532	-80	474	358	-115	810	684	-125
Pathway Integration	440296	945571	Helen Lewis		349	337	-12	491	458	-33	1,135	1,098	-37	840	795	-45	1,484	1,435	-49
Insight, Communication & Involvement	440301	945572	Sabrina Armstrong		172	158	-14	241	193	-48	535	478	-57	413	351	-62	707	636	-71
Partner Relationship Management	440311	945574	Visseh Pejhan-Sykes		134	131	-3	187	194	7	414	410	-4	321	325	4	548	541	-7
Corporate Costs & Services	440316	945575	Sabrina Armstrong		13	10	-3	17	8	-9	38	33	-5	30	18	-12	51	43	-8
Corporate Governance & Risk	440321	945576	Sabrina Armstrong		56	57	2	79	70	-9	174	175	1	135	127	-7	230	232	3
Organisation Development	440331	945577	Sabrina Armstrong	6	46	-13	-59	61	25	-36	138	169	31	107	12	-95	184	156	-28
NHS111/999 contract mgmt	440336	945578	Visseh Pejhan-Sykes		42	45	3	56	61	5	126	138	12	98	106	8	168	183	15
Estates & Facilities	440346	945580	Visseh Pejhan-Sykes		76	78	1	102	52	-50	229	229	0	178	130	-49	305	307	1
Finance	440351	945581	Visseh Pejhan-Sykes		661	641	-20	409	407	-2	898	810	-88	1,070	1,048	-22	1,559	1,451	-108
Admin Reserves	440356	945582	Visseh Pejhan-Sykes	3	-112	70	182	-174	-92	82	-285	491	776	-286	-22	264	-397	561	958
Equality and Diversity	440366	945584	Sabrina Armstrong		119	98	-21	38	13	-25	81	46	-35	157	111	-46	200	144	-56
IT, IG & Digital	440371	945585	Leonardo Tantari		264	276	11	364	331	-33	811	799	-12	628	607	-22	1,075	1,075	-1
IT recharges/NHSE	440376	945586	Leonardo Tantari		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
National Data Lab Funding	440381	945587	Leonardo Tantari		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Public & Patient Involvement - PPI	440406	945592	Sabrina Armstrong		34	7	-27	46	0	-46	103	128	25	80	7	-73	137	135	-2
Population Health Planning	440411	945593	Jenny Cooke		108	105	-3	162	134	-28	407	360	-47	270	239	-31	515	465	-50
Nursing and Quality Assurance	440426	945596	Jo Harding		199	171	-29	280	255	-25	620	607	-13	479	426	-54	819	778	-42
Recharges to Programme (orig incl reserve for ICB core RC rechg)	440431	945597	Visseh Pejhan-Sykes		413	0	-413	-48	0	48	-108	-50	58	365	0	-365	305	-50	-355
Network Development	440441	945599	Tim Ryley		46	74	28	64	53	-11	142	104	-38	110	127	17	188	178	-10
Investment fund	440446	945600	Tim Ryley	5	54	163	109	76	-88	-164	134	142	8	130	75	-55	188	305	117
Planning & Performance	440451	945601	Sabrina Armstrong		60	49	-10	68	46	-22	92	72	-20	128	95	-32	152	121	-30
Leeds Place Committee	440461	945602	Tim Ryley		0	0	0	369	355	-14	827	807	-20	369	355	-14	827	807	-20
RUNNING COSTS TOTAL					4,069	3,621	- 448	4,302	3,814	- 488	9,640	9,940	300	8,371	7,435	- 936	13,709	13,561	- 148
RUNNING COSTS ALLOCATION						3,621						10,085						13,706	
Variance spend to allocation						0						- 145						- 145	

Notes

1. Movements of running costs budgets from Leeds Place to Core actioned in M5 to 7

Trf of ICB board & supporting programmes (9mths) -1,458

Trf of HR budgets to core (9mths) -130

Notes

Non pay buds trf to core eg audit fees (9mths)	-117
Pay uplift back from core to places	191
NI reduction from allocation	-40
Financial Accounting/ Financial Services team from place to core	-267
Corporate Finance team from place to core	-162
	-1,983

2. Underspend of £448k in Q1 as prepared close down statutory accounts for CCG.

Mainly due to budget for recharge of core ICB costs, but no recharge received for Q1

NHSE transferred allocation of £448k from Q1 to Q2-4, in order to bring Q1 to balance and preserve the allocation across the year through 2 organisational formats. So allocation in Q2-4 is £448k than budget

Results in potential to overspend budgets by £448k in Q2-4, and stay within Q2-4 running costs allocation, and balance to budgets across the year and through 2 organisational formats

However underspend in running costs at Q1 required to support programme spend in Q1, so not actually available to spend in Q2-4 running costs

3.Reserves inc Savings target

£600k Reserve now held in forecast excess of vacancy

Negative budget set in respect of this on the admin reserves cost centre £0.2m full year. Increased to £0.4m full year as result of pay rise higher than original 2% reserve. This is currently covered by vacancies/slippage across a number of areas.

This is net of the original 2% pay reserve £191k returned from core budget in M7

4.Overspend on investment fund

M7 Includes unfunded Consultancy work on IDS system flow contractors (Douglas Maxwell and Dola Idowu) £145k

5.ODA

Current forecast of £113k underspend in Q2-4 mainly based on vacancy savings realised to date. This is after forecast of £150k to be spent on contractors from Nov to 31 Mar

6.Training

OD central budget for training of £102k forecast as fully spent, plans currently being worked up

£10k additional training expenses per directorate now forecast (no budget) as agreed by EMT, pressure of £72k (PHP only forecast £2k)

7. Staff costs within programme

Further £8.3m of budgeted staff costs are within programme. Small underspends in some areas due to vacancies

Meeting name:	Leeds Committee of the West Yorkshire Integrated Care Board
Agenda item no.	LC 51/22
Meeting date:	13 December 2022
Report title:	Winter Plan 2022/23
Report presented by:	Helen Lewis, Director of Pathway Integration, ICB in Leeds
Report approved by:	Helen Lewis, Director of Pathway Integration, ICB in Leeds
Report prepared by:	Andrew Baines, Senior Planning, Performance and Sustainability Manager

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

Previous considerations:

Progress on the Winter Plan and adjacent factors is monitored by the System Resilience Operational and Coordinating groups. Extensive governance and reporting oversight mechanisms exist across the West Yorkshire footprint and increasingly through to NHS England.

The Winter Plan has been considered by the Adults, Health and Active Lifestyles Scrutiny Board and progress is reported and monitored regularly through the Leeds Partnership Executive Group.

Executive summary and points for discussion:

In additional to individual winter and resilience plans within organisations, the system in Leeds has a number of additional programmes to support the creation of additional capacity. This additional capacity is to mitigate the modelled increases in demand for acute hospital beds over this period.

Progress on plans and adjacent factors is monitored by the System Resilience Operational and Coordinating groups and assured at the Partnership Executive Group acting as the A&E Delivery Board for Leeds. Extensive governance and reporting oversight mechanisms exists across the WY footprint and increasingly through to NHSE.

Significant risks exist to plans and to systems as a whole exacerbated by likely days of planned industrial action.

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)
<u>The Leeds Committee of the WY ICB is asked to:</u> 1. **Note** the ongoing work, the risks, and the governance arrangements in place to try to mitigate the impact of these demands on the health of our population.
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
N/A

What are the implications for?

Residents and Communities	Risks linked to fuel and food costs are likely to further increase risks to health
Quality and Safety	There is an ongoing risk to the quality and safety of services if increased demand is not met with sufficient increased capacity
Equality, Diversity and Inclusion	None identified
Finances and Use of Resources	Additional services require additional funding not all of which is mitigated by additional flows
Regulation and Legal Requirements	None identified
Conflicts of Interest	None identified
Data Protection	None identified
Transformation and Innovation	None identified
Environmental and Climate Change	None identified
Future Decisions and Policy Making	None identified
Citizen and Stakeholder Engagement	None identified

1. Main Report

1.1 Each organisation in the System has its own winter and resilience plans, decision management tools etc and its own assurance. This report is to bring an overview of the issues and actions at a system level, and in particular to update on plans to increase capacity in the System in the coming months. It also notes uptake of vaccines, given the vital importance of this in helping to mitigate illness requiring acute intervention, particularly among vulnerable groups. It does not cover the significant wider planning of the Council and its partners around food and fuel poverty and the wider communities work to support this.

Acute, Primary care and Community Demand

1.2 High demand at A&E has continued across the summer and into the autumn, with daily patient numbers now on average higher than 2019/ pre-pandemic levels. Pathways are in place to support patients to access Urgent Treatment Centres for minor injuries, and additional same day GP capacity to support minor illnesses.

1.3 Performance against the national A&E targets has been challenged for the majority of this year and unfortunately, patients can wait for extended periods in A&E.

1.4 Acute bed occupancy is regularly 99+% rising above 100% if we include people waiting in the department or other areas for an admission. Admission times are impacted by constricted system flow. Additional acute beds have remained open across the year, and further additional capacity is opening on a phased plan as part of NHS winter plans.

1.5 The numbers of people with Covid in LTHT has reduced again in recent weeks. We have been told that as an initial first wave of Covid is delayed and did not occur mid in November, this may then mean the January peak is also a little later, but it is not easy to predict and there remains a potential for a new variant. We are also expecting a potential influx of flu admissions.

1.6 Admissions are not significantly up in the acute general hospital setting, but we continue to see longer lengths of stay for a wide variety of patients, not only those who require support on discharge.

1.7 Primary medical services (general practice), nationally across West Yorkshire and in Leeds are under significant pressure, resulting from unprecedented demand for services. Over the past four years the registered practice population in Leeds has grown by 30,000. The total number of appointments offered across the 92 GP practices now exceeds pre-pandemic levels.

1.8 Recent data shows delivery of 18,700 appointments per day (during August), rising to over 21,000 in September as practices started the flu and covid vaccination Autumn campaigns. Across our 92 practices currently 44% of all appointments are booked on the same day with a total of 72% being booked within 7 days. In addition to these figures, a further 15,000 appointments per month were delivered through enhanced access services (evenings and weekends in PCN based hubs across the city) and a further 2,800 through the Same Day Response Service.

1.9 Services are generally responding well with most people satisfied with the services they receive, but satisfaction is deteriorating and is variable across our system. This is also borne out by insights from Healthwatch and other organisations. Key concerns include the length of time people wait for appointments, variation in communications approaches used which can lead to confusion around access arrangements and frustrations around processes for booking appointments – including telephony systems.

1.10 Ensuring we focus on the opportunities to improve patient access to, and experience of, general practice is a key priority shared across the Same Day Response and Primary Care Programme Boards. A 24/7 primary care workstream has been established recognising that poor access to same day primary care results in increased pressure elsewhere in the urgent and emergency care system.

1.11 Community health services are also challenged because of demand and staffing, but services prioritise hospital discharge wherever possible. Community health services and primary care staff work closely together to ensure all patients with nursing needs have these met in a timely manner. The Leeds Health and Care Partnership has invested in further community staffing for this winter and partners are working hard to recruit. The virtual wards for frailty and for respiratory conditions are working well, and we are increasing capacity in these too to provide an alternative to admission wherever possible. There are particular pressures on our community health services due to an increased number of people choosing to die in their own homes.

1.12 Work is ongoing to increase joint working between LCH and the LCC reablement service, with alignment of services in Hubs across the City. There is also a strengthened relationship with VCSE partners through significant investment in the pilot Enhance programme where partners are acting as ‘proxy family’ to support with tasks that would previously have needed a statutory partner.

Mental Health Services

1.13 Mental Health Statutory services continue to be under sustained pressure with occupancy across inpatient services at a normalised position of over 100%. This means that we have variable but consistent numbers of people being actively treated out of area, sometimes at considerable distance, from Leeds. We know that from a clinical outcome and a patient experience perspective this is far from ideal and does not provide the care we aspire to. We have a continued work programme to support our shared aspiration to reduce and eliminate the need for Out of Area care. In the interim, LYPFT have sourced a further set of beds to help consolidate patients into fewer locations.

1.14 Over a period of 5 years, we have worked hard to build alternative and community support that enables us to provide care as close to home as possible in urgent and emergency situations, but very often the clinical risk is such that inpatient admission out of area is necessary. We have had numerous interventions in Leeds that reiterate that in acute adult MH services we have the right number of inpatient assessment and treatment facilities in place but that these need to be supported by coordinated and integrated community provision. We have plans in place to continue to drive this as a priority.

1.15 In our older adult services however, this is more problematic with a sustained Delayed Transfer of Care position of inability to admit to Care Home provision and in particular, for people who need provision for more specialist complex and challenging behaviour. At any time around 30% of our beds in our specialist MH Older Adult inpatient services are occupied with people awaiting a new setting.

1.16 We are working closely with LA colleagues to build on the successful model operationalised at the Willows but this will not be in place through the winter of 2022/23. Some additional Independent sector nursing beds for people with more complex dementia have just opened and LCC and NHS colleagues are working closely together to identify the most suitable patients for these beds from across the system which should have an impact on occupancy for both LYPFT and LTHT.

1.17 Our key mental health risks and mitigations over winter include:

- Sustained focus and attention on patient flow in Adult and Older Adult Care (recognising that we will be impacted by staff availability and managing the significant increase in demand in the urgent care response and admission).

- Significant staffing risks in our core Leeds MH Services (including CMHT's and Crisis services) with vacancies in our core services approaching 50%.
- Sustained pressure in CYPMH Tier 4, Forensic. Acute Adult, Eating Disorder, Rehab and Older Adult Services, Crisis services.
- Focus on the interface (and prioritisation) with LTHT colleagues to support and maintain flow in liaison and discharge services from LTHT.

Public Health Plan

1.18 Each year Public Health contributes to strengthening the system wide approach to protect the health of the population during periods of cold weather by preparing for, alerting people to, and protecting from, the major avoidable effects on health.

1.19 Public health contributes to a system wide winter prevention plan focussing on the following key priorities:

- Providing PH leadership through the Health Protection Board in the prevention and management of winter related diseases and infections in Leeds.
- Supporting the winter system resilience plan through commissioning services and system leadership with a focus on:
- Supporting people living with frailty to reduce vulnerability to poor health during the winter period.
- Prevent the major avoidable effects on health associated with cold weather and living in cold and/or damp conditions.
- PH activity contributing to mitigating the adverse health impacts of cost of living crisis during winter 22/23 – in the context of broader city wide work leading on addressing cost of living

1.20 The Public Health Winter Plan is developed and led by the Public Health Weather and Health Impact Group (WHIG). The group ensures prevention plans are in place to protect against the hazardous effects of adverse weather on health. The plan enables people to live healthier lives throughout periods of adverse weather. In addition, the plan supports the health and social care system reduce the pressures brought about by additional demand during the winter period. The actions and interventions within the plan provide additional support to people who are:

- At risk of hospitalisation during winter to avoid admission to hospital where possible
- Unable to return home without measures in place to enable them to do so safely or independently therefore delaying discharge when demand is particularly high.

1.21 This plan also recognises the additional challenges that COVID-19 presents during the winter period both for people and the expected pressures across the health and social care system.

1.22 Public Health have a number of commissioned services that support individuals across our communities and contribute to the systems response to Winter and have a detailed winter plan that covers these areas:

- Community Infection prevention and control service providing support including into care homes and home care and outbreak management response.
- Home Plus (Leeds) enabling and maintaining independent living through improving health at home, helping to prevent falls and cold related health conditions.
- Active Leeds Health Programmes delivering a range of activities to support people to self-manage their health conditions through physical activity and support those at risk of falling to improve their strength, balance and coordination.
- Lunch clubs addressing malnutrition, hydration and social isolation.
- Winter grants with the small grants scheme for community groups.
- Neighbourhood Network Schemes provide a range of services, activities and opportunities promoting the independence, health and well-being of older people throughout Leeds.
- Winter Friends programme building on the success of last year's public facing winter friends programme, and a public facing campaign to promote neighbourliness and kindness in communities focussing on the nine-evidence based high impact interventions.

<u>Vaccination</u>

1.23 Vaccinations are an important element of the prevention agenda.

1.24 Our flu targets for 2022/23 are to meet and exceed uptake rates from 2021/22. Recent numbers for people who are 65 and over are slightly lower than at this stage last year. At the end of the last season 83% was reached for this population cohort. Vaccination rates are monitored closely and actions taken to ensure we focus on increasing uptake, particularly in disadvantaged and at risk communities and groups. There is particular concern around flu this year as we have not had a significant level of flu for the past 3 years, as it was supressed by the actions that were taken to minimise the spread of Covid. We know the flu season started early in Australia and that our current vaccine is a good match for the circulating virus. We need to ensure high levels of coverage to help minimise acute illness and hospital admissions.

1.25 Covid vaccinations rates for the over 50s and clinically vulnerable are also monitored. The autumn booster programme began in September with visits to care homes and housebound. This vaccine is being given at the same time as the flu vaccine wherever possible. Leeds has an 'evergreen offer' so that people who have not yet received any doses for which they are eligible can continue to do so. Detailed data is tracked to help continue to focus on those communities and groups with the lowest rates of vaccination.

Demand Assumptions for Winter

1.26 Modelling scenarios have been calculated by LTHT against best-case, mid-case and reasonable worst-case bases for Influenza, Covid and elective demand, that indicate an increased requirement of acute beds across winter and priority system capacity and improvement plans have been aligned to mitigate this increase.

1.27 Winter activity profiles across urgent and emergency care services also show a seasonal increase in demand for services in November. We saw our highest attendances in A&E so far in the week of 28 November.

1.28 The modelling numbers include an ambition to maintain our current levels of elective activity, mindful of the need to ensure we continue to treat our cancer patients and continue to make progress on treating those patients whose care was delayed during the pandemic and by the ongoing constraints on our capacity caused by its aftermath. Leeds is making good progress in this area, but we still have waits that are far longer than before the pandemic.

Creating additional capacity

1.29 Partners in the health and care system are taking a number of actions to create additional capacity in line with the expected peak of demands.

1.30 Plans and schemes include:

- Acute capacity and efficiency plans to increase bed capacity with plans submitted as part of NHS Winter Plans
- System flow productivity programmes include further improvements in our processes within the multidisciplinary Transfer of Care Hub, on the day discharge to community Neighbourhood Teams, enhanced staffing into Bed Brokerage, productivity improvements as a result of a single queue for Reablement, and additional social work capacity
- A number of schemes contributing to out of hospital capacity including expansion of community virtual ward capacity, additional recruitment to CIVAS, additional 3rd sector capacity, additional care home dementia capacity, and wider support to care homes and additional rehabilitation beds being opened where possible

1.31 Significant risks to all schemes will relate to recruitment of appropriate additional staffing, and the costs of agency staffing which are extremely high. All partners are focused on maximising capacity while recognising the likely level of pressures and acuity which will be exacerbated by higher staff absences during periods of Covid and/or flu.

National planning requirements and resilience response

1.32 The National Winter focus areas as outlined in the going further on winter resilience plans include but are not exclusive to:

- Preparing for new COVID-19 variants/respiratory challenges
- Prevention – Infection Prevention Control, Vaccination Programme
- Workforce
- Better support people in the community and preventing avoidable admissions
- Deliver on our ambitions to algin capacity and demand, maximising resources – additional funding
- Support improvements in ambulance services – 111 and 999 focus on reducing handover delays
- Ensure timely discharge and support people to leave hospital when clinically appropriate to support flow
- Maintaining elective activity including cancer and diagnostics
- System and Trust oversight and incident management arrangements – System Control Centre
- Regular performance monitoring – Board Assurance Framework (BAF)

1.33 The NHS Winter Board Assurance Framework contains the following 6 nationally mandated winter metrics:

- 111 call abandonment.
- Mean 999 call answering times.
- Category 2 ambulance response times.
- Average hours lost to ambulance handover delays per day.
- Adult general and acute type 1 bed occupancy (adjusted for void beds).
- Percentage of beds occupied by patients who no longer meet the criteria to reside

Risks

1.34 There remain significant risks to the delivery plans outlined not least of which is the capacity to recruit additional staffing both for the winter wards and for the community capacity.

1.35 The ICB has identified the following risks, which are replicated at Place level.

- Maintaining quality and safety
- Workforce pressures – exceptional levels of sickness and vacancies
- Impact of delivering vaccination programme, maintaining pace and uptake
- Increased COVID-19 demand above modelled levels– prolonged recovery, concurrent peaks of Flu, RSV
- Pressures in primary care and same day urgent care services
- Increased 999 & 111 demand– excessive response times
- Pressures in mental health services
- Contingency for electives
- Imbalance in demand and capacity e.g. Bed capacity
- Breakdown in system flow – community services and social care unable to maintain services to meet demand
- Public expectation and behaviour
- Supply chain issues
- Cost of living and fuel poverty
- Industrial action

2. Next Steps

2.1 The programmes in support of winter planning all continue, with progress reported and monitored at our Partnership Executive Group.

3. Recommendations

3.1 The system enters winter having had a sustained period of high demand and ongoing difficulties in ensuring people are discharged promptly from hospital when they no longer need acute services. The Leeds Health and Care Partnership is working hard to plan for the coming period, mindful of the pressures on citizens and staff which may exacerbate the health and care needs of our system.

The Leeds Committee of the WY ICB is asked to:

a) **Note** the ongoing work, the risks, and the governance arrangements in place to try to mitigate the impact of these demands on the health of our population.

Meeting name:	Leeds Committee of the West Yorkshire Integrated Care Board
Agenda item no.	LC 52/22
Meeting date:	13 December 2022
Report title:	Refresh of the West Yorkshire Partnership's Five-Year Strategy - Working Draft
Report presented by:	Jenny Cooke, Director of Population Health Planning, ICB in Leeds
Report approved by:	N/A
Report prepared by:	Esther Ashman, Associate Director Strategy, WY ICB

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

Previous considerations:

The draft strategy attached will be considered by the West Yorkshire Partnership Board on 8th December 2022 and will also be considered at all place committees and Health and Wellbeing Boards across West Yorkshire, ahead of final approvals in March 2023.

Executive summary and points for discussion:

In December 2019, the WY Partnership Board approved the Five-Year Strategy for the Partnership, *Better health and wellbeing for everyone*. This document was the culmination of a long period of public and partnership engagement and set out the vision, ambitions and ways of working for the partnership.

Since its publication, the context and focus for our work has changed significantly. While we have made good progress across a range of areas, the Covid-19 pandemic has meant that our partnership has necessarily needed to shift its focus away from our priorities to more immediate operational pressures. The scale of challenge has also increased in a number of areas, most notably the widening of inequalities. A current position against the 10 Big Ambitions is set out in Appendix A. In addition, the changing landscape of health and care brought about by the Health and Care Act 2022, has set out new ways of working together to achieve a truly integrated system.

In March 2022, the WY Partnership Board agreed an approach to refreshing the Partnership's Five-Year Strategy and developing an improvement and delivery framework to affect its implementation. This approach has its foundations in places with the strategy being built from the five places' Health and Wellbeing Strategies.

The strategy refresh has been undertaken using an inclusive approach. There has been the opportunity for all members of the Partnership and the wider system to be involved through a networked approach to engagement and open and transparent opportunities to be part of the dialogue. There has been the opportunity for effective challenge, enabling diversity of thought and keeping open minds and hearts. The work has been driven by a strategy design group which reflects the broad diversity of the Partnership and who have been working hard since April 2022, to develop ways in which the system can connect itself better and use tools to support an improvement ethos to ensure delivery of the strategy.

In September 2022, an update on the work undertaken to date was brought to WY Partnership Board for both assurance of the work and agreement of the proposed changes in focus for the strategy.

A working draft of the strategy is attached for comment, which is intended to retain the continuity of purpose that the Partnership previously set out, whilst recognising the changing context we live and work in. It is important to note that this draft has been developed in a time of significant uncertainty, with budgets and allocations for coming years yet to be finalised i.e. there is a lack of clarity of funding to support the delivery of the strategy. In addition, expected guidance on the development of Joint Forward Plans to deliver the strategy has been substantially delayed as is yet to be published, however we continue to focus on what we know is right for us in West Yorkshire and how we work collaboratively to design the future we want to see. With this in mind, there may need to be further discussion around the trajectories and targets for our ambitions once this detail has been received.

An important element of the strategy work has been to consider evaluation and how we will know that we have been successful in its delivery. Whilst much of the focus to date has been around national oversight metrics and those metrics through which we are currently measuring progress against the 10 big ambitions, the strategy design work seeks to enhance this further. It is proposed that moving forward we use an approach where we bring these together with a third element, ‘the integrated care experience’ to ensure that we are able to have an holistic richness to our information and can truly understand what is telling us about our system, the extent to which people feel their care is joined-up and seamless based on their own experiences interfacing with multiple different teams and organisations, what needs to change and what it needs to look like.

We know that there is already promising practice around gathering this information across the Partnership, not least in large scale transformation programmes, places and Local Authorities. Our work includes building on and implementing the recommendations from the Independent Review of Involvement and Good Governance Institute, where not already in place. This will involve where needed, a renewed focus, capacity and investment. The Leeds Committee is asked to support this approach to the ongoing delivery of the strategy.

The work to finalise the draft strategy is still under development, with engagement taking place over the coming weeks and months at the Joint Health Overview and Scrutiny Committee and place Health and Wellbeing Boards. A final copy of the strategy will be presented to the March 2023 meeting of the Partnership Board for approval.

Which purpose(s) of an Integrated Care System does this report align with?
☒ Improve healthcare outcomes for residents in their system ☒ Tackle inequalities in access, experience, and outcomes ☒ Enhance productivity and value for money ☒ Support broader social and economic development
Recommendation(s)
The Leeds Committee of the West Yorkshire Integrated Care Board is asked to: 1. **Note** the work that has been undertaken across the Partnership as part of the refresh of the strategy; 2. **Support** the proposition to further build the 'integrated care experience' into the way in which we work to deliver the strategy; and 3. **Comment** on the current draft of the strategy, noting the further work to be undertaken as part of its development.
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. Appendix 1 - 10 Strategic ambitions – Update December 2022 2. Appendix 2 – West Yorkshire Partnership's Five-Year Strategy - Working Draft
Acronyms and Abbreviations explained
N/A

What are the implications for?

Residents and Communities	The strategy sets out the vision for integrated health and care for residents and communities.
Quality and Safety	Quality and safety are fundamental to the delivery of the strategy, embedded in everything we do with an approach described in the strategy itself.
Equality, Diversity and Inclusion	Our strategy is also focused on making all groups of people feel included and valued within their society or community so that there isn't a negative effect on their health and wellbeing and so everyone can access the care they need.
Finances and Use of Resources	The strategy sets out a vision for using money and resources in an innovative way in order to deliver

	the strategy. The detail of this is not included in the strategy.
Regulation and Legal Requirements	N/A
Conflicts of Interest	N/A
Data Protection	N/A
Transformation and Innovation	The strategy sets an ambition to innovate and build new ways of working in order to transform integrated health and care for the West Yorkshire population.
Environmental and Climate Change	The strategy sets out an ambition to achieve for tackling climate change, including embedding sustainability and climate change into all plans.
Future Decisions and Policy Making	The strategy sets the direction for future decisions and policy making.
Citizen and Stakeholder Engagement	The strategy and this cover note describe the way in which citizen and stakeholder engagement have been embedded into the development of the strategy refresh. It also highlights the desire to strengthen the role of citizen experience of integrated care into the development of the delivery plans and ongoing evaluation and transformation.

West Yorkshire
Health and Care Partnership

Agenda item LC 52/22

10 Strategic ambitions - Update December 2022

Appendix 1

West Yorkshire
Health and Care Partnership

Ambition 1 - Metric 1

We will increase the years of life that people live in good health in West Yorkshire and Harrogate compared to the rest of England. We will reduce the gap in life expectancy by 5% (six months of life for men and five months of life for women) between the people living in our most deprived communities compared with the least deprived communities by 2024.

These graphs show, for females and males at birth and age 65, the difference in life expectancy (in years) between the most and least deprived areas in each place. A lower value indicates less inequality in life expectancy.

On these graphs, a higher value indicates greater inequality.

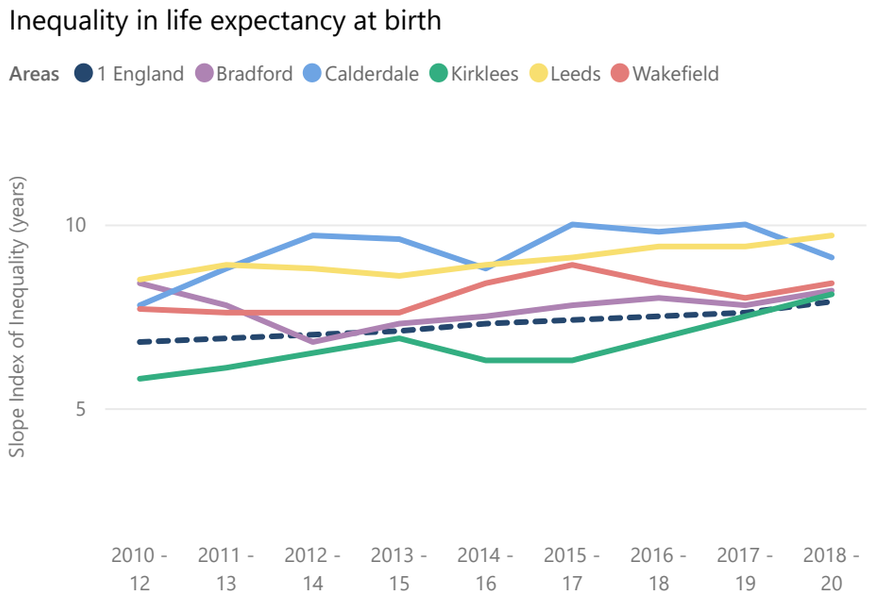
Metric 1 - Inequality in life expectancy at birth - Female
Metric 2 - Inequality in life expectancy at birth - Males
Metric 3 - Inequality in life expectancy at 65 - Female
Metric 4 - Inequality in life expectancy at 65 - Male

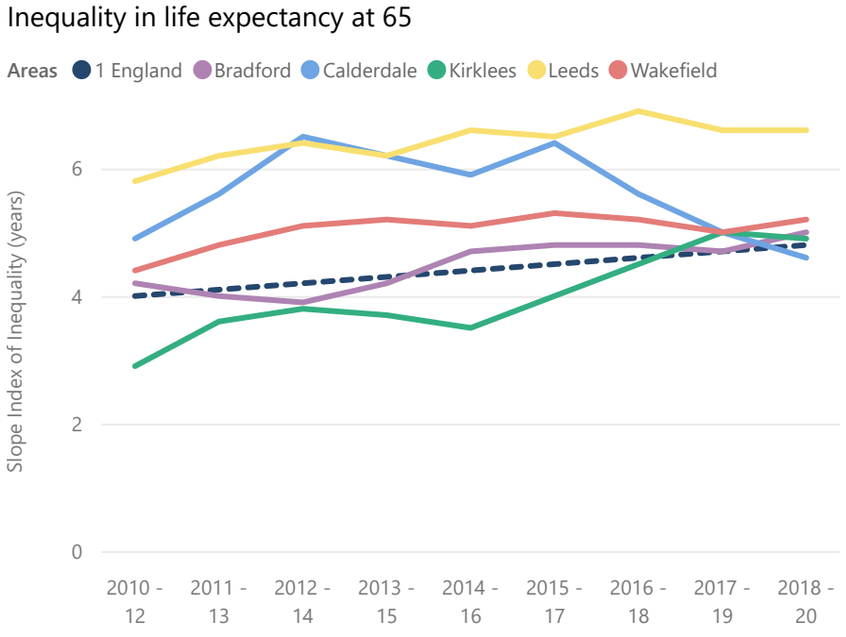
Data Sources

Figures calculated by Office for Health Improvements and Disparities using mortality data and mid-year population estimates from the Office for National Statistics and Index of Multiple Deprivation 2010, 2015 and 2019 (IMD 2010 / IMD 2015 / IMD 2019) scores from the Ministry of Housing, Communities and Local Government.

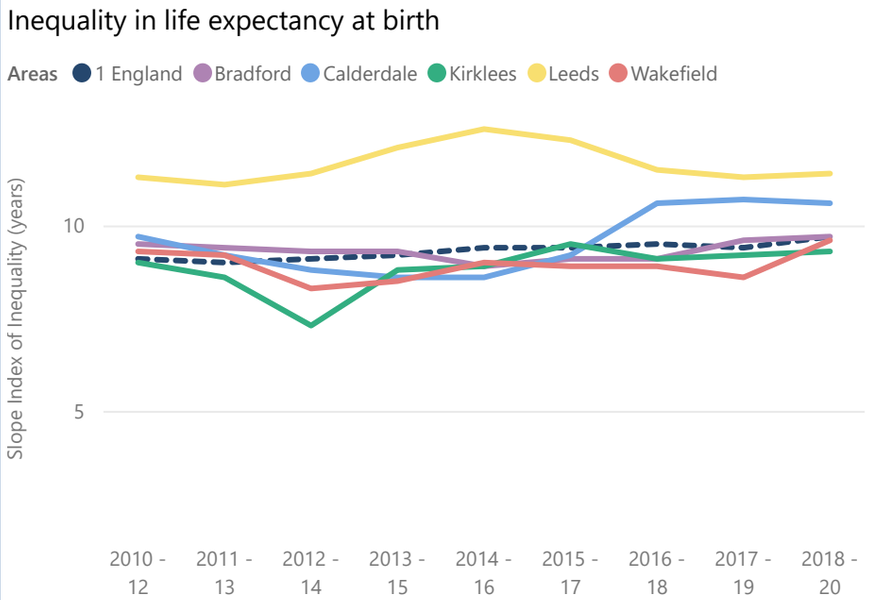
Extracted from Fingertips (OHID)

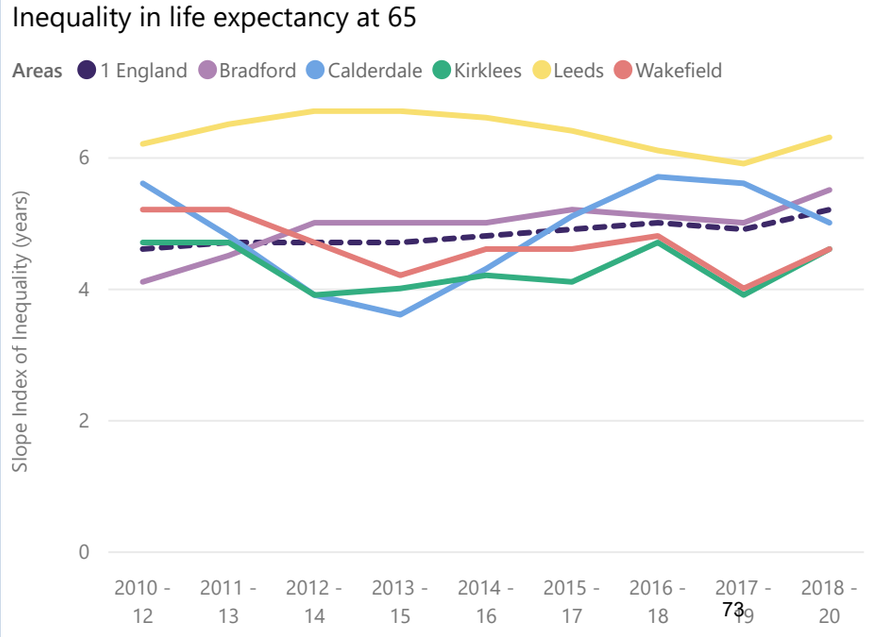
Female





Male





West Yorkshire
Health and Care Partnership

Ambition 1 - Metric 2

We will increase the years of life that people live in good health in West Yorkshire and Harrogate compared to the rest of England. We will reduce the gap in life expectancy by 5% (six months of life for men and five months of life for women) between the people living in our most deprived communities compared with the least deprived communities by 2024.
These metrics relate to 2 of the 3 levels of disease prevention for 2 of the main causes of death in West Yorkshire - CVD and COPD:

Metric 1 - % of patients with CHD prescribed aspirin, APT or ACT.
Metric 2 - % of patients with COPD who have had influenza immunisation.

Data source
Calculated using Quality Outcomes Framework (QOF) data. NHS Digital. 2020/21. CCGs.
Extracted from Fingertips (OHID).

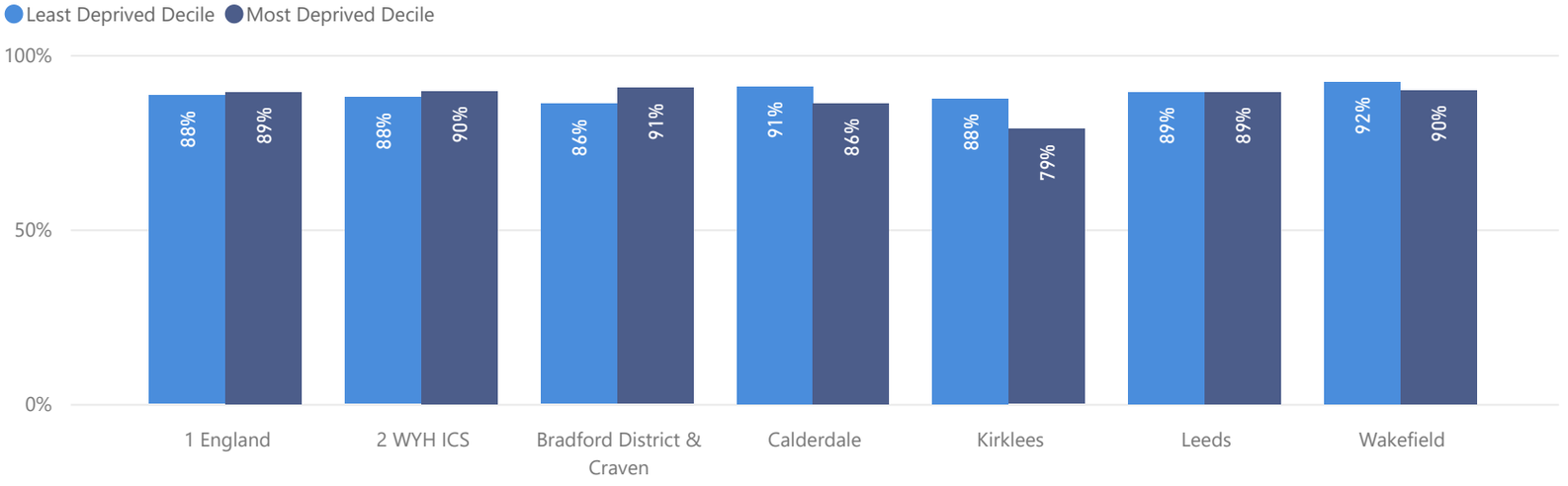
Least deprived decile is not always decile 10, and where unavailable the next decile has been used.

Timeperiod
2020/21

Cardio-Vascular Disease (CVD)

Tertiary Prevention

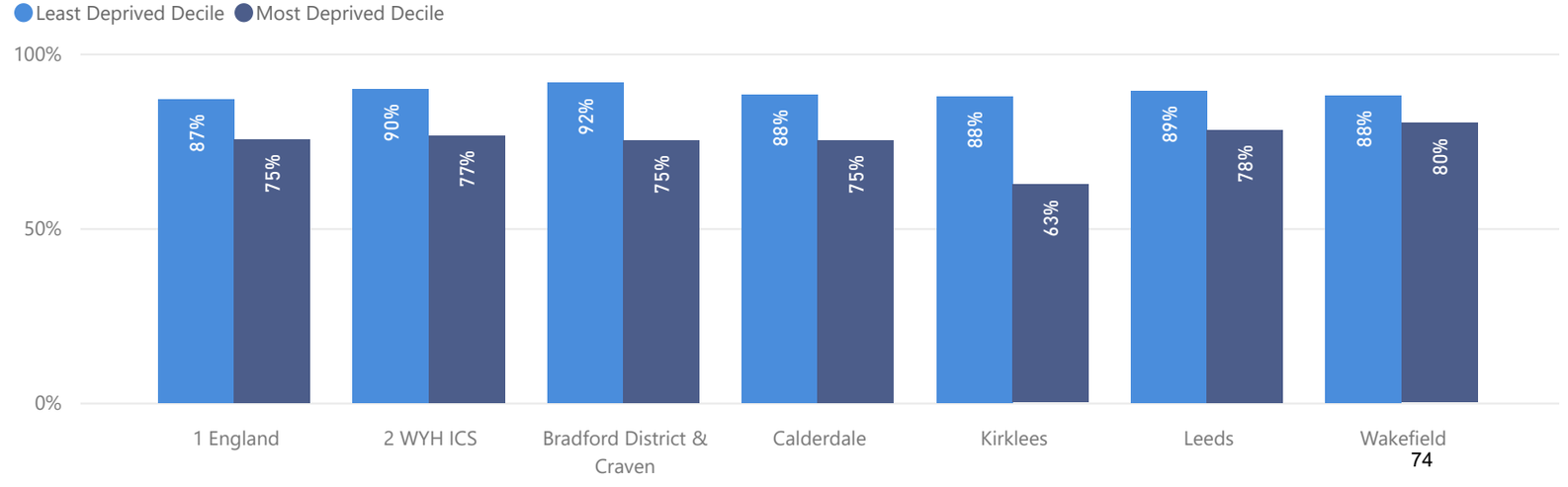
CHD prescribed aspirin, APT or ACT in last 12m



Chronic obstructive pulmonary disease (COPD)

Tertiary Prevention

COPD with Influenza Immunisation



West Yorkshire
Health and Care Partnership

Lung Cancer

Ambition 1 - Metric 3

We will increase the years of life that people live in good health in West Yorkshire and Harrogate compared to the rest of England. We will reduce the gap in life expectancy by 5% (six months of life for men and five months of life for women) between the people living in our most deprived communities compared with the least deprived communities by 2024.

These metrics relate to the 3 levels of disease prevention for another main cause of death in West Yorkshire - Lung Cancer:

Metric 1 - Smoking prevalence in adults in routine and manual occupations (ages 18-64).

Metric 2 - % of lung cancer diagnosed at an early stage (stage 1 or 2). Cancer Alliance Data, Evidence and Analysis Service (CADEAS) data. 2018. Based on most and least deprived quintiles.

Metric 3 - Proportion of baseline levels of 1st treatments for lung cancer. CADEAS data. Mar - Dec 2020 vs Mar - Dec 2019.

Data sources

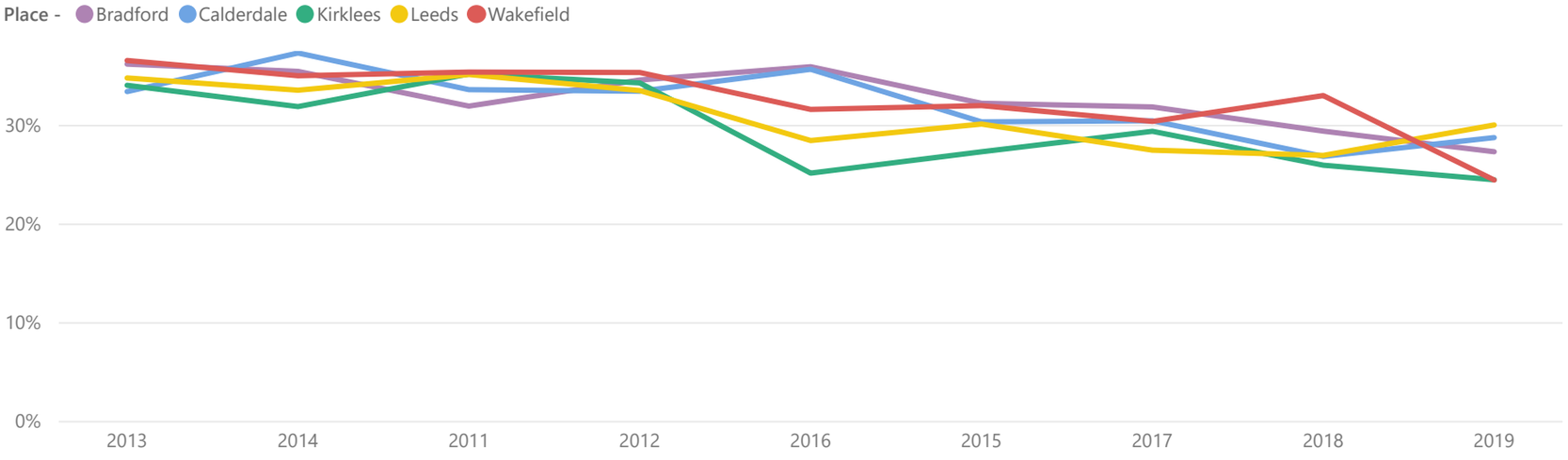
Annual Population Survey (APS). 2013 - 2019. CCGs. (Metric 1) Extracted from Fingertips (OHID).

Cancer Alliance Data, Evidence and Analysis Service (CADEAS). 2019. (Metric 2).

Cancer Alliance Data, Evidence and Analysis Service (CADEAS). Difference between 2019/20 - 2020/22.

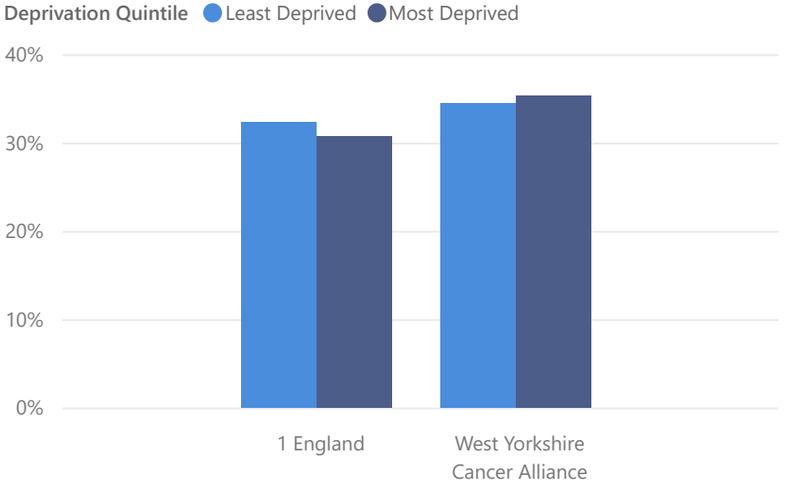
Primary Prevention

Smoking Prevalence in adults in routine and manual occupations (18-64)



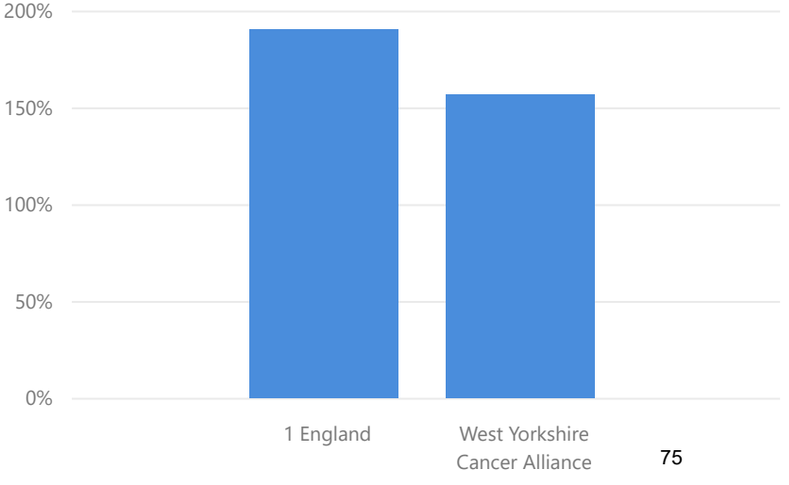
Secondary Prevention

% of lung cancer diagnosed at early stage



Tertiary Prevention

Proportion of baseline levels of 1st Treatments for Lung Cancer Mar - Dec 20 vs Mar - Dec 19



West Yorkshire
Health and Care Partnership

Ambition 2 - Metric 1

We will achieve a 10% reduction in the gap in life expectancy between people with mental health conditions, learning disabilities and/or autism and the rest of the population by 2024 (approx 220,000 people). In doing this we will focus on early support for children and young people.
These metrics relate to the wider determinants of health such as housing and employment, and to primary prevention.

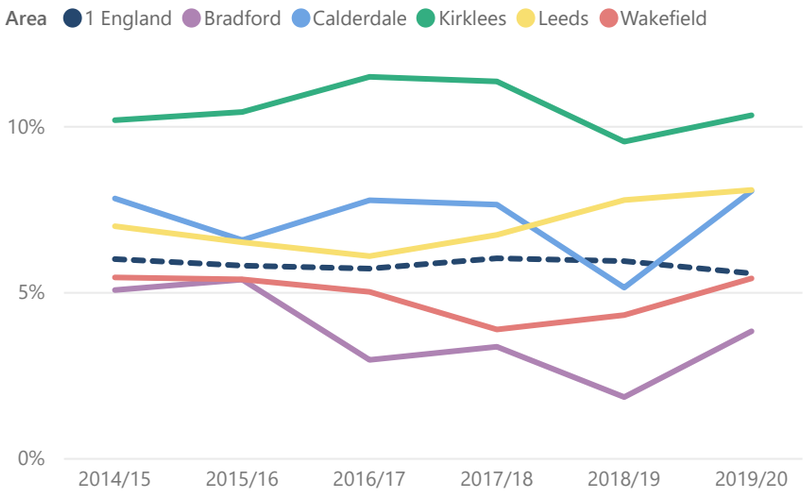
Metric 1 - Proportion of supported working age adults with learning disability in paid employment. PHE Fingertips. 2019/20. Local Authorities.
Metric 2 - Proportion of supported working age adults with learning disability living in settled accommodation. PHE Fingertips. 2019/20. Local Authorities.
Metric 3 - Proportion of eligible adults with a learning disability having a GP health check. PHE Fingertips. 2018/19. Local Authorities.

Data sources

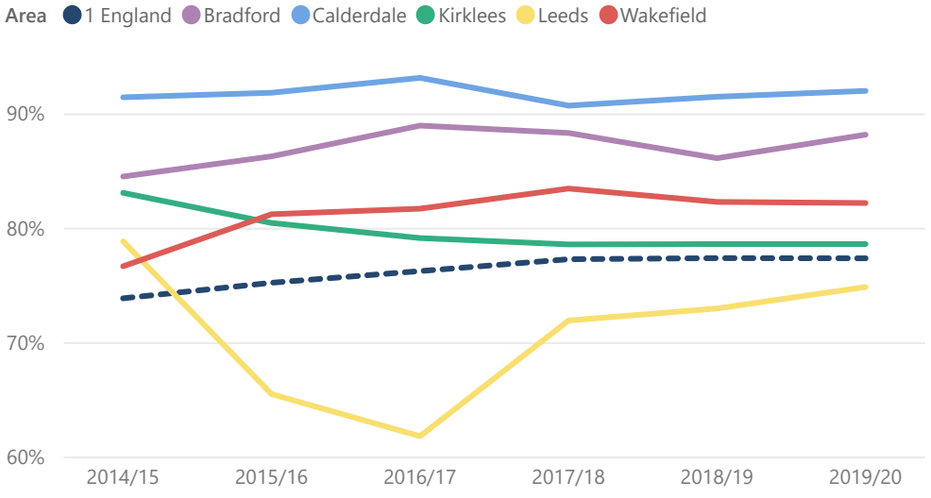
NHS Digital, Adult Social Care Activity and Finance Report, Short and Long- Term Care Statistics (Metrics 1 and 2)
NHS Digital, Learning Disabilities Health Check Scheme Statistics (numerator) and QOF data (denominator)
Extracted from Fingertips (OHID).

Determinants of Health

Employment - Proportion of supported working age adults with learning disability in paid employment from 2014/15 to 2018/9

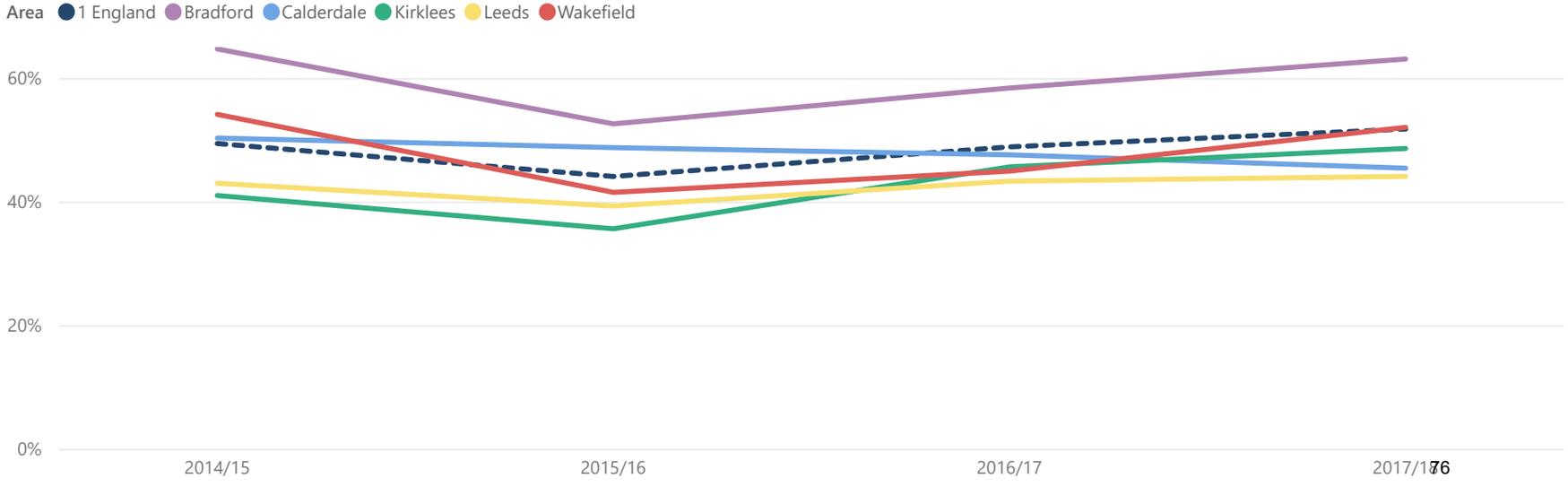


Housing - Proportion of supported working age adults with learning disability in settled accommodation from 2014/15 to 2018/19



Primary Prevention

Proportion of eligible adults with a learning disability having a GP health check - All ages



West Yorkshire
Health and Care Partnership

Ambition 2 - Metric 2

We will achieve a 10% reduction in the gap in life expectancy between people with mental health conditions, learning disabilities and/or autism and the rest of the population by 2024 (approx 220,000 people). In doing this we will focus on early support for children and young people.
These metrics relate to primary care interventions linked to Cardio-Vascular Disease.

Metric 1 - Record of blood pressure check in preceding 12 months for patients on the Mental Heath (MH) register in general practice.
Metric 2 - Record of Body Mass Index (BMI) in the last 12 months for patients on the MH register in general practice.

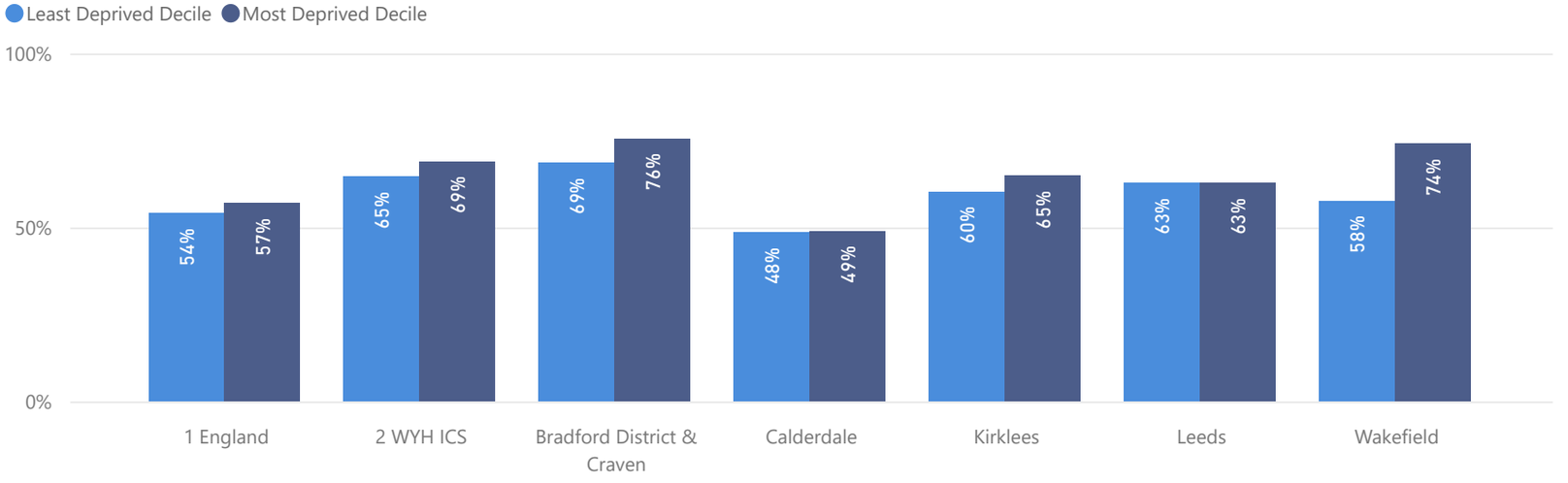
Data source for all metrics
Calculated using Quality Outcomes Framework (QOF) data. NHS Digital. 2020/21. CCGs.
Extracted from Fingertips (OHID).

Cardio-Vascular Disease (CVD)

Timeperiod
2020/21

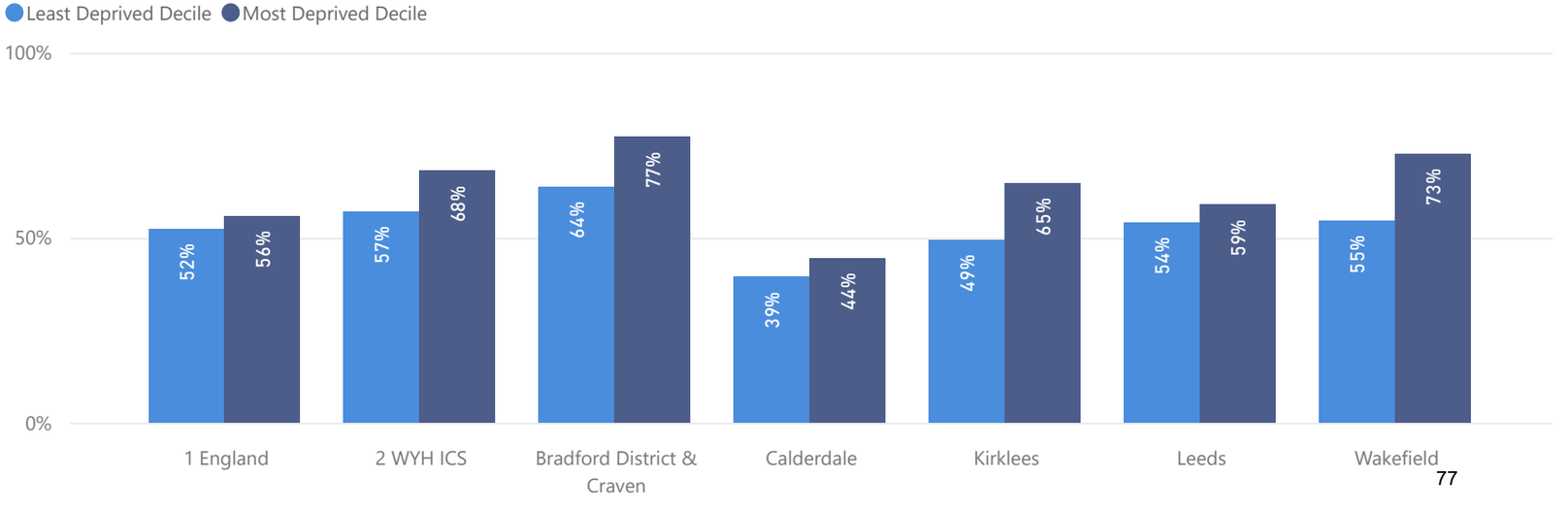
Secondary Prevention

Record of blood pressure check in preceding 12 months for patients on the MH register in general practice



Primary Prevention

Record of BMI in the last 12 months for patients on the MH register in general practice



West Yorkshire
Health and Care Partnership

Ambition 3 - Metric 1

We will address the health inequality gap for children living in households with the lowest incomes. This will be central for our approach to improving outcomes by 2024. This will include halting the trend in childhood obesity, including those children living in poverty
These graphs show, for both reception and year 6, the proportion of children who are either over-weight, obese or severely obese.

Metric 1 - Prevalence of Overweight Children - reception.
Metric 2 - Prevalence of Overweight Children - year 6.
Metric 3 - Prevalence of Severely Obese Children - reception.
Metric 4 - Prevalence of Severely Obese Children - year 6.

Data Source
NHS Digital, National Child Measurement Programme.
2010/11 - 2019/20. Local Authorities.
Extracted from Fingertips (OHID).

West Yorkshire
Health and Care Partnership

Ambition 3 - Metric 2

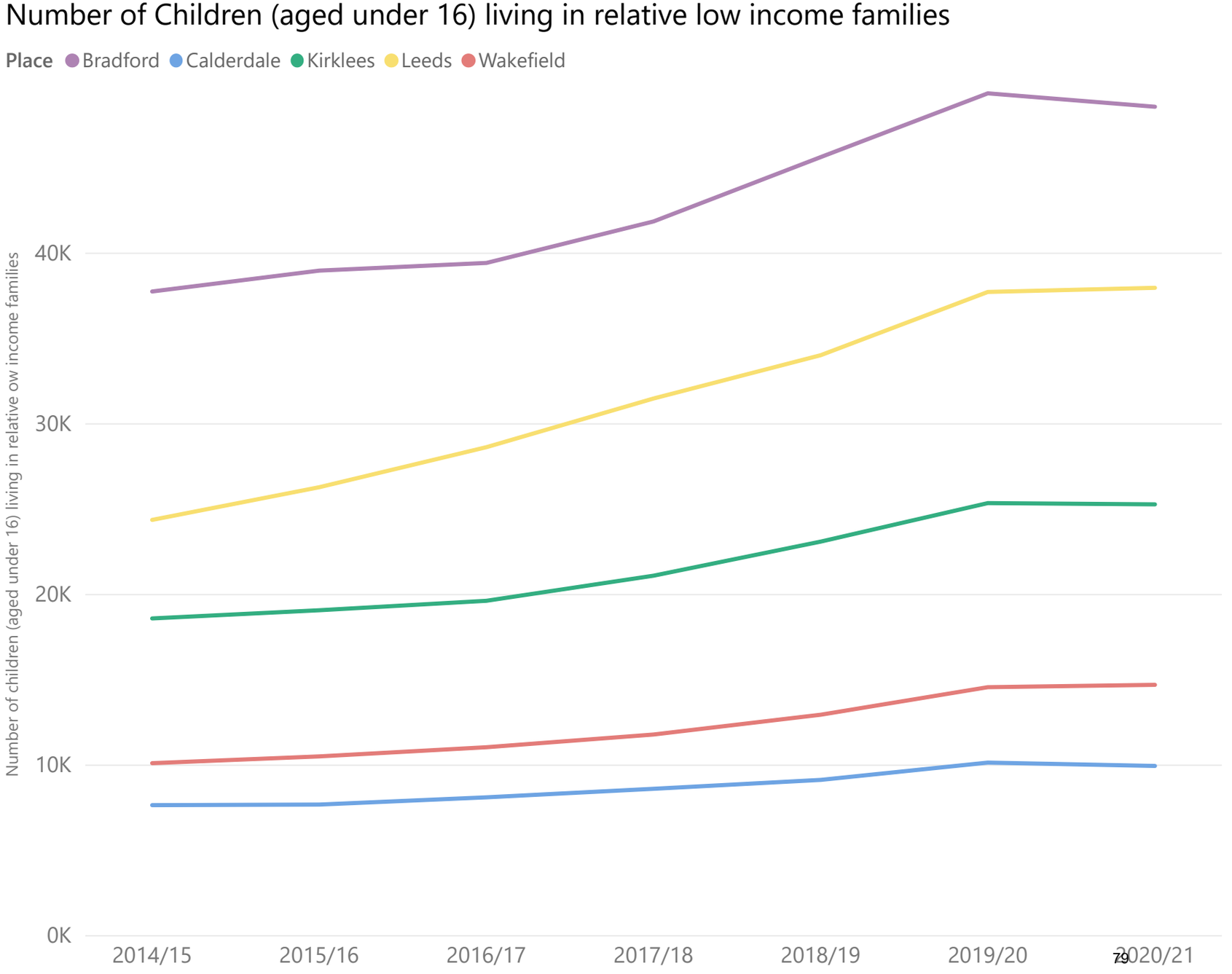
We will address the health inequality gap for children living in households with the lowest incomes. This will be central for our approach to improving outcomes by 2024. This will include halting the trend in childhood obesity, including those children living in poverty

This graph shows how the number of children living in relative low income families has changed between 2015 and 2020. There are now over 138,000 children living in those families, based on provisional 2020 data.

Metric 1 - Number of Children (aged under 16) living in relative low income families.

Data Source

The Office for Health Improvement and Disparities. 2014 - 15 - 2020 - 2021. Local Authorities.
Extracted from Fingertips (OHID).



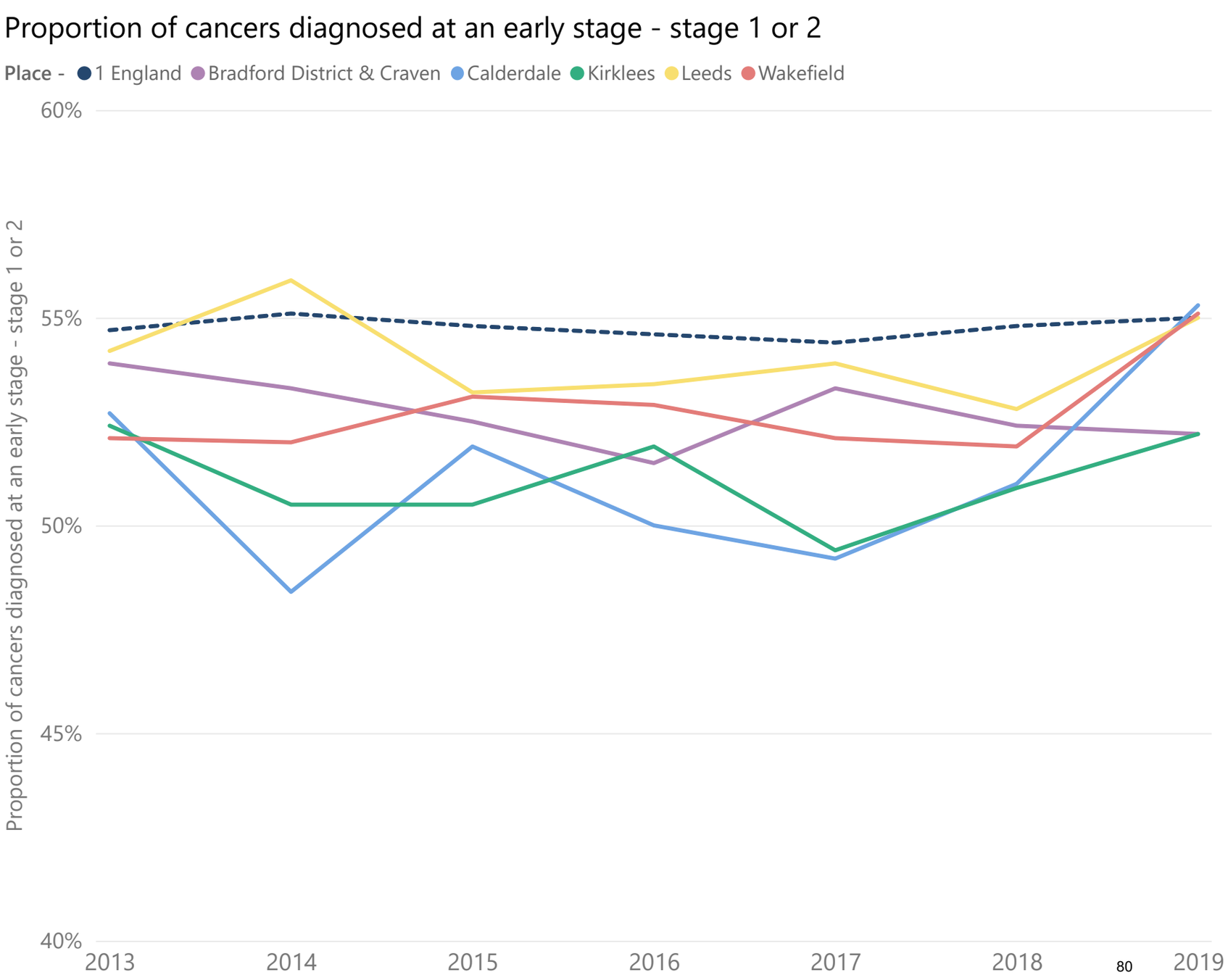
West Yorkshire
Health and Care Partnership

Ambition 4

By 2024 we will have increased our early diagnosis rates for cancer, ensuring at least 1,000 more people will have the chance of curative treatment.
The overall proportion of cancers diagnosed at an early stage (either stage 1 or 2) was 51.9% in 2018. This is based on the latest published data.

Metric 1 - Proportion of cancers diagnosed at an early stage - stage 1 or 2.

Data Source
Cancer Alliance Data, Evidence and Analysis Service (CADEAS). 2013-2019. CCGs.



West Yorkshire
Health and Care Partnership

Ambition 5

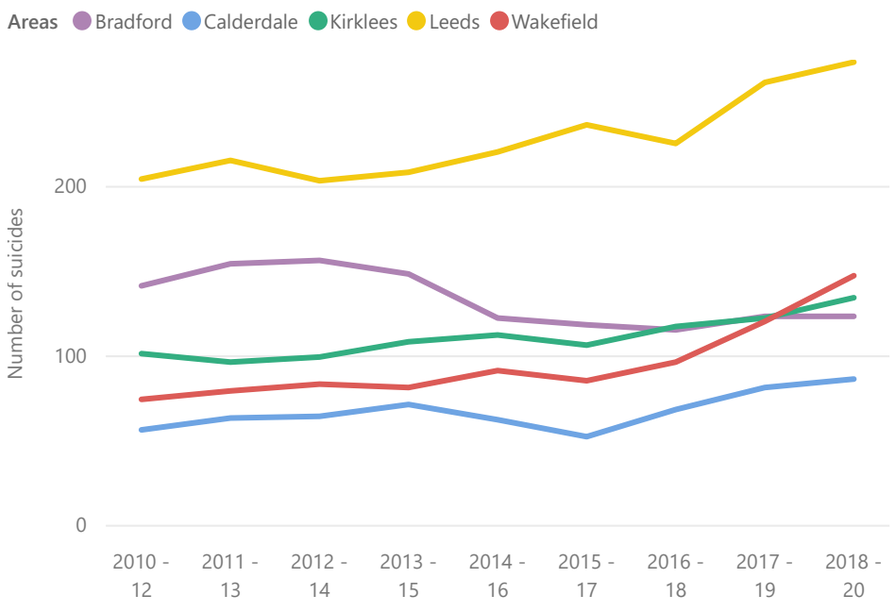
We will reduce suicide by 10% across West Yorkshire by 2020/21 and achieve a 75% reduction in targeted areas by 2022.

In 2019 there were 277 suicides recorded in West Yorkshire, a 22% increase on the 2015 number of 227 suicides. There is a significant degree of variation in both numbers and change over time between the places in West Yorkshire, as can be seen from the graphs to the right.

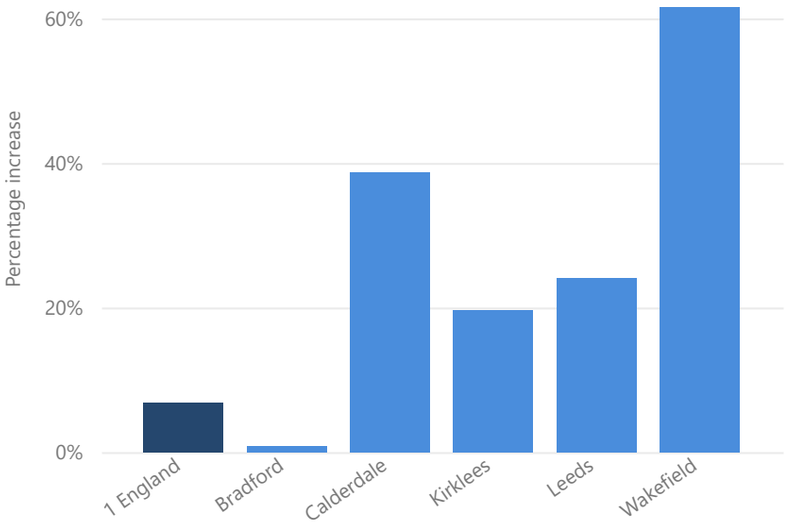
Metric 1 - Number of Suicides.
Metric 2 - Percentage change in the number of suicides between 2014 -16 - 2018 -20.
Metric 3 - Age-standardised suicide rates per 100,000 population, standardised to the 2013 European Standard Population. ONS data. 3 year average, 2017-19. Local Authorities.
Metric 4 - % Change in age standardised suicide rate between 2014 -16 - 2018 -20.

Data source for all metrics
Office of National Statistics (ONS) data, 2010-12 - 2018-20. Local Auhtorities.
Percentages calculated using ONS data
Extracted from Fingertips (OHID).

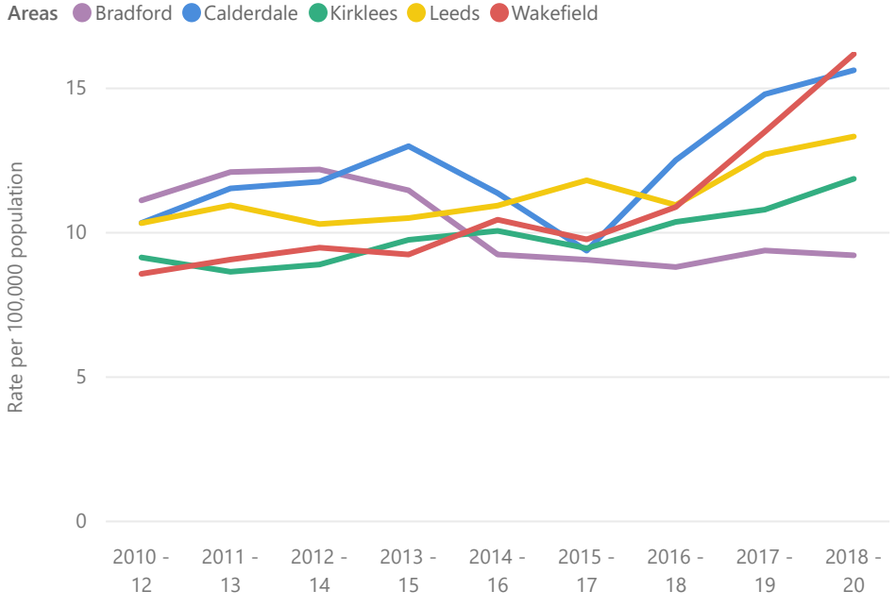
Number of Suicides



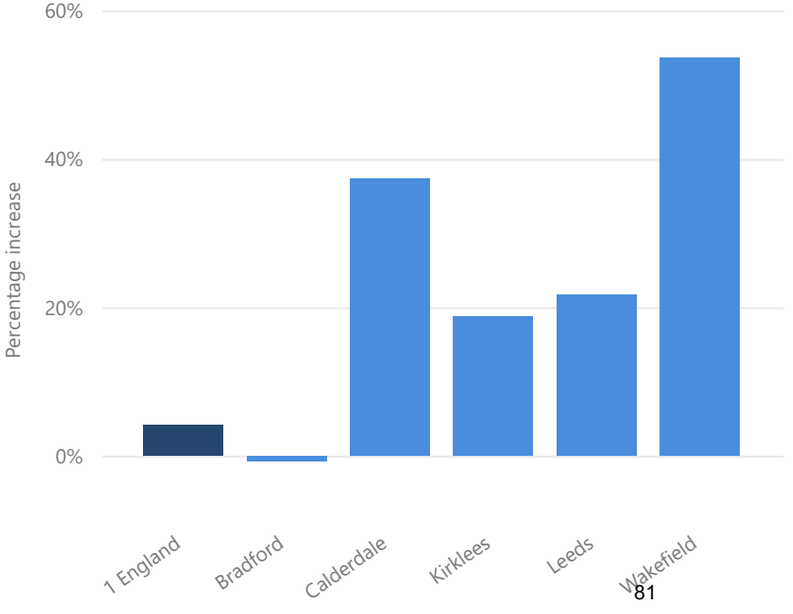
% change in number of suicides 2014-16 - 2018/19



Suicide rates per 100,000 population



% Change in age standardised suicide rate 2014-16 to 2018-20



West Yorkshire
Health and Care Partnership

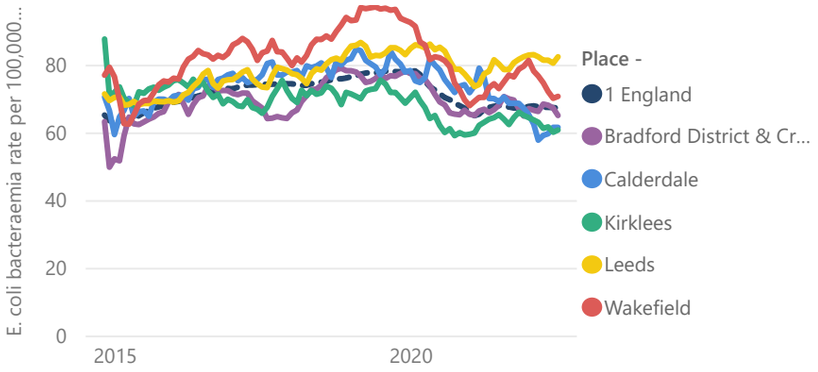
Ambition 6

We will achieve at least a 10% reduction in anti-microbial resistant infections by 2024 by, for example, reducing antibiotic use by 15%.
The graphs to the right show the trends for key metrics related to antibiotic prescribing in both secondary and primary care.

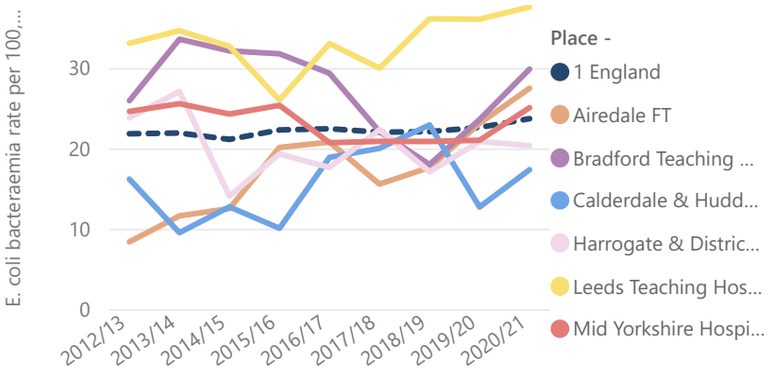
Metric 1 - E. coli bacteraemia. 12-month rolling rate per 100,000 population. May 2021. CCGs.
Metric 2 - E. coli bacteraemia 12-month rolling rate per 100,000 bed days.
Metric 3 - Antibiotic Guardians per 100,000 population
Metric 4 - Twelve-month rolling total number of prescribed antibiotic items per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR-PU)
Metric 5 - Percentage of antibiotic prescriptions for lower UTI in older people meeting NICE NG109 guidance and PHE Diagnosis of Urinary Track Infection (UTI) guidance in terms of diagnosis and treatment.

Data source for all metrics, in order
HCAI Mandatory Surveillance Data (Metric 1, 2)
AntibioticGuardian.com
ePACT2 from NHSBSA
Quarterly Commissioning for Quality and Innovation (CQUIN) returns made to UKHSA by NHS Trusts
All extracted from Fingertips (OHID).

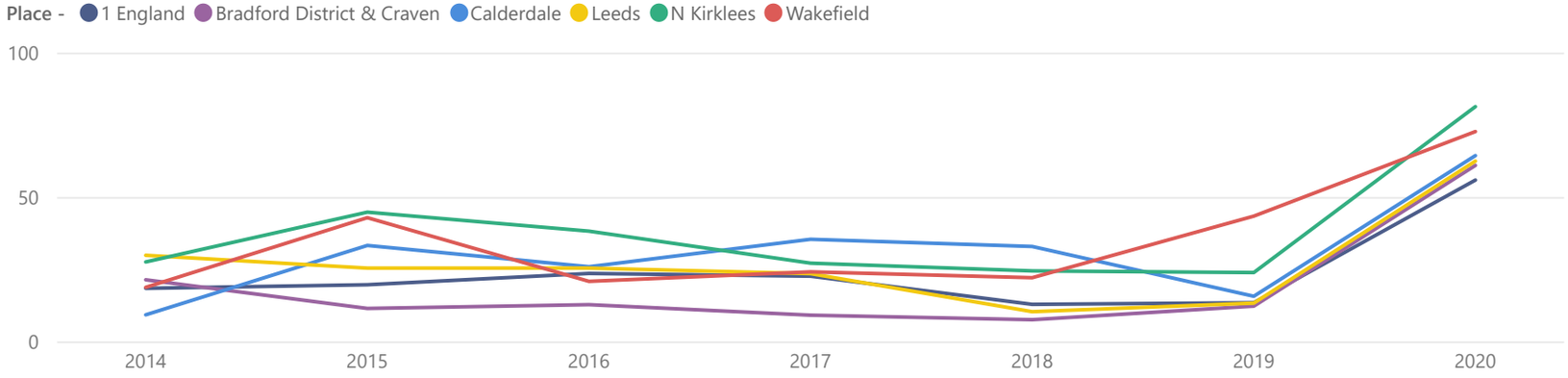
E. coli bacteraemia 12m rolling rate per 100,000 population



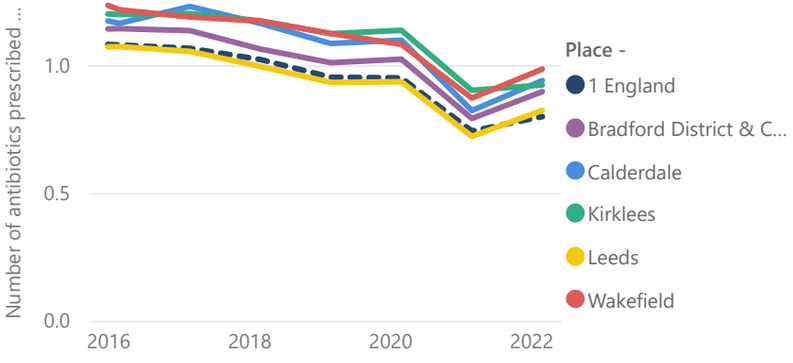
E. coli bacteraemia 12m rolling rate per 100,000 bed days



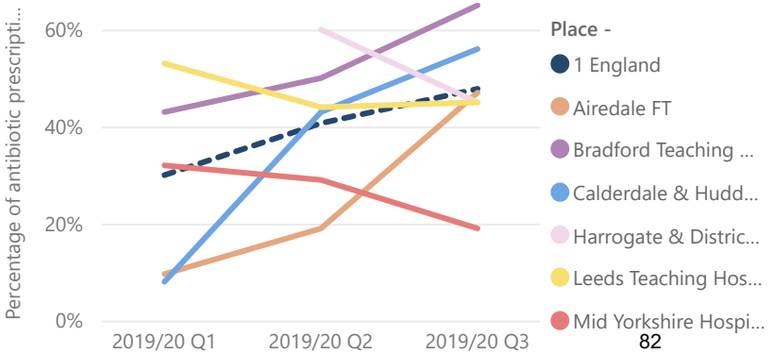
Antibiotic Guardians per 100,000 population



Twelve-month rolling total number of prescribed antibiotic items per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR-PU)



Percentage of antibiotic prescriptions for lower UTI in older people meeting NICE & PHE guidance



West Yorkshire
Health and Care Partnership

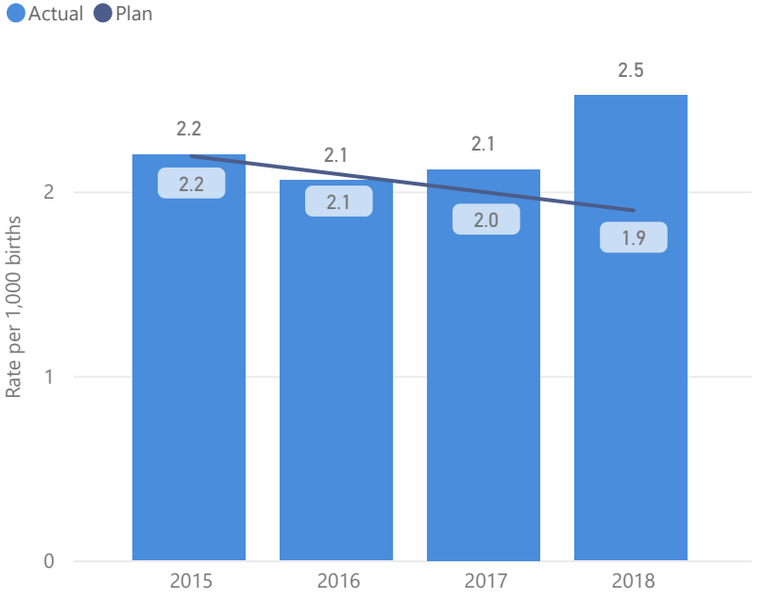
Ambition 7

We will achieve a 50% reduction in stillbirths, neonatal deaths, brain injuries and a reduction in maternal morbidity and mortality by 2025.
The graphs to the right show the trend in achievement for 4 key maternity metrics, including trajectories where applicable.

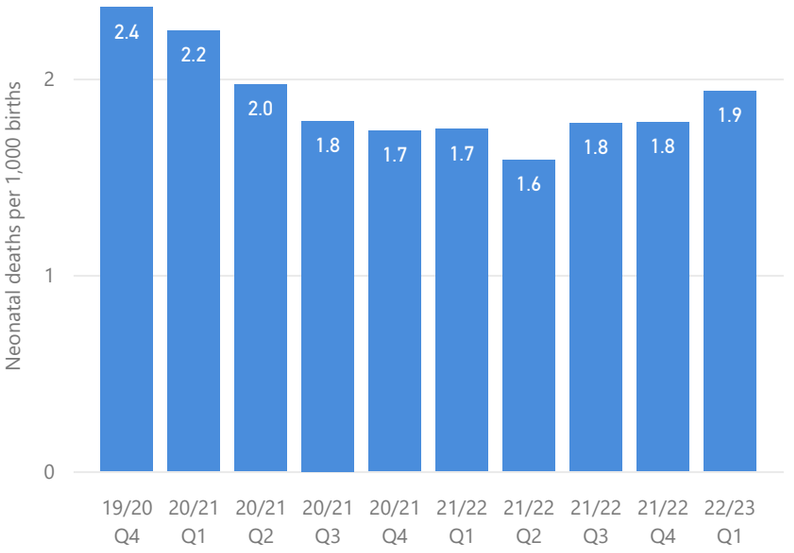
Metric 1 - Neonatal deaths per 1,000 births. Data source - MBRRACE (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries).
Metric 2 - Rolling 12 month in unit Neonatal deaths per 1,000 births. Data source - Yorkshire and Humber Operational Delivery Network Neonatal Dashboard.
Metric 3 - Intrapartum brain injuries - Brain injuries per 1,000 live births. Data source - Neonatal Data Analysis Unit, Imperial College London.
Metric 4 - Rolling 12 month stillbirths per 1,000 births. Data source - Yorkshire and Humber Clinical Network's Maternity Dashboard.

Data sources for all metrics
All data for West Yorkshire and Harrogate Local Maternity System (LMS). 2015-2022.

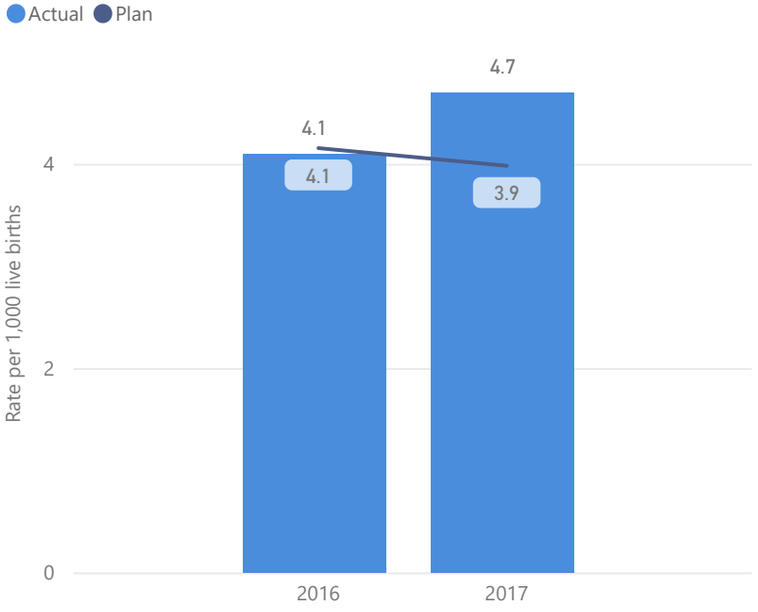
Neonatal deaths per 1,000 births



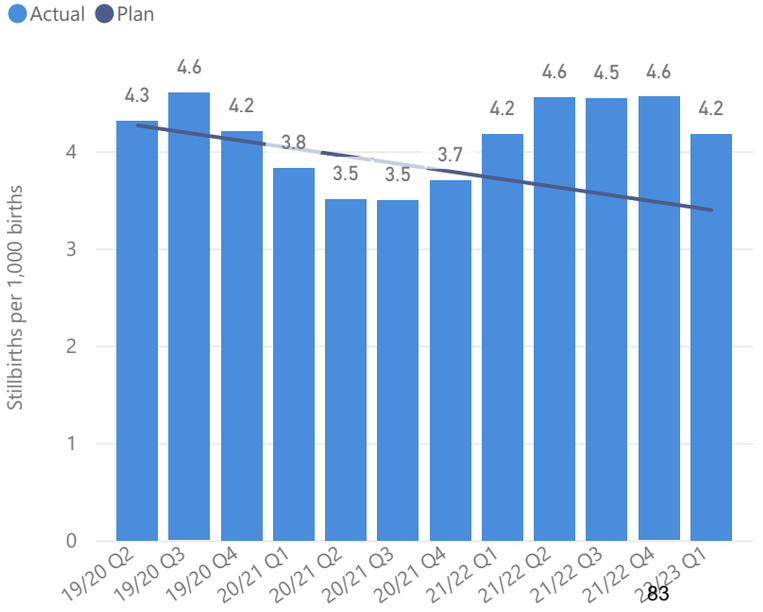
Rolling 12 month in-unit Neonatal deaths per 1,000 births



Brain injuries per 1,000 live births



Rolling 12 month stillbirths per 1,000 births



West Yorkshire
Health and Care Partnership

Ambition 8

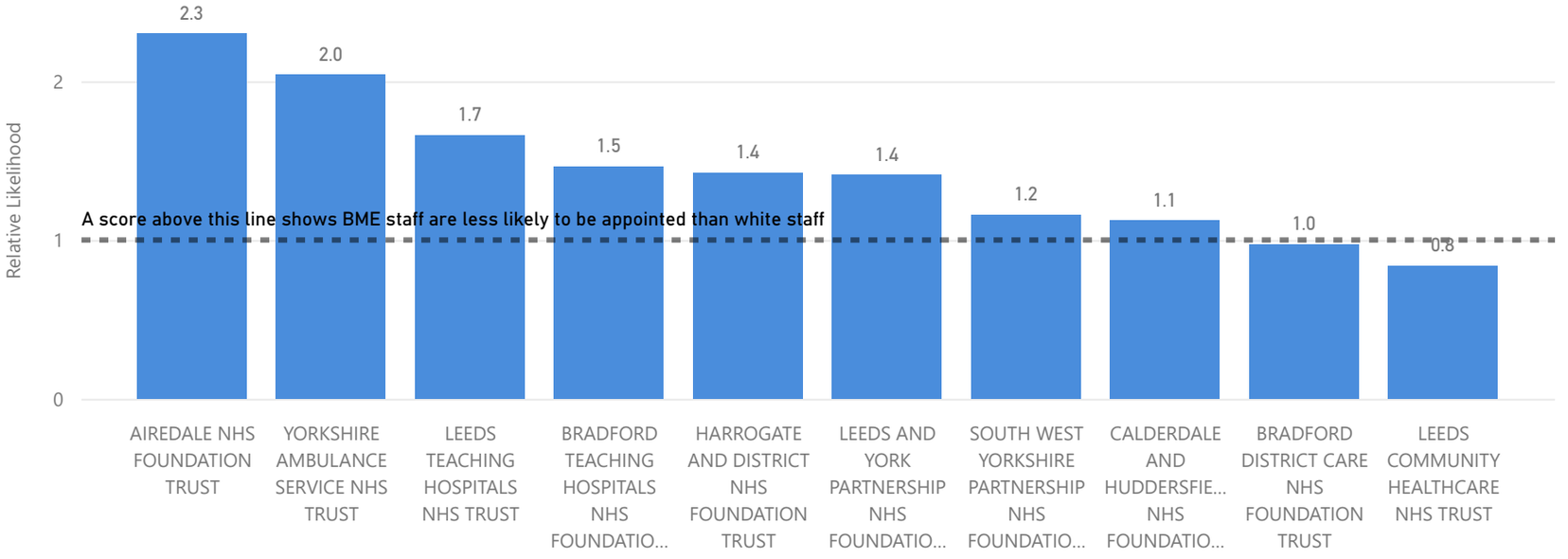
We will have a more diverse leadership that better reflects the broad range of talent in West Yorkshire and Harrogate, helping to ensure that the poor experiences in the workplace that are particularly high for staff from Ethnic Minorities will become a thing of the past.
The graphs to the right show how 3 key metrics relating to the experience of ethnic minority staff vary across NHS Trusts.

Metric 1 - Relative likelihood of white staff being appointed from shortlisting compared to Black and Minority Ethnic (BME) staff. .
Metric 2 - % of total Board members that are BME.

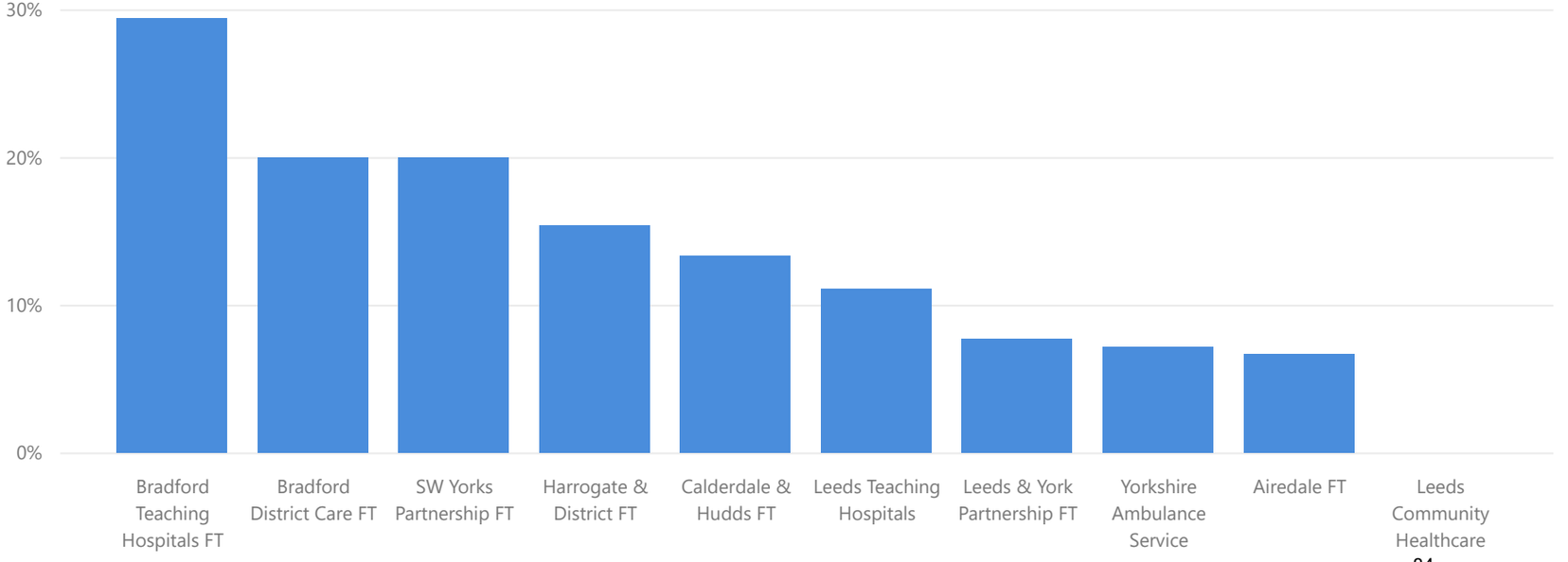
Data sources

NHS Staff Survey and NHS Workforce Race Equality Standard publications. 2021. NHS Trusts.

Relative likelihood of White staff being appointed from shortlisting compared to Black and Minority Ethnic staff



% of Total Board Members - Black and Minority Ethnic



West Yorkshire
Health and Care Partnership

Ambition 9

We aspire to become a global leader in responding to the climate emergency through increased mitigation, investment and culture change throughout our system.
These metrics reflect NHS Trust and CCG achievement against several measures published as part of the Greener NHS Dashboard. Whilst these initial metrics focus on carbon reduction, the scope of the programme is system wide.

Emissions from building energy use - Organisations are placed into quartiles with other organisations of the same type e.g. Community Trusts are bench-marked against other Community Trusts. Emissions resulting from electricity, gas, coal, oil, hot water and steam and water and sewerage use are included. 2018/19. Highest quartile = better performance. NHS Trusts.
Green Plans - does the organisation have an up to date, board approved Green Plan. 2019/20. NHS Trusts.
Sustainable Development Assessment Tool - score out of 100 of the organisation's most recent published assessment. Organisations are placed into quartiles with other organisations of the same type e.g. Community Trusts are bench-marked against other Community Trusts. December 2020. Highest quartile = better performance. NHS Trusts.
Metered Dose inhalers prescribed - proportion of prescribed inhalers that are Metered Dose inhalers. October 2021. 0. Lower percentage shows a lower environmental impact. CCGs.

Data Sources for all metrics
Greener NHS Dashboard.

Emissions from building energy use

Trust Name Quartile

Trust Name	Value
CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST	Mid-high quartile
LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST	Mid-high quartile
LEEDS COMMUNITY HEALTHCARE NHS TRUST	Mid-high quartile
YORKSHIRE AMBULANCE SERVICE NHS TRUST	Mid-high quartile
LEEDS TEACHING HOSPITALS NHS TRUST	Low-mid quartile
SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST	Lowest quartile
AIREDALE NHS FOUNDATION TRUST	Highest quartile
BRADFORD DISTRICT CARE NHS FOUNDATION TRUST	Highest quartile
BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST	Highest quartile
HARROGATE AND DISTRICT NHS FOUNDATION TRUST	Highest quartile
MID YORKSHIRE HOSPITALS NHS TRUST	Highest quartile

Green Plans

Trust Name Plan Available?

Trust Name	Value
AIREDALE NHS FOUNDATION TRUST	No data
BRADFORD DISTRICT CARE NHS FOUNDATION TRUST	No data
BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST	No data
CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST	No data
HARROGATE AND DISTRICT NHS FOUNDATION TRUST	No data
LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST	No data
LEEDS COMMUNITY HEALTHCARE NHS TRUST	Yes
LEEDS TEACHING HOSPITALS NHS TRUST	No data
MID YORKSHIRE HOSPITALS NHS TRUST	No data
SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST	No data
YORKSHIRE AMBULANCE SERVICE NHS TRUST	No data

Measures and metrics to be agreed and updated following the Strategy Refresh meeting on the 2nd of November 2022

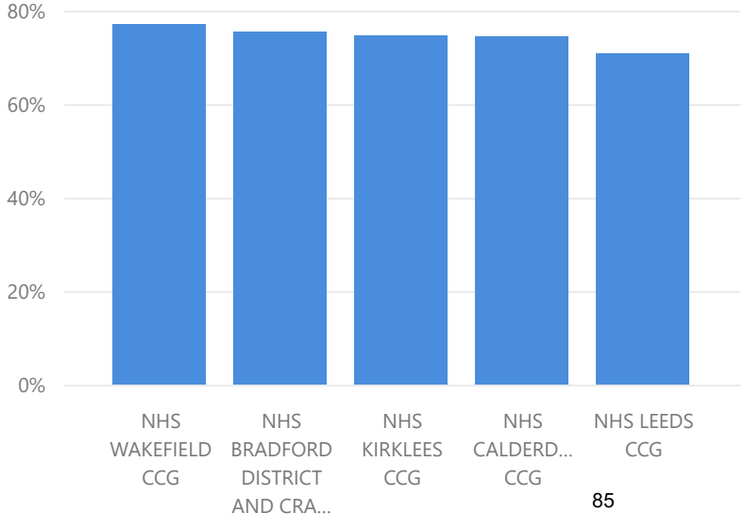
Sustainable Development Assessment Tool

Trust Name Quartile

Trust Name	Value
YORKSHIRE AMBULANCE SERVICE NHS TRUST	Highest quartile
SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST	Lowest quartile
MID YORKSHIRE HOSPITALS NHS TRUST	Highest quartile
LEEDS TEACHING HOSPITALS NHS TRUST	Unpublished
LEEDS COMMUNITY HEALTHCARE NHS TRUST	Lowest quartile
LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST	Highest quartile
HARROGATE AND DISTRICT NHS FOUNDATION TRUST	Lowest quartile
CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST	Lowest quartile
BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST	Lowest quartile
BRADFORD DISTRICT CARE NHS FOUNDATION TRUST	Highest quartile
AIREDALE NHS FOUNDATION TRUST	Highest quartile

Metered Dose Inhalers Prescribed

Percentage of Metered Inhalers by CCG - Oct 2021



West Yorkshire
Health and Care Partnership

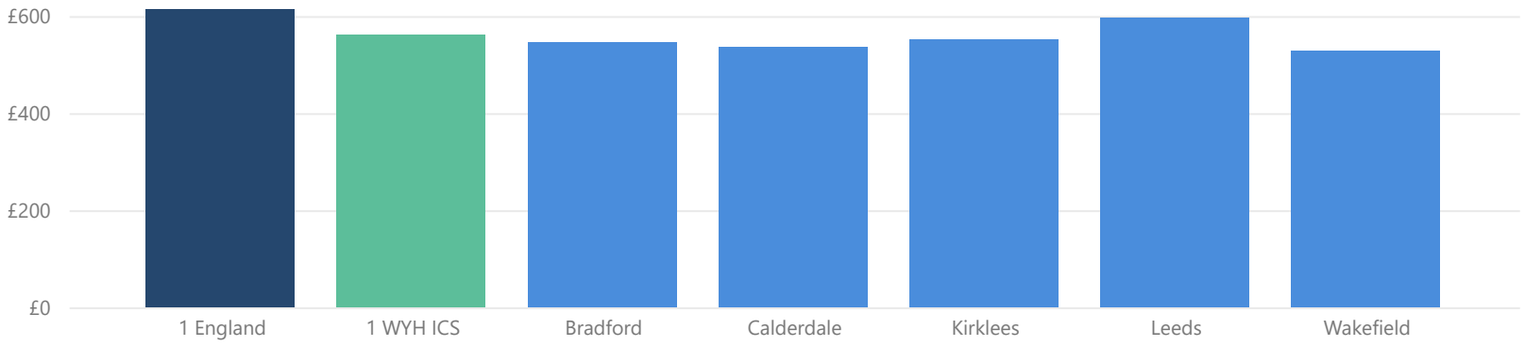
Ambition 10

We will strengthen local economic growth by reducing health inequalities and improving skills, increasing productivity and the earning power of people and our region as a whole.
The graphs to the right show how three key economic indicators vary across Local Authorities in West Yorkshire and Harrogate, and how they compare with England.

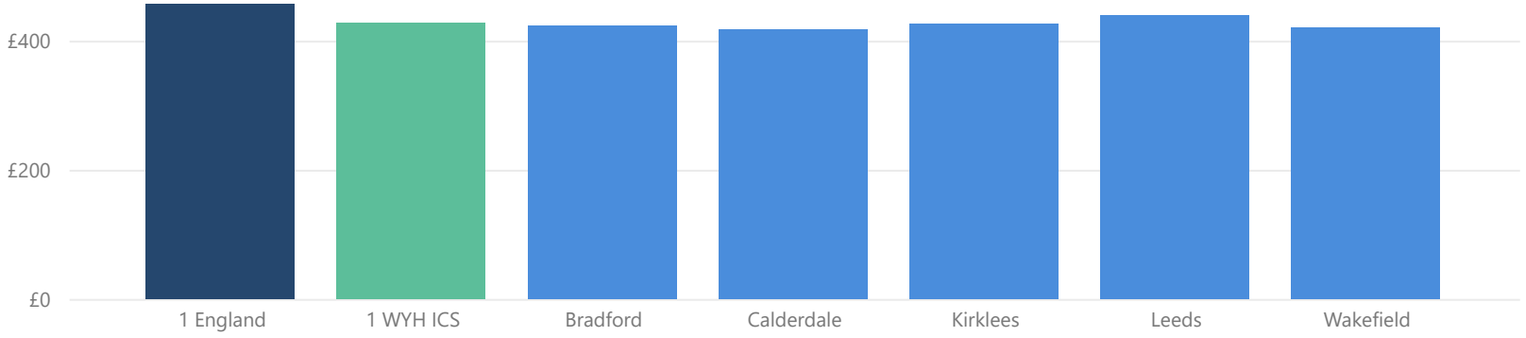
Metric 1 - Median weekly earnings (£). 2021.
Metric 2 - 25th percentile earnings (£). 2021.
Metric 3 - Employment rate aged 16 - 64 (%)

Data source for all metrics
NOMIS - Official labour market statistics from the Office of National Statistics (ONS). Local Authorities.

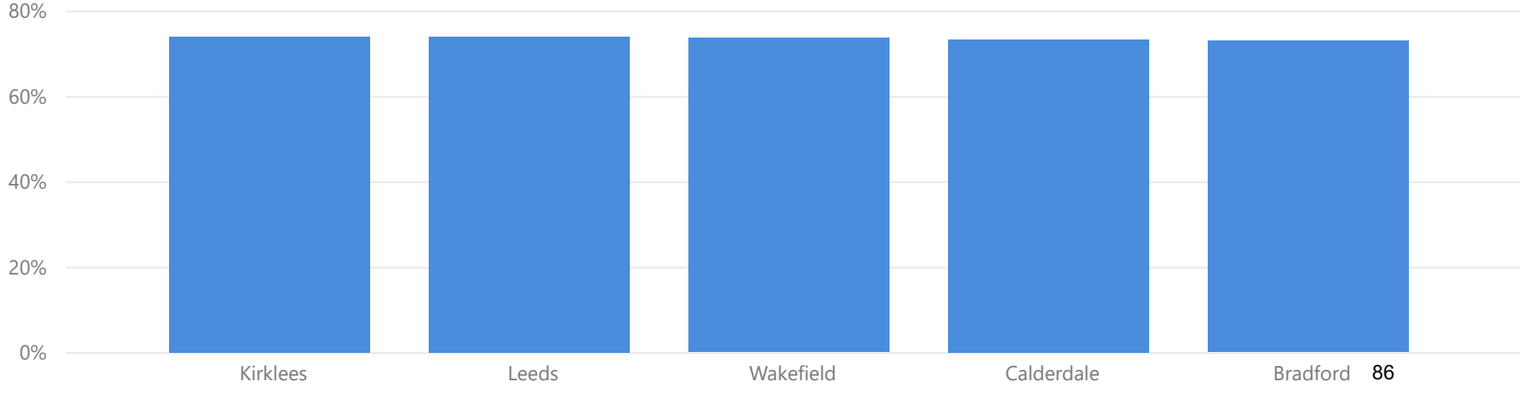
Median weekly earnings (£)



25th percentile earnings (£)



Employment rate aged 16 - 64 (%)



West Yorkshire
Health and Care Partnership

Agenda item LC 52/22

Appendix 2

West Yorkshire Health and Care Partnership

West Yorkshire Integrated Care Strategy

(Easy read, plain text, audio and BSL versions to follow on final draft)

Examples, case studies and infographics to be added and finalised

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Foreword (TO ADD):

Councillor Tim Swift (Chair of the Integrated Care Partnership)

Rob Webster (Lead Chief Executive for the Integrated Care System)

Introduction

Proud to be a partnership

Our Partnership has existed since 2016. It was established on the fundamental belief that working together towards common goals rather than competition is the best way to join up services to meet people's needs, tackle inequalities and improve outcomes.

We know that only 10-20% of health outcomes are directly influenced by the NHS, which is why close collaboration partners such as the voluntary and community sector, universities, the West Yorkshire Police, the Combined Authority and the housing sector is so important to us. Our previous strategy was published in March 2020 and included our 10 big ambitions for health and care, delivery of which are dependent on the strength of these relationships.

During the COVID-19 pandemic we witnessed the best of the health and care service. We rapidly changed working practices so that we could safely treat people with COVID-19 whilst supporting peoples ongoing needs; we significantly increased capacity to deal with the peaks of infection and severe illness; and we delivered the biggest vaccine roll out in our country's history. All of our teams across the health, care and voluntary and community sector pulled out all of the stops to keep people safe and well.

The demand for health and care has been rising over time, as a result of an ageing population and more people with multiple long-term conditions. The pandemic further increased demand for health and care services, as well as disrupting what could be safely be provided to the risk of transmission. This now means the pressure on services is higher than ever. People who need an operation are waiting longer than any time in the past 15 years, and the accessibility of services such as primary care and urgent care is not as good as we would like it to be. These challenges will be further exacerbated by the significant pressure on funding and workforce pressure on the social care sector.

This is the challenge that our Integrated Care System must now address, by focusing on prevention and proactively supporting people to stay well at home; and secondly by arranging services in a way so that people receive care from the right people in the most appropriate setting. This will mean multidisciplinary teams working together to organise care around people and their families, and professional and organisational barriers being broken down.

Whilst these challenges are significant, we believe that collaboration at all levels in the system is the best way of tackling them. Our Partnership acts as a strategic influencing voice at regional and national levels for our populations who live, work or study in West Yorkshire in relation to health and wellbeing. This strategy describes how we will do this, and the ambitions we hope to achieve.

Integrated care partnerships

The Health and Care Act 2022 introduced new legislative measures that aim to make it easier for health and care organisations to deliver joined-up care for people. As part of the new statutory arrangements, the Act describes how 'Integrated Care Partnerships' (ICPs, for West Yorkshire this is our Partnership Board) will bring together a wider range of partners, not just the NHS, to develop a strategy to address the broader health, public health, and social care needs of people and communities.

'Joining up care for people, places and populations', the government's proposals for health and care integration published on 9 February 2022 has signalled the importance of integrated 'place' level working towards a common set of locally agreed outcomes. This is something which is at the heart of our existing plan and the way in which we work as a Partnership.

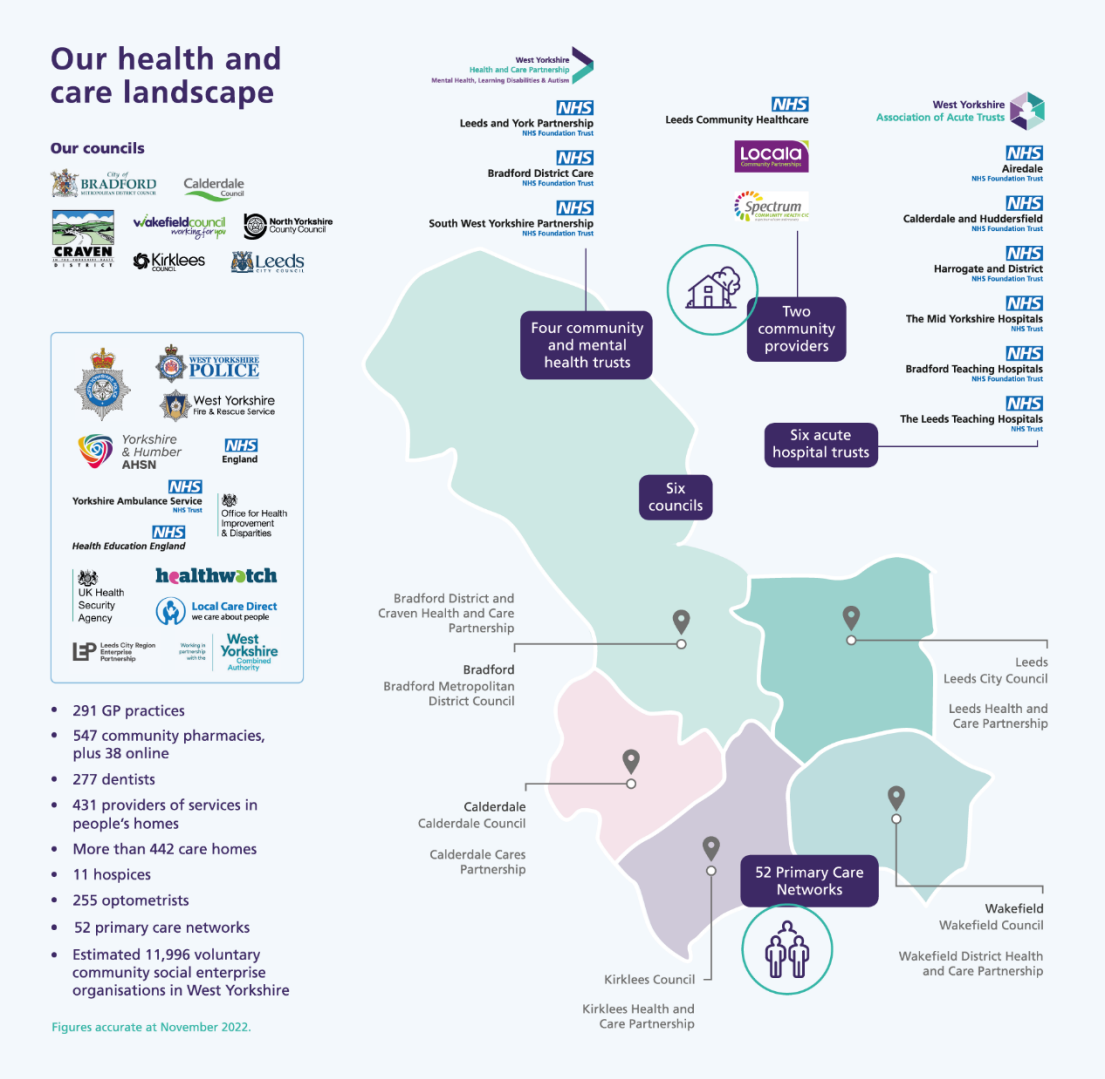
The Health and Care Act also sets out how ICPs should develop an Integrated Care Strategy to set the direction of the system and to show how they intend to deliver more joined-up, preventative, and person-centred care for their whole population, across the course of their life.

The West Yorkshire Health and Care Partnership

West Yorkshire Health and Care Partnership (the Partnership) is a large integrated care system (ICS) that supports 2.4 million people, living in urban and rural areas. 770,000 are children and young people. 530,000 people live in areas ranked in the most deprived 10% of England. 20% of people are from minority ethnic communities. There are an estimated 400,000 unpaid carers, as many don't access support. Together we employ over 100,000 staff and work alongside thousands of volunteers.

Our ICS is made up many different organisations and collaboratives across West Yorkshire, including our Partnership Board which is the Integrated Care Partnership for West Yorkshire. It also contains the NHS West Yorkshire Integrated Care Board (WY ICB) which is the statutory NHS organisation responsible for developing a plan in collaboration with NHS trusts/foundation trusts and other system partners for meeting the health needs of the population. These are all supported by organisations working together across all services.

Our work begins in the neighbourhoods across West Yorkshire, keeping people, families, the health and care teams that support them within local communities at the centre of everything we do. Our five local places (Wakefield, Leeds, Calderdale, Bradford and Craven and Kirklees) support this work, coming together as partners in the place to meet the needs of local populations. An infographic of the system sets this out below:



Within the Partnership we have many partners working together across the NHS, local authorities, the voluntary community social enterprise sector (VCSE), Healthwatch, hospices, and wider public sector organisations. We come together to better join up integrate health and care, to tackle health inequalities and to improve health and wellbeing for everyone.

We also come together in partnership with some of our wider partners like the West Yorkshire Mayor, the West Yorkshire Combined Authority, Local Resilience Forum and universities to maximise resources, for example buildings, skills and expertise and to work together for a common purpose of reducing health inequalities we know exist.

The West Yorkshire Health and Care Partnership (our Integrated Care System), published 'Better Health and Care for Everyone: Our Five Year Plan' in March 2020, setting out how we work together to give everyone in West Yorkshire the very best start and every chance to live a long and healthy life.

Since its publication, the context and focus for our work has changed significantly. Whilst we have made good progress across a range of areas in our strategy, the COVID-19 pandemic and cost of living crisis has meant that our Partnership has

necessarily needed to shift its focus away from our long-term ambitions, to more immediate operational pressures.

The scale of challenge has also increased in a number of areas, most notably the widening of inequalities, increasing levels of trauma and adversity and mental health difficulties and the ongoing impact of poverty.

Responding to this changing context, we have refreshed our existing five-year strategy to develop this new strategy. Putting people at the heart of the strategy, it is built from our Health and Wellbeing Strategies for our five places. These have been developed to respond to and are informed by their local Joint Strategic Needs Assessments (JSNA). This strategy sets out where there is opportunity and need to address an issue at a West Yorkshire level. We do this through our three tests:

- Sharing good practice across the Partnership
- Working at scale to ensure the best possible health outcomes for people
- Working together to tackle complex issues

Our vision

Our Partnership has an agreed vision for the future of health, care and wellbeing in West Yorkshire, where all partners are working together so people can thrive in a trauma informed, healthy, equitable, safe and sustainable society. We want to help people live well and stay healthy for as long as possible, and if they have mental health or physical problems, they can easily access services that meet their needs in a safe, sustainable and trauma informed way.

Places will be healthy. We will work in partnership to prevent ill health by improving the physical environment where people live and work. Places will be supportive of good health by having access to healthy green and blue spaces that provide safe spaces for outdoor activities and exercise and are biodiverse with good air quality. We aim for this to be the case for this and future generations.

You will have the best start in life so you can live and age well and die in the place of your choosing. We will work to make sure you are not disadvantaged by where you live, your background, gender or ethnicity. We will focus on supporting you to stay healthy and prioritise approaches of preventing trauma, adversity and ill health, delaying onset of disease and reducing the impact of long term-conditions.

There will be a culture of prevention across the partnership, making this everyone's business. This will include primary, secondary and tertiary prevention alongside the determinants of health and a focus on reducing health inequalities and the impacts of climate change.

If you have a long-term health condition **you will be offered trauma informed personalised support to self-care**. This will include peer support, technology and communities of support from people like you.

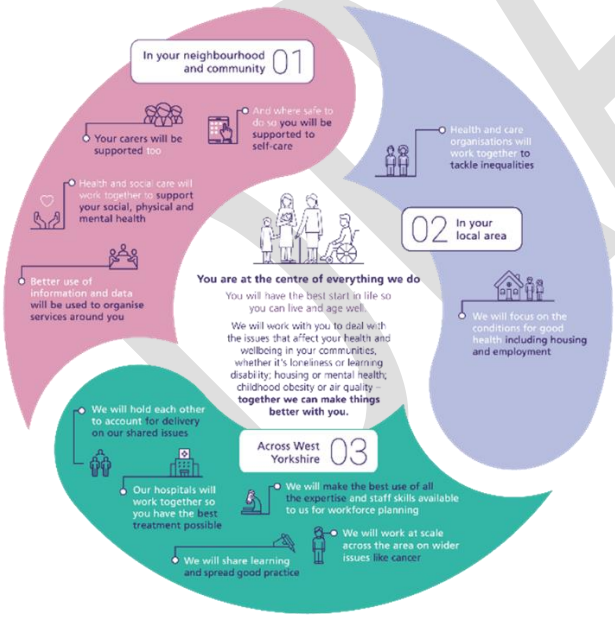
If you have multiple health conditions, **you will be in a team with your GP, community care staff, social services and voluntary and community organisations including community pharmacy working together.** This will involve you, your family and carers, the NHS, social care and community organisations. All working on what matters to you.

If you need hospital care, it will usually mean that your local hospital, which will work closely with others, will give you the best care possible.

Local hospitals will be supported by centres of excellence for services such as cancer, vascular (arteries and veins), stroke and complex mental health. They will deliver world class care and push the boundaries of research and innovation.

All of this will be planned and paid for once between the NHS, local councils and community organisations **working together and removing artificial barriers to care.**

Our people and communities will be involved in the design, delivery and assurance of services so that everyone truly owns their healthcare.



Our objectives and ambitions

What we've heard from people in West Yorkshire

Listening to what people and communities tell us is important to them has been central to the development of all work, including this strategy. As a Partnership we have a continual dialogue with the people of West Yorkshire, supported by Healthwatch partners as set out in our Involvement Framework and the work of our local places.

As part of the development of this strategy, a number of reports summarising what people are telling us is their experience of health and care have been produced. This includes a Healthwatch Insight Report published in August 2022, a mapping report published in May 2022 setting out involvement and consultation activity across West Yorkshire and lastly a further mapping report from across the Partnership which provides oversight of engagement in all other areas of work.

There are a number of themes which have been raised over the last year (2022) as a result of these discussions in relation to healthcare across West Yorkshire. The changing context has in many cases placed a new emphasis on some of the themes and more recently the cost-of-living crisis has been an escalating issue.

Access to primary care remains a key area of concern. Primary Care is considered the front door to the wider health and care service and many feel let down when they can't access their GP in a way that works for them. There is a deep concern that this has a detrimental impact on their health and wellbeing.

Access to dentistry services continues to be an issue raised for both children and adults. This is both in terms of being able to register with an NHS dentist and access to appointments and treatment when registered. It was also raised that access to urgent dental care was not as responsive as needed.

Of increasing concern is the **cost-of-living crisis** which continues to escalate and impact on peoples' lives. This impacts significantly on the ability to make choices that positively impact their wellbeing, such as accessing healthcare, undertaking activities that support mental wellbeing, eating healthy nutritious food and being able to live in warm, safe housing. These challenges are having a particular impact on those who are living with social disadvantage, serious illness, addictions and those people who are carers. We know that suicide rates rise during times of economic recessions and financial exclusion is a significant risk factor in suicide deaths.

There continues to be concern around **accessing support for mental health** in a timely manner, an issue which has increased with the impact of the pandemic. Of significant concern is access to support for our children and young people and the level of support for children who are waiting for assessment for, or have been diagnosed with, autism. Self-harm rates are rising, and the people we are supporting

with mental health issues are becoming more unwell, more quickly than they have previously.

We know that the pandemic has led to significant **delays in treatment** and people are telling us that this is causing a deterioration in their physical, mental and emotional health. The impact of this is also extending to family members and carers.

The choice people have in **accessing care that is right for them** highlighted concerns about digital exclusion with many appointments and support moving to online. Many of our population do not have access to digital technology or have additional challenges in using it. This was particularly a challenge for people with learning disabilities

Negative experiences of **quality of care** are starting to emerge in some care settings. Whilst it is acknowledged that this is in part due to challenges arising from the pandemic in terms of staff shortages, it is still important to be treated with care and compassion. We know that children and young people from ethnic minority backgrounds and those in more deprived areas with diabetes have consistently poorer blood sugar control. We also recognise that there is a variation in access to digital technology such as continuous glucose monitoring.

The four strategic objectives of our Integrated Care System

Our strategy is centred around our four strategic objectives which set out the core purpose of our ICS. These are:

Our ambitions for the people of West Yorkshire

Improving outcomes in population health and healthcare

We will increase the years of life that people live in good health in West Yorkshire

Health inequalities are avoidable and unjust differences between people or groups due to social, geographical, biological or other factors. These differences have a huge impact, because they result in people who are worse off experiencing poorer health and shorter lives.

To achieve this ambition, we will take a trauma informed whole systems approach, that addresses the conditions people live in and recognises the importance of the wider determinants on the health and wellbeing of the population.

This will also require a strong focus on preventing trauma, adversity and ill health by addressing the root causes for health harming behaviours - including tobacco, alcohol, drugs and gambling, in a joined-up systems approach.

A focus on reducing health inequalities for the partnership will aim to address some of the preventable differences that contribute towards inequalities. Working as a partnership we will consider variations in; risk factors for ill health, early diagnosis and screening and access to effective support – all of which contribute towards inequalities in health outcomes.

We will aim for early identification of risk factors and long-term conditions so that we can act early and, prevent or delay onset or progression of different health conditions. We will also focus on key areas that contribute most to the years of life lost or lived in ill health, such as cardiovascular and respiratory diseases, cancer and suicide.

The work we are undertaking to mitigate the effects of poverty and the cost-of-living crisis will have an impact on quality of life, prevention of ill health and timely access to health and care services.

Access to good quality health and care services continues to be a challenge for the population of West Yorkshire as we recover from the pandemic. Whilst our primary care services continue to provide more appointments than pre-pandemic we know that public satisfaction with access to services has deteriorated significantly. We continue to work collaboratively to provide timely and appropriate services.

Our hospitals are also working hard to recover from the impact that COVID has had on our diagnostic and elective care services.

By 2024 we will have increased our early diagnosis rates for cancer

Our work on enabling the transformation of cancer services in West Yorkshire is coordinated at a system level, via the West Yorkshire and Harrogate Cancer

Alliance, which is hosted by the NHS West Yorkshire Integrated Care Board (WY ICB). Cancer Alliances are non-statutory bodies which bring together clinical and managerial leaders from different hospital trusts and other health and social care organisations, to transform the diagnosis, treatment, and care for cancer patients in their local area.

Our local Cancer Alliance has an ambition to bring local partners together to deliver better outcomes and focusses on being empathetic, being honest and driven, being people focussed (including a focus on the cancer workforce) and being role models for effective collaboration. They help to oversee the cancer components of the NHS Long-Term Plan and the merger between nationally set priorities for transformation and locally derived need.

They work on a co-production model with patients and service users to ensure that our priorities and ways of working are informed by the experiences of people who are using cancer services. This is critical to ensure that patient experience of care is treated with parity of esteem around what care is delivered.

The Cancer Alliance works together with colleagues across all our West Yorkshire places, and Harrogate, to ensure that we are taking decisive action across the cancer pathway. This includes improved primary and secondary cancer prevention; better population awareness; promoting earlier diagnosis; achieving better treatment access including to new therapies and innovations; and adopting a person-centred approach both to follow-up, and end of life care where needed. They also work closely with partners involved in delivering the other ambitions, so that our work is joined up and connected for the common benefit of the people we serve.

We are clear why work to transform cancer care is important. In the future, it is estimated that one in two people could be diagnosed with cancer in their lifetimes, with four out of ten cancers being avoidable if we can achieve changes to lifestyle including healthier weight; safe sun care; reduced tobacco consumption; avoiding alcohol and substance misuse; and acting on wider determinants of health status, including air quality. The burden of cancer is one of the most significant faced by the West Yorkshire ICB and will be across the duration of this and subsequent planning strategies. Overall, cancer outcomes remain poorer than international comparators, and are strongly associated with wider prevailing health inequalities experienced across West Yorkshire.

Progress against our cancer ambition since 2020 has been good but we know that the data we have is usually around two years in arrears.

We know that:

- The net number of referrals into our local cancer services, including reduced volumes during the acute phase of the pandemic has closed.
- Almost all reduced treatment activity has been recovered on the same measure.

- The number of patients coming forward and being assessed for cancer symptoms has grown significantly since 2018, as has the number of patients being treated for cancer.

We have also made some good progress with our partners on encouraging uptake of the bowel cancer screening programme through local awareness raising campaigns and the activities of our public health, screening, and primary care network partners. Cancers detected via screening programmes are often at an earlier stage (and are therefore commonly more treatable).

We will reduce suicide by 10% across West Yorkshire by focusing on health inequalities, achieving a greater understanding of impact of inequality on suicide, so that suicide prevention becomes everyone's business.

Every death by suicide is devastating and can have a lifelong impact, with each death impacting 135 people on average. Suicide is our biggest killer of both men under 50 and young people. Suicide is one of our partnership's wicked issues, with no easy solution that one person/organisation can complete on their own.

Office for National Statistics data shows that despite a focus on prevention in recent years, suicide rates have not reduced. We need to work together to do something differently if we want to change this picture over the next five years. In order to achieve our collective ambition on suicide prevention, all partners have a part to play.

Our vision is to collaborate and create a movement for change - this will make suicide prevention everyone's business. We have adopted a zero-suicide approach where we believe that even one death by suicide is one too many. We have collaborated on a West Yorkshire suicide prevention strategy, which complements place-based suicide strategies and plans and has 13 core evidence-based themes on which we'll focus our work in the coming years:

We acknowledge that there are national and international factors, some of which are beyond our control, which may impact suicide rates. For example, Government policy, the economic climate and worsening poverty, widening inequalities and discrimination, harmful content online, the gambling industry and its regulation, and the climate crisis each have an impact. In order to mitigate these impacts, we need to:

- Invest in inclusive and preventative measures locally, including becoming a trauma informed system
- Ensure that suicide prevention is embedded across all organisations, eliminating stigma
- Build everyone's skills and confidence to recognise and address adversity and trauma, which is closely linked to suicide
- Improve and learn from evidence

- Provide inclusive and compassionate support for all people affected by suicide
- Support people with core risk factors for suicide

West Yorkshire Health and Care Partnership will work together to prioritise suicide prevention, creating a paradigm shift that makes suicide prevention everyone's business. Every organisation in the partnership will take demonstrable action on suicide prevention.

We will achieve at least a 10% reduction in anti-microbial resistant infections by 2024

We know that the Northeast and Yorkshire region has the second highest antibiotic rates in England. All parts of West Yorkshire are prescribing over the national target in relation to antibiotic prescribing. Whilst the number of people presenting with infection reduced during the pandemic, data is currently telling us that prescribing is now increasing back towards pre COVID 19 rates.

Whilst the burden of infectious disease is known to disproportionately impact vulnerable groups, the evidence base for the burden of antibiotic-resistant infections is sparse. However, we do know that rates of prescribing are much higher in highly deprived areas. We are working to understand this in order, to develop actions to redress this trend.

A priority for our strategy will be sharing expanding successful work in this area across West Yorkshire. The Leeds 'Seriously' campaign to raise awareness of antibiotic resistance is a good example of where positive campaigns can have success.

One of the main priorities for our WY Anti-Microbial Resistance Board is to reduce Gram-negative bloodstream infections caused by E. coli and reduce inequalities related to E. coli bloodstream infections. This work will be set out in our delivery plans.

We will achieve a 50% reduction in stillbirths, neonatal deaths, brain injuries and a reduction in maternal morbidity and mortality by 2025.

The West Yorkshire Local Maternity and Neonates System (LMNS) covers West Yorkshire and Harrogate and supports a number of Maternity Voices Partnership (MVP) groups across our system to transform our maternity services together. The MVPs are a team of women and their families, commissioners and providers (midwives and doctors) working together to review and contribute to the development of local maternity care.

The LMNS has already implemented seven of the initial immediate and essential actions from the Ockenden Report and each trust is currently being measured against these. The remaining issues raised from the report will be considered alongside the Independent Investigation into East Kent Maternity Services report,

with a further set of recommendations expected to be published in the early 2023. The actions to address these recommendations will form part of the Joint Forward Plan to deliver this strategy.

We continue to work at place and West Yorkshire to address the workforce challenges for maternity and neonatal services.

Tackling inequalities in outcomes, experience and access

We will achieve a 10% reduction in the gap in life expectancy between people with mental health conditions, learning disabilities and/or autism and the rest of the population.

On average, we know that people with serious mental illness (SMI) live 12-15 years fewer than someone without an SMI, and 4 in 5 deaths related to SMI are linked to common and preventable or treatable conditions such as heart disease, lung disease and cancer. For people with learning disabilities or autism, this gap is even bigger, with a difference of around 14-18 years compared to someone without a learning disability or autism. These deaths are often also caused by the same conditions. We also know that neurodiverse people and those with diagnosed and undiagnosed mental health problems are more likely to take their own lives, and that suicides contribute to the remaining gap in life expectancy not explained by those common physical health conditions.

The reasons this gap exists can be divided into two main groups - increased risk of physical health conditions because of different risk factors and medications, and poorer access to health care when it is needed. This is more simply explained by saying that people with SMI, learning disabilities and autism face a range of inequalities that negatively impact their health and lives.

There are many ways that as a Partnership we can start to address this. We can:

- Listen to the voices of our populations to understand where the biggest barriers to good quality health care are across West Yorkshire
- Use the numeric data we have more effectively to understand what conditions we could target to reduce inequalities
- Work to ensure that as many people as possible can access a high quality, meaningful physical health check and any ongoing care that is identified
- Work with our acute hospitals to ensure that factors such as SMI, learning disabilities and autism are taken account of when planning elective care

We plan to do all the above, and more, to actively work to reduce the life expectancy gap for people with SMI, learning disabilities and autism, and reduce the health inequalities faced by this population

We will address the health inequality gap for children living in households with the lowest incomes

Children and young people who experience adversity and trauma are at higher risk of poor physical/mental health and emotional wellbeing and adopting anti-social and health-harming behaviours including serious violence, poor attendance/exclusion at school and decreased educational attainment. As a result, WYH&CP and WY Violence Reduction Unit (WYVRU) have recognised this as an area where it is essential, we work together across the whole system ensuring combined actions to address these issues.

We will do this by working together to prevent and reduce the causes of trauma and adversity for children, young people and families who are vulnerable and experiencing complex needs, including households living in poverty.

Ensuring that children, young people and families in WY have access to and receive integrated support from a range of professionals across health, mental health, education, social care, youth justice, the police and the voluntary sector to ensure that their needs are met in a coordinated way.

We know that we need to ensure that better support is available for children and young people with complex needs/special educational needs and disabilities (SEND). In addition, providing consistent and equitable support for managing long term conditions and seamless transition into adulthood will be a key element of reducing health inequalities and providing the best start in life for our children and young people.

We will have a more diverse leadership that better reflects the broad range of talent in West Yorkshire, helping to ensure that the poor experiences in the workplace that are particularly high for Black, Asian and Minority Ethnic staff will become a thing of the past.

We see the diversity of all communities and colleagues as a strength to help inform the way we plan, design and commission health and care services for people living across West Yorkshire. We want to make sure that everyone is treated fairly and given an equal chance to access opportunities. Ensuring that we meet the needs of everyone to ensure that our population all have good outcomes.

We recognise and value individual as well as group differences, treating people as individuals and placing positive value on the diversity they bring because of a protected characteristic or cultural background.

Our strategy is also focused on making all groups of people feel included and valued within their society or community so that there isn't a negative effect on their health and wellbeing.

Our plans include delivering the actions for the Integrated Partnership of Sanctuary, development of the West Yorkshire health inclusion unit and continuing the great work across West Yorkshire led by partners across place.

Our delivery will value equality, diversity and inclusion at the heart of everything we do and through our Involvement Framework we will listen to people to ensure that we get this right.

Our fellowship and allyship programmes continue to be a success in contributing to the diversity of leadership across our Partnership. The fellowship builds on existing good practice and complements existing local and regional programmes to make sure that we have adequate representation of ethnic minority colleagues in our next generation of leaders. We know that there is more to do in embedding this in our organisations beyond the fellowship programme itself, supported in part through the roll out of the racial inequalities training.

Enhancing productivity and value for money

As part of our work to develop this strategy we have taken an approach to ensure that we use the process to help create the way we want health and care to look like in the future. We have done this by building system leadership through the process, ensuring that we can better integrate all our work in a way which enhances productivity, value for money and most importantly improves health and wellbeing outcomes for our people.

Through our work we have embedded an improvement ethos, connecting our system to more of itself to ensure that we can identify where there are issues in transitions and gaps in care. We know that in developing our plans to deliver this strategy, through being connected and integrated in this way, we will be able to use our resources to maximise outcomes for our population.

Our enabling strategies such as finance, people, digital and estates will also support the best use of our resources in a way which will support us to deliver this strategy collectively ensuring value for money for our population.

Supporting broader social and economic development.

We aspire to become an industry leader in responding to the climate emergency through increased mitigation, investment and culture change throughout our system.

We are already seeing the impact of climate change on the health and wellbeing of our population, with people living with vulnerabilities or living in more deprived areas experiencing disproportionate harm. It is also felt through long term health conditions such as respiratory and cardio-vascular disease. Air pollution is currently the 8th leading risk factor for death and contributes to approximately 40,000 premature deaths per year in the UK. Climate harms are felt first and most keenly by those who are already experiencing inequality and vulnerability.

We know that excess plastics in the environment have a significant impact on our health, as does building antibiotic resistance due to drugs in our watercourses. There are also wide-reaching impacts on physical health, mental health and wellbeing as a result of significant weather events.

As a Health and Care system, we need to also adapt to the impact of climate change now and in future. This requires a whole system response which includes considerations for supply chains, estates, transports, how we deliver care, housing, planning of the physical environment – so the whole system becomes resilient which is central to tackling health inequalities and enabling our population, including future generations, to live well.

As a partnership we're committing to making fundamental changes to the way we work, through increased investment, mitigation, and culture change throughout our health and care system. We want to create the conditions for all organisations and individuals across West Yorkshire to be empowered to take action on climate change in their day-to-day work. This includes how our staff get to and from work and how we support patients in accessing health care, and how we adapt to climate harms.

This will also support the achievement of the NHS Carbon Zero ambition by 2040. (2038 in West Yorkshire in line with our system partners the West Yorkshire Combined Authority and the 5 Local Authorities).

Our 'all hands in' campaign was an important step in this work, using a system wide approach to behaviour change. The campaign supported our workforce to become more aware that their individual actions have a direct impact on sustainability and in decreasing carbon emissions, which collectively is a good thing for population health.

We will strengthen local economic growth by reducing health inequalities and improving skills, increasing productivity and the earning power of people and our region as a whole.

We know that economic activity has a significant impact on health and wellbeing. Having a purpose and a living wage contribute significantly to a sense of belonging and being able to live a life well. Both the pandemic and the cost of living crisis has significantly impacted on this for many people in West Yorkshire.

As an employer our workforce is our greatest asset and our ambition through the life of this strategy is to grow and retain our workforce. Exploring innovative ways of recruiting and training staff and creating new roles to deliver integrated health and care.

Our strategy aligns to the West Yorkshire Combined Authority Economic Strategy and its vision:

'West Yorkshire to be recognised globally as a great place with a strong, successful economy where everyone can build great businesses, careers and lives, supported by a superb environment and world-class infrastructure.'

An improving population health strategy

This strategy is poverty and trauma informed, and demonstrates a commitment made by our Partnership. Both have been strong themes coming out of our engagement with partners, staff people and communities.

Viewing West Yorkshire as a whole population gives us the opportunity to consider what action we can take to improve health and wellbeing for people living and working here as a partnership on a larger scale. Health status is determined by much more than health and care services alone. It is well established that the wider determinants of health (housing, work, education, social relationships and the local environment) contribute more than three quarters of the impact on our health and wellbeing, and direct healthcare less than a quarter. Working as a partnership will allow us to work together to more effectively address these wider causes of ill health.

Helping those facing the most inequality

Our Independent Review to tackle health inequalities for Black, Asian and Minority Ethnic Communities and Colleagues, highlighted a number of recommendations which are woven through this strategy and our Joint Forward Plan to deliver it. The COVID-19 pandemic has highlighted the impact of deep-seated and long-standing health inequalities faced by some of our communities.

What causes these inequalities is the subject of much debate. This can be linked to the deeper impact of wider societal inequalities beyond the operation of health and social care services. These include broader environmental, social and economic factors that exert a profound ability to shape health outcomes for communities. Structural racism and the impact that this has is a particular concern and we will continue to prioritise our work in this area and embed it throughout our programmes of work.

We are committed to targeting action around the recommendations of the review, including how we better support our own workforce, particularly around leadership development, reflected in our ambitions. You can see examples of the positive difference we are making. There is still much to do.

Our most vulnerable people often face the biggest inequalities in health and our strategy is focused on trying to mitigate this. We have approximately 400,000 unpaid carers across West Yorkshire, many of whom we know don't access the support they may need. We know children and young people from deprived areas have more than twice the level of tooth decay than children from less deprived areas. We are working collaboratively with public health and local authority leads to discuss oral health provision across West Yorkshire. It is important to recognise the challenges our population face around health literacy and literacy in being able to plan to support people in the right way to make a change.

Many of our unpaid carers are young carers who can be invisible and are often not identified at school or in health settings so do not have access to the support that is there to help them. With their help we have developed an app which will help ensure they are able to help their loved ones whilst looking after their own physical and mental health coupled with working towards a bright and healthy future for themselves.

We know that often those without a voice or advocacy, can experience the most inequality, as highlighted in many national reviews over the last year. We have worked hard through the pandemic to provide the best support we can, for example prioritising those with a learning disability for elective care. Advocacy for children and young people can be even more difficult, we have established a West Yorkshire Youth Collective to help influence our top priorities and decision making. We know however that there is much more that we can do.

The people in West Yorkshire who are involved in serious violence, exploitation and the criminal justice system are at increased risk of additional social needs, inequalities and poor health and wellbeing. We know that the majority of people in the criminal justice system have experienced trauma and adversity, often in childhood.

Working with partners across West Yorkshire including the West Yorkshire Violence Reduction Unit, West Yorkshire Policing and Crime Team and NHSE Health and Justice team, we will provide support for people when they enter, during and leaving the criminal justice system. We will also provide support for their families and victims

Our population and demographics continue to change and it is important to listen to our place based joint strategic needs assessments in order to plan for them. It is also however, important that our system has the flexibility to be responsive at short notice when challenges arise.

Climate change

Our world is facing a climate change crisis and as a Partnership we are committed to taking collective and individual responsibility to take action against it, and adapt to change already taking place. We will do this through embedding sustainability in everything we do and changing the culture in West Yorkshire so that we build resilience to climate change across the system.

We will work towards creating a healthy, equitable and environmentally sustainable society and reduce the climate change impacts of healthcare through a high quality, equitable and environmentally sustainable health and care system. We will also reduce our vulnerability to climate change harms, focusing on prevention by building climate resilience among our partners and in our communities.

Poverty and cost of living

We have committed as a partnership to mitigate the impacts of poverty and the increased cost of living on the health and wellbeing of our population and workforce, including:

- Supporting people to have good mental health and wellbeing and taking a zero-suicide approach, making suicide prevention everyone's business
- Enabling the West Yorkshire voluntary and community sector to support people and communities most affected by poverty and increased cost of living
- Preventing serious violence, abuse and exploitation
- Responding to increasing levels of trauma and adversity
- Identifying opportunities to influence the increase of welfare/benefits and income from employment
- Working in partnership with our local places Bradford District and Craven, Calderdale, Kirklees, Leeds and Wakefield to identify people whose health is at greatest risk from poverty and increased cost of living and targeting ways to reduce that risk

A trauma informed approach

The people in West Yorkshire who are involved in serious violence, exploitation and the criminal justice system are at increased risk of additional social needs, inequalities and poor health and wellbeing. We know that the majority of people in the criminal justice system have experienced trauma and adversity often in childhood.

Working with partners across West Yorkshire including the West Yorkshire Violence Reduction Unit, West Yorkshire Policing and Crime Team and NHSE Health and Justice team, we will provide support for people when they enter, during and leaving the criminal justice system. We will also provide support for their families and victims

As a health and care partnership we are committed to understanding and responding to the root causes of serious violence, violence against women and girls and keep our communities safe.

We know that some population groups face multiple complex disadvantages for a number of reasons, complicated further by also experiencing poverty or destitution and impact of poor air quality and poor housing. These populations groups are often referred to as inclusion health groups and include groups who are socially excluded, typically experience multiple overlapping risk factors for poor health (such as poverty, violence and complex trauma), experience stigma and discrimination, and are not consistently accounted for in electronic records (such as healthcare databases). These experiences contribute considerably to increasing health inequalities and frequently lead to barriers in access to healthcare and extremely poor health outcomes, often much worse than the general population.

Inclusion health groups include people who experience homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in contact with the justice system and victims of modern slavery but can also include other socially excluded groups.

We have a special focus on supporting people experiencing multiple disadvantages to attempt to reduce some of the barriers they face and to improve their experiences and outcomes relating to healthcare, but also the quality of their lives. This will require working with a wide range of partners across the WY Health and Care Partnership to address issues linked to the wider determinants of health (including the quality of housing people live in, the places and communities they live in and relationships they have, as well as a sense of purpose through giving back to the community or being in good quality employment, and having sufficient financial resources to meet their needs).

West Yorkshire is pursuing the status of ICS of sanctuary. In West Yorkshire, we see our Migrants, Refugees and Asylum Seeker population as an asset to our cities, towns and communities not a burden. Providing a safe and welcoming place of sanctuary for individuals and families should be seen as an opportunity not a threat.

Improving population health fellowship [example in a text box]

Our Improving Population Health Fellowship programme is helping to embed this work throughout our partnership. The Fellowship launched in 2021 with 33 equity fellows and will continue for a second year expanding to include, trauma, adversity and resilience, suicide prevention and climate change fellows. Our fellows are receiving training, implementing their learning in work and embedding their thinking across the Partnership and in everything we do.

Health inequalities academy [example in a text box]

Our Health Inequalities Academy continues to work to bring together partners to explore progress and share learning on tackling health inequalities. Our recent celebration of the first year of the academy, highlighted the work taking place to improve the lives of the most disadvantaged people living in West Yorkshire. The aim of the academy is to support everyone working across the partnership, whatever their role, to understand the part we can all play in creating a more equitable system.

By acting as a forum to raise awareness and bringing people together, the Academy provides support and showcases interventions which are being implemented locally and can be adapted across the whole of West Yorkshire and beyond.

Personalised care

An important part of improving people's health and wellbeing is through better delivery of trauma-informed personalised care, with and alongside them. Personalised care means people have choice and control over the way their care is

planned and delivered, based on ‘what has happened to them’, ‘what matters’ to them and their individual strengths, needs and preferences.

This happens within a system that supports people to stay well for longer and makes the most of the expertise, capacity and potential of people, families and communities in delivering better health and wellbeing outcomes and experiences. As a result of personalised care, health and care is tailored to what matters to the individual, in the context of their whole life, such that personalised care can support programmes and systems to address inequalities in access, experience and outcomes.

Our ambition for personalised care is important in tackling inequalities for communities and people, especially those who don’t always know how best to access the care and support they need. For example we know that people with learning disabilities die 15-20 years earlier than the general population, as do people with complex mental illness. We also know that children and young people from ethnic minority backgrounds experience poorer health outcomes, with higher asthma rates and obesity.

We also know that only 55% of adults living with long-term conditions feel they have the knowledge, skills and confidence to manage their health and wellbeing on a daily basis Our continued approach to patient activation tools (which is a tool that assesses an individual's knowledge, skills and confidence to managing their own health and healthcare), personal health budgets, community-based support, shared decision making, personalised care and support planning all contribute to this.

How we will work together to achieve this

Our principles

As a large Partnership, agreeing the way we work together is an important part of building on the strong foundations already in place since 2016. This involves building on our common purpose and vision, agreeing values through which we work and the behaviours that when demonstrated ensure that we deliver. It is important that we get this right to deliver our strategy.

We have a long history of working together in West Yorkshire to improve outcomes for our population which means that the new statutory arrangements are already building on a successful way of working. This is demonstrated through some of the West Yorkshire work we have undertaken together across the Partnership, for example national award winning campaigns such as ‘Root out Racism’, ‘Looking out for our Neighbours’ and the ‘Check-in Staff Suicide Prevention’ Campaign.

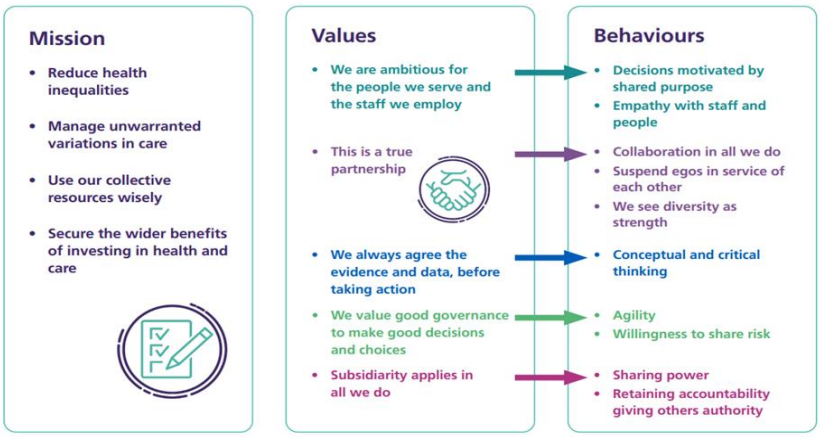
We have agreed as a Partnership that:

- We will be ambitious for the populations we serve and the staff we employ.

- The Partnership belongs to us all, local government, NHS, VCSE and communities.
- We will do the work once – duplication of systems, processes and work should be avoided as wasteful and potential source of conflict.
- We will undertake shared analysis of problems and issues as the basis of taking action
- We will make decisions as close to individuals as possible – with work taking place at the appropriate level and as near to local people and communties as possible

Our mission, values and behaviours

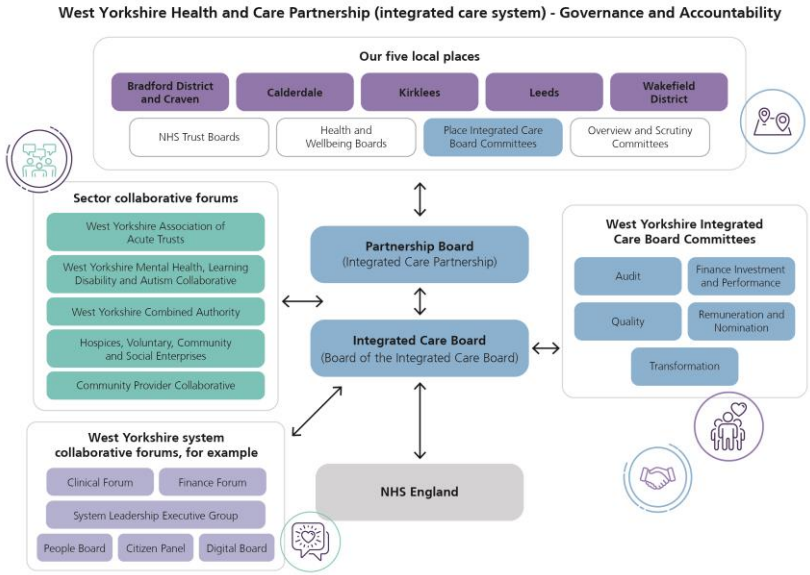
The way in which our Partnership will put these principles into action is set out in the diagram below:



The way we work has been demonstrated in being the Health Service Journal Integrated Care System of the year in 2021 and 2022, where leadership values across all health and care sectors was highlighted as a success of how we improve care for people and communities.

The way in which we organise ourselves to deliver better care for all

With the introduction of the new statutory arrangements following the Health and Care Act 2022, we have developed a new set of arrangements through which, we can ensure that we deliver our work for West Yorkshire people and communities. Details of these arrangements are available here. An illustration of how these arrangements work and how the different elements of our Partnership fit together is shown in the diagram below:



Building from Neighbourhoods

Our strategy begins with individuals, families and in the local communities or neighbourhoods in which they live. The ability of integrated neighbourhood teams, working together in an increasingly integrated way across the breadth of health and care services, to meet the needs of our communities underpins our ambitions to improve outcomes and tackle inequalities. We know that in recent years we have seen increasing pressure across primary care, community health services, social care and within the voluntary sector. This has been largely due to a combination of increased demand for care resulting from factors including an ageing population with greater morbidity, changes in the nature of population needs following the pandemic, and increased pressures on the primary care and community workforce.

Since our original strategy was published in 2019, and often in the face of the pressures created by the covid pandemic, we have continued to see local teams and services within our neighbourhoods work more closely together – for example through primary care networks and other related models of community and locality working. This is better for our populations in terms of helping provide a more joined-up experience, more personalised to people's needs and that helps people stay healthier and well at home and close to home. More integrated working also creates further opportunities and rewarding roles for our staff. But we know this is an on-going journey and one that we will need to keep in focus and support together across the Partnership over the next five years.

For example, as we take on responsibility for pharmacy, optometry and dental services over the coming year, there is also an opportunity for us to also integrate these services further into our integrated neighbourhood model of working. Our Voluntary and Community Sector partners are already an integral part of the way we work in our neighbourhoods and there is valuable learning as to how other partners can integrate their work and their teams. This will then ensure that we have a diverse team representing not just traditional health and care but also wider

determinants of health, to wrap around individuals and families providing the support they need.

Our ambition is that our neighbourhood teams will be supported in adopting population heath management approaches to proactively identify and support people in their communities, helping to prevent ill health, reduce health inequalities, and being able to act earlier before people are at risk of poorer health and wellbeing outcomes. Our strategy also commits to ensuring that we are able to meet the workforce challenges (including investing in expanding and developing neighbourhood teams), capital requirements (to help ensure we have high quality facilities where teams can work together and further support local communities) and digital enablement to support the implementation of this approach.

Working in local places

Our Health and Wellbeing Boards have a long history of delivering real change in our local places and their representation reflects the breadth of contributors to health and wellbeing. They provide the strategic vision for each local place, working closely with the Place Based Committees of the ICB to oversee the delivery of the NHS elements of our Integrated Care Strategy.

Many of the Health and Wellbeing Board Strategies have been refreshed over the course of this year and they have all informed the development of this strategy. They all have a strong focus on tackling health inequalities through a life course approach, including giving people the best start in life, living well and having a good death. Many are based on the Sir Michael Marmot Report principles, a review of which is available on this website.

Our Local Health and Wellbeing Strategies are available on local place websites.

- Wakefield Health and Wellbeing Strategy
- Kirklees Health and Wellbeing Strategy
- Calderdale Health and Wellbeing Strategy
- Bradford Partnership Strategy
- Leeds Health and Wellbeing Strategy

Our local places are delivering their Health and Wellbeing Strategies in partnership overseen by Health and Wellbeing Boards and their Place Committees of the NHS West Yorkshire Integrated Care Board. Starting with neighbourhoods they are bringing teams and staff together to deliver joined up health and care, This includes partners such as housing, Police, Fire and Rescue and the Department of Work and Pensions. Sharing learning and scaling up good practice across West Yorkshire is key, as is collaborating when it makes sense to deliver joined up health and care services between places and always intervening early to prevent poor health and wellbeing.

In many of our places integrated work begins with the leadership teams, with joint appointments at a senior management position. For example in Wakefield our place

lead also undertakes the role of Adult Social Care Director and Director of Community Services in the hospital (Mid Yorkshire Hospitals NHS Trust). In Calderdale Local Authority Chief Executive is also the place lead.

This approach is also replicated in teams across local places and in some cases has been happening for many years. This has involved commissioning staff working in provider organisations and local authorities to ensure rich and varied skills and expertise in the planning and delivery of services. This way of working not only leads to better integrated care around the person but is also a more effective use of resources and a driver for a joined-up partnership culture.

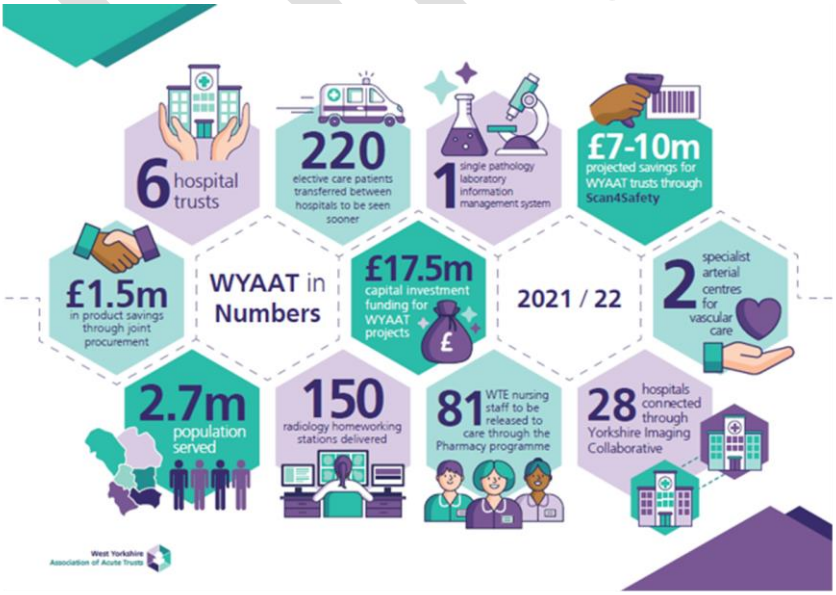
Often there is additional benefit in providers from across West Yorkshire working together as a team across a larger footprint (we call this provider collaboratives) in This is in addition to working together with other partners in their local places.

Working in collaboration at West Yorkshire level

Most of our work happens in our local places, communities and neighbourhoods, taking decisions and delivering integrated services as close to people and families. Sometimes however, there is real benefit in providers of services coming together (we call this provider collaboratives) across West Yorkshire to collaborate on agreed programmes of work. This work is in addition to working in collaboration with other partners within their local places.

West Yorkshire Association of Acute Trusts Provider Collaborative (WYAAT)

Our acute hospitals have worked together through WYAAT since 2016 providing a collaborative, partnership model of integrated acute and specialist healthcare across West Yorkshire. Their vision is to deliver outstanding, high quality acute and specialist healthcare for the whole population of West Yorkshire.



We know that the pandemic has had a significant impact on hospital services in the same way that it has elsewhere in our partnership. There are significant workforce challenges which we are seeking to resolve through our WY People Plan and we know that people are waiting longer than before the pandemic to receive hospital care.

In addition to the WY People Plan, WYAAT's developing strategy is aligned to our integrated care strategy in ensuring that we can collectively provide the best health and care for our population, whilst tackling health inequalities, as well as supporting sustainability and broader social and economic development. To ensure WYAAT is able to proactively collaborate where it makes sense to do so, the strategy contains five pillars:

- Workforce
- Service Delivery (clinical and non-clinical)
- Ways of working
- Recognising and reducing variation
- Estates

There are already a number of ongoing work programmes to deliver the strategic vision. For more information, please visit the WYAAT website here

Mental Health Learning Disabilities and Autism (MHLDA) collaborative

Our MHLDA Collaborative consists of our four mental health/learning disability trusts across West Yorkshire. It is designed to help drive forward the system changes that need to be made, remove barriers to integration and ultimately ensure that our resident population receive the best care and support that can be offered within finite resources.

Through the Collaborative, providers will share and learn from their experiences, including what has not gone well, offer peer support and challenge. Boundaries between services, organisations and across the provider/commissioner landscape will begin to blur focusing on becoming "one workforce" with a collective ambition.

We know that the pandemic has had a significant impact on mental health and this is now compounded by the cost of living crisis. As a collaborative much work has been undertaken over recent years to transform services and this will continue through the delivery of this strategy.

Community Health Services Provider collaborative

Our collaborative of Community Services Providers, which formed in 2021, has come together work collectively on shared issues that of common interest to the sector, such as enabling more healthcare to happen close to home, and where joint approaches or shared learning, such as in workforce development and service redesign, can add collective value.

The collaborative has an important contribution in delivery the strategy through both working together and with other partners, ensuring that community services has a clear and engaged stake in the direction and decisions

Hospice collaborative

In West Yorkshire we have an ambition that people will die well and have a good death. Our Hospice Collaborative is built from a powerful trust base and has strong relationships through which, it delivers a manifesto for palliative and end of life care.

Through our strategy we plan to provide the very best palliative & end of life care for the population of West Yorkshire, which will be personalised, holistic, accessible, a good life to the end of life & a good death. We will provide Effective and personalised support for carers, families & friends and ensure access and inclusion of diverse communities across West Yorkshire.

We want to make sure that hospices are working in a seamless way with the NHS and palliative end of life care system, to meet the needs of patients, reduce unnecessary hospital admissions and enable patients to be discharged home or to the setting of their choice.

Working with NHS England

Services are planned for and provided at, a range of different footprints and whilst this is best carried out as close to the individual as possible, sometimes it is more appropriate to be carried out at a much larger footprint. When this is the case, we work with NHS England to do this on behalf of our people in areas such as health and justice, specialised services, dental, optometry and pharmacy services.

From April 2023 the NHS West Yorkshire Integrated Care Board will be taking on responsibility for the planning and delivery of dental, optometry and pharmacy services, details of which will be set out in our delivery plans.

Specialised Services

The Specialised Commissioning and Health and Justice Team are responsible for commissioning services across a diverse portfolio of care that is provided at specialist tertiary centres, within prison settings as well as in specialised inpatient mental health units across the region. These services are planned at a regional level due to low volume, complexity of the services, and the potential financial risk associated with provision.

Specialised services have an important part to play in the delivery of the long-term plan ambitions for Yorkshire and the Humber. Many of the specialised services which NHS England commission are part of broader pathways of care. Working in partnership with West Yorkshire ICB, South Yorkshire ICB, and Humber and North Yorkshire ICB, specialised commissioning will explore ways to deliver new service models to integrate specialised services into care pathways, focussing on population

health for each ICB. We will do this through joint collaborative commissioning approaches as set out in the Roadmap for integrating specialised services within Integrated Care Boards, published in May 2022. We will explore opportunities for more advanced integrated arrangements where these will support the delivery of outcomes for our population.

To optimise equity of access for specialised services, while ensuring care as close to home as possible, we will build on our current clinical engagement to expand new models of service delivery through network approaches, this will ensure that we can deliver care for our population while improving clinical governance and oversight. These successes will help us to develop networked solutions that are appropriate for the population of West Yorkshire.

Some of the joint priorities for 23/24:

Healthy Childhood (Maternity and Neonates)

- Work with the Northern Neonatal Operational Delivery Network (ODN) and Local Maternity Systems (LMS) to deliver the 5-year implementation plans for the ICS for the national Neonatal Critical Care Review, this will ensure delivery in the reduction in neonatal mortality. This will include plans for developing neonatal capacity, further developing the expert neonatal workforce and enhancing the experience of families through care coordinators and investment in improved parental accommodation.

Cancer

- Work with providers of Paediatric Radiotherapy Services and Cancer Alliances to develop new service model for Y&H that will ensure access to the best care and treatments.

Cardiovascular

- Review and assure plans for the delivery of mechanical thrombectomy for the ICS as set out in the Long-Term Plan and reduce the likelihood of disability from stroke.
- Work with the West Yorkshire Cardiac Network to deliver the national Cardiac Improvement Programme to improve patient pathways and quality of care. This includes reducing waiting times for Cardiac Surgery and improving the pathways for patients with Aortic Stenosis.

Other

- Develop an Adult Critical Care Transfer Service that will support best use of critical care capacity across the Yorkshire and the Humber patch, particularly in times of high demand for services.

Working with wider partners

We need to work effectively with partners outside of health and social care in order to make the most impact on health and wellbeing, as so much of good health is related to wider determinants of health such as employment, technology, policing, the economy the climate crisis

We have a long history of successful working in relation to wider determinants of health, for example through our work on health and housing. In some parts of West Yorkshire, we have successfully introduced housing advisors into hospital settings in order to ensure that we can begin to address people's housing needs as soon as they are admitted into hospital, therefore supporting the discharge process. We are also undertaking an assessment of the housing needs of people with Learning Disabilities, Autism and Severe Mental Illness to drive change in future planning decisions and ways of caring for people outside of hospital settings.

There are a significant number of large employers in a broad range of sectors across West Yorkshire. Taking a proactive approach to working with employers on health promotion and prevention will be mutually beneficial and more accessible for the population. Working with education and early years provisions to support children to have the best chances in live and outlook for their future is an important element of our wider working.

As a Partnership we are committed to working with both the West Yorkshire Combined Authority and the West Yorkshire Mayor on work which will in turn improve the health and wellbeing of our population. We know that employment, housing and transport all have an impact on health and wellbeing and are all factors of concern in the cost-of-living crisis. We know that this is an issue for both our workforce and our population.

In delivering this strategy we aim to be work more closely with our partners to tackle this, placing more focus on the action we can take. The Mayoral Pledges align well to this strategy and provide us with a good opportunity to focus our work around supporting broader social and economic development working on the factors that are important to our communities and our workforce. As a partnership we have opportunities to work more joint up with these wider stakeholders.

Delivering our strategy

How we involve our people

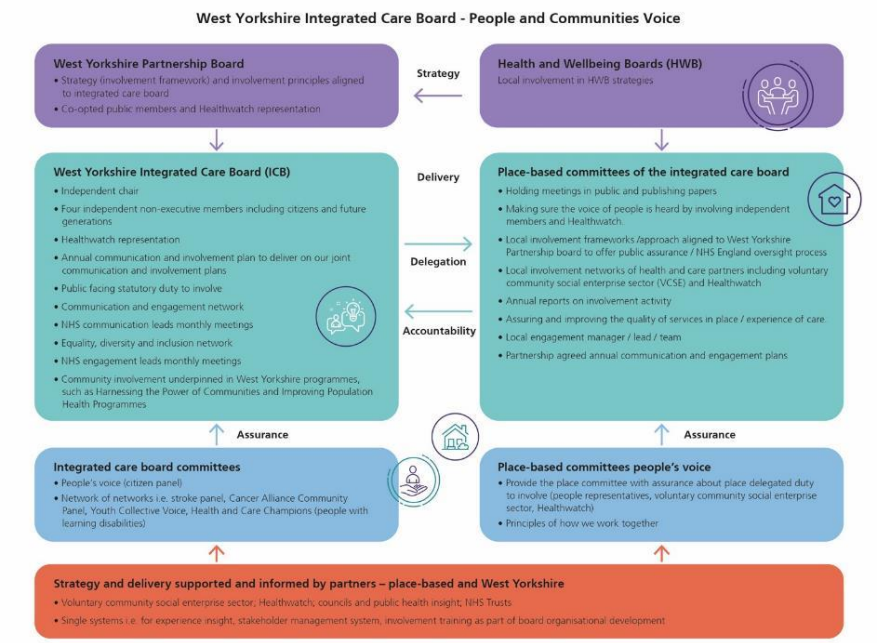
Our Partnership is committed to ensuring that our approach to involvement, in all its forms meets the needs of people living, working, and caring in West Yorkshire. No decision will be made about changes to health and care services that people receive without talking with and listening to people receiving those services or who may do in the future, about it first. It is important that people have their say to shape and improve local services and those provided on a wider geography.

Engaging with partners, stakeholders and the public in the planning, design and delivery of services is essential if we are to get this right. Wherever and whenever possible we will include meaningful involvement as part of our work. We want people to help us design, develop and improve services by sharing their views and experiences.

We know that the people we listen to and involve need to reflect the communities we serve. We know that many people are often not heard in our system and to ensure our services / commissioning meet the needs of all people we work creatively and accessibly to reach those whose voices / views / opinions are too often ignored or not sought. We have agreed principles of how we work together and with people and communities.

Our involvement framework describes our approach to involvement across West Yorkshire and how our engagement is helping us to tackle health inequalities. Through this approach we are able to ensure that we are putting the people of West Yorkshire at the heart of everything we do. We have used the involvement framework to guide us in the development of this strategy and this will be especially important in the development of our plans to deliver the strategy.

The way in which the people voice is heard in our system is outlined in the diagram below:



How we will develop plans to deliver: our Joint Forward Plan

To ensure as a Partnership we deliver this strategy, we will develop a Joint Forward Plan together which will be overseen and owned by the NHS West Yorkshire Integrated Care Board. This plan will set out how over the next five years we intend to deliver the ambitions we have set out in this strategy. The plan will also include national NHS ambitions including:

- Continuing to reduce the waiting times for people needing diagnostic or planned care (such as cancer treatments and orthopaedic surgery);
- Continuing to improve access to primary care services;
- Reducing demand for emergency care; and
- When people have an emergency or urgent need, they can be seen quickly by the most appropriate service.

In the same way that this strategy will be refreshed from time to time, our Joint Forward Plan will be reviewed each year. This will allow us to consider the progress made, what people are telling us about their health and wellbeing and how we might need to change our plans to respond to this. Using our involvement framework to support an ongoing discussion with people in West Yorkshire will be an important part of this work and will take place annually.

Our plans will be developed with a lens which will ensure that everything we do is developed and delivered in a way which will support sustainability and tackling climate change, mitigate the impact of poverty and respond to trauma.

We will publish our Joint Forward Plan on our website alongside information each year on the progress we have made. Our initial Joint Forward Plan will be published in April 2023 and if you would like to be involved in its development, please email westyorkshire.ics@nhs.net.

How we will plan for our workforce

Our people are our greatest resource, we are proud of their commitment to the people of West Yorkshire and the resilience they have shown through the Pandemic. The resilience shown over recent years in challenging times reflects their strength and compassion and as a Partnership we want to make sure that we are supporting them in the best way that we can,

In 2021 we developed our West Yorkshire People Plan which recognises the diverse nature of our partnership. It represents the full range of health and care sectors, including universities, those working and volunteering in the voluntary, community

and social enterprise (VCSE) sector and unpaid carers. The Plan sets out the current challenges which the plan needs to address but also the ambition for our people. It sets out what we are doing now and what our future plans will include.

We know that the pandemic has brought huge challenges for our workforce and we continue to both adapt and learn from this to ensure that we can support our workforce now; plan to ensure that we grow a workforce for the future; build new ways of working and delivering care and build our partnership.

Equality, diversity and inclusion

We see the diversity of all communities and colleagues as a strength to help inform the way we plan, design and commission health and care services for people living across West Yorkshire. We want to make sure that everyone is treated fairly and given an equal chance to access opportunities. Ensuring that we meet the needs of everyone to ensure that our population all have good outcomes.

We recognise and value individual as well as group differences, treating people as individuals and placing positive value on the diversity they bring because of a protected characteristic or cultural background.

Our strategy is also focused on making all groups of people feel included and valued within their society or community so that there isn't a negative effect on their health and wellbeing and so everyone can access the care they need.

Our plans to deliver will have valuing equality, diversity and inclusion at their heart and through our Involvement Framework we will listen to people to ensure that we get this right.

Clinical and professional leadership

Clinical and professional leadership is central to all of our work, helping us put the person at the centre of our decision making. The West Yorkshire Clinical Forum provides clinical leadership and expertise into all programmes of work. It is supported by networks of nurses, allied health professionals, pharmacists and medical directors from across the health and care system. The forum also provides clinical leadership to dental and optometry services. The development of this strategy has been informed by their voice.

Ensuring our services are of good quality

Listening to clinical leaders and people's experience of health and care is an effective way of us ensuring that our services across West Yorkshire are of good quality. We also work through our Integrated Care Board System Quality Group to ensure that we are delivering our statutory quality functions and strategic objectives in a way that secures continuous improvement in the quality of our services. It also provides valuable assurance for the delegation of some functions of commissioning.

Listening to our workforce and our people is also central to the way in which we design and deliver care and how we transform our services in response to their experience of providing and receiving care.

Safeguarding people

Our joined-up approach to safeguarding across our Partnership is based on arrangements within our five places and the statutory duties that organisations at place hold. Our Partnership's Safeguarding Committee spans these place arrangements to facilitate peer support and shared learning and an interface with NHS England and lead professional networks.

How we will use data and intelligence

In delivering this strategy, we will ensure that our decisions are data and intelligence informed. Much of the data will be built upon the Joint Strategic Needs Assessments in each place which look at the current and future health and care needs of local populations. These are designed to inform and guide the planning and commissioning (buying) of health, well-being and social care services.

By bringing together our data alongside what our people and staff are telling us will support improving outcomes and reducing health inequalities for the population of West Yorkshire. This will not only ensure that we are able to tell a compelling story as to how our services are being delivered, but also help us consider where we can best focus our efforts on improving them.

To ensure that we are doing this in the right way, we need to make sure that we understand where this intelligence is in our system and how we can ensure that it is brought together to help our decision making on an ongoing basis. We will also gather and make sense of the data and intelligence we have, in the right place at the right time to ensure that we can improve efficiency and productivity.

In order to deliver the strategy and achieve our ambitions we will need to grow our analytical capacity and capability over the next five years, freeing up time to innovate and support our plans. We will be able to do this through shared learning and development and shared resources with an aim of all parts of the West Yorkshire system being able to contribute to, access and use, the best possible analysis of our information.

To deliver the strategy and the innovation we need to make a real impact on reducing health inequalities, we will look to constantly advance the technology we use. Building on our use of modelling to understand future demand and how we might innovate to meet the need.

Money and resources

In West Yorkshire, we have worked to a set of guiding values and behaviours which have ensured that decisions around how we allocate monies and manage financial

risk have been made collectively together. We know that the budgets of all organisations within our partnership are going to be challenging over the coming years. All of these pressures run alongside the cost-of-living issues that people are facing across West Yorkshire, and the unequal impact on poorer communities. and that this will be felt at both system, organisation and individual level.

We know that demand for services is likely to increase across all ages. The impact on some sectors such as our VCSE has also been noticeable and has threatened their sustainability whether through reductions in grant funding or charity donations from the public alongside increased demand.

We have a strong history of working together across organisations and sectors to better use our resources to improve health and care. An example of where we have made a difference through our collective action is the deployment of £1million into social care providers in 2021/22 to allow the early introduction of the national living wage for low-paid employees. This ensured early action to tackle the cost-of-living crisis whilst also supporting a more sustainable care workforce.

This work has been successful due to the way in which we work together across our partnership to a common vision, the level of trust we have and the relationships we have built. We will continue to do this over the lifetime of this strategy to ensure that we can use our resources to reduce health inequalities and improve health and wellbeing in our population.

We make our decisions as close to the individual as possible, starting our planning of services from places and communities. Our resources enable the delivery of plans at this level, ensuring that they are used effectively, efficiently and in new innovative ways where possible.

Our 2022-2027 Finance Strategy sets out our approach to how we will use our resources and make our financial decisions to support deliver of our strategy. It outlines the actions we will take to use our finance and resources in tackling health inequalities; managing unwarranted variations in care; using our collective resources wisely; and securing the economic and social benefits of investing in health and care.

Buildings and estates

To deliver joined up health care and new ways of working together we also need to look at how we make the most of our buildings (our estates). The way in which we work as organisations together across our Partnership helps us make the most of both our buildings and other assets available to us. We will look to use our estates effectively as an organisation and support our NHS Trusts to adapt to the new ways of working. Planning for future changes as more and more people become flexible and take positive advantages of hybrid working.

This work begins in our communities, using our estates to support bringing teams together to wrap around and support people, unpaid carers, communities and

neighbourhoods. This extends beyond traditional health and care, looking at how we can use our estates across our wider partnership to truly integrate the way in which we work together. Our estates are led by the clinical strategy around the services that we provide.

Our capital and estates work are also important in supporting our organisations to deliver their services in a safe and effective way. In order to deliver this strategy we need to ensure that we are able to develop and prioritise bids for capital funding to ensure that we have high quality buildings which support us to deliver health and care safely, collaboratively and in an innovative way.

Through working together on capital, we been able to successfully bid for NHS England capital to support system-wide capital investments over recent years. This has brought an additional £300m into West Yorkshire. We will work with WYCA to support investment within the region in economic and workforce development.

The way in which we will learn and develop

As a forward-thinking innovative partnership, we continue to develop and deliver innovative ideas and solutions to improve the health and wellbeing of the 2.4million people living across our area. We do this through working together with organisations from industry, universities, and public and VCSE partners, so that we can create a culture that uses ‘innovation’ to improve people lives. This helps to make sure people have the best start in life and every opportunity to live a long, happy, and healthy one.

Our partnership with the Yorkshire and Humber Academic Health Science Network provides us with a valuable opportunity to work with a range of professionals and organisations with expertise in a wide range of areas. Through this work we have been able to develop an Innovation Hub, one of two across Yorkshire and Humber.

One of the aims of the Innovation Hub is to support West Yorkshire to develop and foster our culture of innovation and improvement whilst highlighting areas of best practise and helping us to deliver on the systems innovation goals. Within the Innovation Hub, there is also a Digital Primary Care Innovation Hub, which supports our understanding and innovative work on issues facing primary care.

We also work closely with the Yorkshire and Humber Applied Research Collaborative which supports people-powered research that aims to tackle inequalities and improve health and well-being for our communities. With themes of healthy childhood, mental health and multimorbidity, older people and urgent care, this work provides us with an opportunity to both learn and commission work in these areas to support the delivery of our strategy and ambitions.

In the development of our plans to deliver our strategy, we will lean from both organisations to inform our plans and we also identify opportunities to use their expertise to help us understand areas where we have significant challenges.

There is also much we can learn from each other within West Yorkshire. We know that there is good work happening in neighbourhoods, places, providers, collaboratives and across West Yorkshire. We will continue to share and learn in a collaborative way to understand where we can implement good practice and innovation into our work to improve outcomes for our population.

The way in which we will use digital and technology

In West Yorkshire we are embracing technology to empower people to take control of their own health and care and continually improve the way we deliver services so we can be the best we can be. Our Digital Strategy sets our vision that people will have a choice to use digital channels to access services and monitor their own health.

Our Digital Strategy also seeks to ensure that our services are designed using evidence from data and that our workforce can work from anywhere in the region and access the information that they need to care for the individual person. This will support us in our recovery from the pandemic and ensuring that people can access health and care and receive diagnoses at the right place and the right time.

An example of where we have made a difference is through our online GP consultation. Whilst we have continued to deliver face to face appointments over the last year, for those who have wanted to and been able to, the opportunity to access online GP consultations has been a valuable resource through the pandemic.

Useful information

Helpful publications & web links

Contact details

Availability in alternative formats

Meeting name:	Leeds Committee of the West Yorkshire Integrated Care Board (ICB)
Agenda item no.	LC 53/22
Meeting date:	13 December 2022
Report title:	Leeds City Digital Strategy
Report presented by:	Leonardo Tantari, Chief Digital and Information Officer
Report approved by:	Leonardo Tantari, Chief Digital and Information Officer
Report prepared by:	Nichola Stephens, Associate Director of Strategy & Innovation, ICB in Leeds & Stephen Blackburn, Innovation and Strategy Lead Manager

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

Previous considerations:

An outlined of the strategy was considered and approved at Leeds City Council Executive Board 19th October this was a public meeting. The report has been presented to the Partnership Executive Group (PEG) in Leeds with the recommendation a paper is taken PEG in January to support delivery of the strategy. In addition, the report has been presented and approved by Executive Management Team at the Leeds Office of the ICB and the Council Leadership Team with the action to have a high level delivery plan which sits underneath to performance manage the strategy and ensure it is a live document.

Executive summary and points for discussion:

The City Digital Strategy provides a high-level overview of the digital ambitions and aspirations for Leeds City Council and the Leeds Health and Care Partnership (LHCP). It has been written however, from a 'whole city' view rather than from any specific organisation's perspective to encourage participation in its delivery.

This report will outline the contents of the new digital strategy for the city and how it will support the Best City Ambition and three pillars of Inclusive Growth, Health & Wellbeing, and Zero Carbon. It will outline the planned programme of innovation and how it will align with the high-level digital strategy and more detailed digital roadmaps (priorities) that are being drawn up for specific services.

The strategy articulates the priority areas that will be taken forward by the Integrated Digital Service with a focus on improving service delivery and realising efficiencies. It provides a steer for targeting resources in the right areas and supporting the council in addressing the financial challenge it faces in the current economic climate.

Digital solutions and technologies can radically improve how services are delivered in Leeds. There are of course challenges that will need addressing to realise a more sustainable, equitable Leeds that we all aspire to. However, these should be viewed in relation to the opportunities that exist that will enable people, businesses and communities to prosper.

It should be noted that this is not about replacing all analogue services with digital ones. It's about adopting a 'Digital First but not Digital Only' approach that recognises that not everyone will want to access services via a digital channel all of the time, and that any digital offer will be complimentary to existing channels such as face-to-face and over the telephone. To safeguard this approach we will prioritise our digital inclusion work to ensure no-one is excluded and that the people of Leeds are supported.

The use of digital technology, to support in the delivery of our services, offers many opportunities that we must encourage and embrace. This is not simply about moving services online however, we must also transform how we work. Bringing the digital services of the council and the Leeds Health and Care Partnership together to create a combined Integrated Digital Service is the start of this digital transformation, enabling us to provide a more joined up digital offer for the people of Leeds.

To progress and build on this digital transformation approach, a dedicated Strategy and Innovation team will focus on identifying new, innovative digital solutions, opportunities and proof of concepts that showcase best practice and outline how services can be delivered differently and more efficiently.

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)

<u>The Leeds Committee of the West Yorkshire ICB is asked to</u>:

1. **Support** the approach being outlined in the digital strategy, the digital transformation approach, and the innovation programme.
2. **Approve** the strategy and agree that it can be published.

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. Leeds City Digital Strategy 2022 – 2025

Acronyms and Abbreviations explained

N/A

What are the implications for?

Residents and Communities	The strategy takes a 'person-centred, life-course' approach. It has been written following extensive consultation with a wide variety of stakeholders and focuses on how digital technology can improve people's lives throughout every stage of their life: Starting well, Living well, Working well, and Ageing well.
Quality and Safety	It identifies the priorities that the Integrated Digital & Innovation Service (IDS) will focus on to improve existing services and use digital technology to deliver services in new and innovative ways.
Equality, Diversity and Inclusion	The strategy, and subsequent delivery is inclusive of all people and communities. It outlines that a 'Digital First but not Digital Only' approach will be taken to ensure that traditional services will always be available. It will provide the steer for the IDS innovation programme that will encourage participation from members of the public and community groups to co-design future services that they will access.
Finances and Use of Resources	The areas of work outlined in this report all have the aim of delivering more efficient services and improving outcomes for the people of Leeds. The strategy articulates the priority areas that will be taken forward by the Integrated Digital Service with a focus on improving service delivery and realising efficiencies. It provides a steer for targeting resources in the right areas and supporting the council in addressing the financial challenge it faces in the current economic climate. For example, work is already underway to review how automation technology can improve processes across the organisation, enabling front line staff to work more effectively. Taking a strategic approach to innovation will enable the council to test and trial how technology can support these aims resulting in targeted investment that is sustainable. The primary focus for the innovation work is to identify how a more efficient use of data and technology can positively impact on resource allocation, whilst maintaining or improving service delivery. The delivery of projects is funded through existing funding and capital funding which is sourced from

	Leeds City Council and the NHS. We will also bid for additional funding as it becomes available.
Regulation and Legal Requirements	There are no specific legal implications or issues relating to access to information.
Conflicts of Interest	There are no conflicts of interest.
Data Protection	There is no use of any personal data contained within this report or within the Strategy itself.
Transformation and Innovation	The high-level strategy, alongside more detailed service digital roadmaps (priorities), is a key document that provides the steer for the digital service's digital transformation and innovation programme. It is important to have a clear link between the Best City Ambition, three pillars, City Digital Strategy and the resulting programme of innovation.
Environmental and Climate Change	All decisions made relating to the delivery of the Strategy will consider any environmental and climate change impacts and be subject to the appropriate scrutiny and governance.
Future Decisions and Policy Making	Future decisions will be made through thorough consultation and approval.
Citizen and Stakeholder Engagement	The development of the digital strategy has been written following extensive consultation that included thirteen workshops covering wide-ranging areas such as digital ethics, business and economy, and primary and social care. Those engaged included Leeds City Council's Neighbourhoods and Communities team, Third Sector Partnership Group, Person-Centred Care Expert Advisor Group, British Sign Language (BSL), members of the public, academia, and those working in the public, private and third sectors. Additionally, an outline of the strategy and innovation programme proposals has been presented to the Executive Management Team and Leeds City Council's Executive Board, Infrastructure, Investment and Inclusive Growth Scrutiny Board and Strategy and Resources Scrutiny Board, all of which include cross-party councillor representation. Approval to the approach was received at all Boards. The strategy itself takes a 'digital first but not digital only' approach, outlining that this is not about removing existing services (e.g. telephone or face to face) but about enhancing the existing offer.

	It takes a person-centred approach, that is, that the people of Leeds are at the heart of what we do and will be engaged with and consulted on in respect of how we utilise digital technology and collected data to deliver services. Any digital innovation work will take a person-centred and outcomes-focused approach. People who will ultimately access services will be engaged to co-design those services to ensure they are fit-for-purpose. Innovation activity will take place in communities to engage with people wherever they live and work. The delivery of this work will be in close consultation with the 100% Digital Leeds (digital inclusion) team who are already well connected through 3rd sector organisations working with communities across the district.

1. Leeds Digital Strategy

1.1 The strategy has been written following extensive consultation including 13 workshops (public-facing and internal) and numerous one-to-one conversations. People from all sectors and backgrounds have contributed to the discussions and their feedback is reflected in the content.

1.2 As introduced in Best City Ambition, the strategy adopts a four-stage 'life course' approach, Starting Well, Living Well, Working Well and Ageing Well, that clearly articulates the opportunities and challenges at every stage of a person's life and how digital can support them throughout their lives. For the purposes of the strategy, Living Well and Ageing Well have been combined.

1.3 Each section provides an overview of ambitions and then more detail about how we will achieve these, and what this means for the city and the people of Leeds.

1.4 Whilst it focuses on Leeds, its people, and services, it is written in the context of national policies and strategies that focus on the wider challenges facing the UK and which will have a significant impact on our plans such as the NHS Long Term Plan, the UK National Data Strategy and the UK Government's Technology Code of Practice.

1.5 The following sections summarise the main sections of the strategy. The full strategy is attached as Appendix 1.

1.6 **Starting Well:** We will use modern digital technologies to understand the challenges associated with population health and education and how they affect individuals from birth through to old age. Understanding health and economic conditions prevalent across Leeds will help reduce inequalities through providing more relevant and impactful services to families. For example, the improved collection and analysis of data about the population of Leeds, their needs, and their health that leads to support the design and commissioning of council services and health initiatives.

1.7 We will work increasingly with schools, colleges and community groups to encourage children and young people to get involved in after school activities, code clubs and digital innovation work that helps develop their digital skills and get them interested in the technology sector. We will promote the breadth of opportunities the sector offers, and ensure that they acquire work-ready digital skills from an early age.

1.8 **Living and Ageing Well:** We will implement intelligent and automated processes that make services more efficient, convenient and joined up, and that are designed around the individual and their needs. For example, we will

build an information sharing approach that is consent-based and person-centred to ensure their data and information can follow people regardless of which organisation and/or service they are engaging with.

1.9 We will use data to understand the challenges and inequalities being faced by the people of Leeds, and share this intelligence with partners to define and deliver effective, personalised services that support people to live good and healthy lives.

1.10 **Working Well:** We will build on existing collaboration across workforces in all sectors by improving information flow between organisations and supporting the city's inclusive growth ambitions.

1.11 A thriving digital community, modern infrastructure and skilled workforce will attract new and established businesses to invest in Leeds improving opportunities for the city and people of Leeds. Taking a people-centred approach to service-design, we will deliver a co-ordinated innovation network and community that champions Leeds as a city of innovation excellence. We will encourage the testing and trialling of new technology in a real-world environment that both supports local businesses and addresses city challenges.

1.12 **Digital Foundations:** Whilst the strategy outlines the ambitions for digital services and technologies in Leeds, to deliver these, we need to get the basics right. Five digital foundations have been outlined that set the baseline for which the rest of the strategy is built on and will ensure that our ambitions are grounded, achievable and inclusive:

1.13 **Data management, use and access:** Data underpins everything we do. It is a valuable resource that has the power to revolutionise how businesses are run and services are delivered. It's important however, that when collecting, using, storing, disposing, or sharing personal data, it is managed appropriately and within an information governance framework that instils confidence and is in line with data protection laws.

1.14 The Chief Data Officer for the Integrated Digital Service will oversee the creation and delivery of a new Leeds Data Strategy. Aligned with the National Data Strategy, it will identify where current data gaps exist and outline opportunities and initiatives that will benefit the city.

1.15 We will expand the Office of Data Analytics which brings together data science expertise and technologies resulting in improved data intelligence, decision making and service delivery.

1.16 **Connectivity and infrastructure:** Protecting our data and information is of paramount importance. To ensure data and systems are protected from any threats (cyber or physical), deliberately or otherwise, we will deliver a 24/7 365 security operations centre that will prioritise the safety and security of people's data and be accessible by any organisation across Leeds.

1.17 We will follow a 'Cloud First/Multi-Cloud' approach that delivers best value for money, best technological approach, and the highest security standards. We will take an open standards approach for all software developments to ensure the maximum potential for systems integration and interoperability.

1.18 21st century connectivity and infrastructure provide the backbone for world-class service delivery and supports our 'connected place' ambitions. The council is working closely with its Full Fibre network partner BT, to provide gigabit capable fibre to 1,400 council buildings and other public sector buildings (e.g. NHS and schools). Furthermore, it will enable up to 90% of homes and businesses to access super-fast broadband by 2026, and supports the build out of a 5G network providing faster mobile connectivity across the district.

1.19 Additionally, the installation of the Leeds Wireless Innovation Network (Leeds WIN), that supports the collection of real-time data from devices, is now complete and is being used by innovators across the city and by the council to test temperature, air quality and footfall sensors.

1.20 **Digital inclusion:** The barriers to digital inclusion for many people are complex and link to wider factors beyond the common issues of lack of skills, motivation or access to a device. We will address these barriers to ensure that everyone in Leeds has equal opportunity to use digital tools, technology and services in the right way for them.

1.21 Through further investment in the city's flagship 100% Digital Leeds programme and by working collaboratively through partnerships and networks, we will continue to build a co-ordinated and connected digital inclusion ecosystem in more communities where people can gain the motivation, skills and confidence to get online.

1.22 **Digital skills:** We take a life-long learning approach that will ensure everyone in Leeds has the right skills to access services in a way that suits their needs, and that digital channels will be accessible, well designed and so easy to use that they become most people's preference. It is important however, that we adopt a 'Digital First but not Digital Only' stance that recognises that not everyone will want to access services via a digital channel all of the time and that any digital offer will be complimentary to existing channels.

1.23 In addition to supporting improving digital skills of the public and the wider workforce, it is important that our own workforce has the requisite skills to facilitate the digital transformation that the organisation requires. A digital academy will be created that will upskill staff in areas such as data intelligence, cyber security and cloud.

1.24 **Digital and data ethics:** Data is easier to collect than ever before and technology is developing so quickly that it is often difficult to keep pace. It's therefore important that as these new technologies become increasingly prevalent and are introduced more widely, that we have a thorough understanding of them. Just because something can be done using technology, doesn't mean to say it should be.

1.25 We will develop data and digital ethics principles that provide checks and balances for any use of data, or introduction of new technology, and draw upon expertise from across the city to provide additional support and scrutiny. Leeds is already a champion of the "tech for good" approach by taking a person-centric approach; embedding strong governance procedures will support the approach that Leeds is regarded as the best destination for anyone who wants to deliver services ethically and equitably.

2. Digital Innovation Programme

2.1 The high-level strategy, alongside more detailed service digital roadmaps (priorities), is a key document that provides the steer for the digital service's digital transformation and innovation programme. It is important to have a clear link between the Best City Ambition, three pillars, City Digital Strategy and the resulting programme of innovation.

2.2 In line with the approach being promoted in the strategy, it is important that as a city, we are equally co-ordinated in respect of innovation activity. A collaborative and joined-up approach will not only ensure that the best skills and capabilities are tapped into, but also avoid duplication and repetition.

2.3 Any innovation activity must focus on one, or all, of the following:

i. Improves the services we deliver
ii. Improves outcomes for people
iii. Delivers efficiencies/savings

2.4 A dedicated Strategy and Innovation team (part of the Integrated Digital Service) will co-ordinate and have oversight of all digital innovation activity across the council and Leeds Health and Care Partnership. Utilising a new innovation platform, it will also connect with other activity that is taking place across the city to promote best practice, ensure a co-ordinated approach, and

promote the city as a ‘centre of innovation excellence’. Work will be co-ordinated with that being undertaken by Economic Development and the development of the ‘Innovation Arc’.

3. Next Steps

3.1 The digital strategy has a 3-year timeframe however, it will be regarded as a ‘live’ document that will be updated and amended as dictated by external factors. A comprehensive review of the strategy will take place in 2024 lead by the strategy and innovation team.

3.2 The innovation programme is currently planned over an 18 month timeframe, however as additional funding becomes available, this will be augmented and extended.

3.3 Timeframes for the majority of the projects all have a final end date of March 2024.

4. Recommendations

4.1 <u>The Leeds Committee of the West Yorkshire ICB is asked to:</u>

1. **Support** the approach being outlined in the digital strategy, the digital transformation approach, and the innovation programme.
2. **Approve** the strategy and agree that it can be published.

5. Appendices

5.1 Leeds City Digital Strategy 2022 – 2025

Appendix 1

#TeamLeeds

Digital strategy 2022-2025

Leeds Integrated Digital Service

The strategy has been written following extensive consultation and engagement that included thirteen workshops covering wide-ranging areas such as digital ethics, business and economy, and primary and social care.

Those engaged included members of the public, academia, and those working in the public, private and third sectors.

The main leads for developing the strategy have been Leeds City Council and Leeds NHS Clinical Commissioning Group* in partnership with the wider Leeds Health and Care Partnership that includes the third sector (community organisations).

Collaboration between organisations across all sectors, communities and the people of Leeds is key and already well-established. The strategy has therefore been written from a ‘whole city’ view rather than from any specific organisation's perspective to encourage participation in its delivery.

It is intended to be a 'live' document that will be updated as progress is made and priorities change.

* Since 1st July 2022 – Leeds NHS Clinical Commissioning Group is now part of the West Yorkshire Integrated Care Board.

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Forewords

Cllr Debra Coupar

Deputy Leader of Council & Executive Member Resources

Leeds is the third largest city in the UK with a diverse population of nearly 870,000*. It is often selected to host trials of national policies and innovations as our demographic closely mirrors that of the country as a whole.

This, however, means that the challenges experienced by people nationally such as poverty, homelessness, educational and financial pressures, are also felt here.

We now face additional, significant challenges associated with the fallout of Brexit, climate emergency, the cost of living crisis, and ongoing the effects of the pandemic.

* GP registered population, April 2021.

Focusing on everyone's health and wellbeing is at the heart of this strategy. We want people to have the very best start in life; have access to the best services; have access to a buoyant high-paid, high-skilled jobs market; and to live long, healthy and independent lives.

Improved use of data and technology already enables us to access some services around the clock and manage our own health better in ways that were unimaginable even 10 years ago. And whilst digital continues to play an increasing role in how people live and work, for far too many, it is still a barrier. To ensure no one is left behind, it is essential we prioritise those who are digitally excluded.

We're starting from a position of strength, with strong collaboration across the city focusing on areas such as delivering superfast broadband, improving digital inclusion, and better use of data to improve health outcomes. We must build on this joined-up approach by encouraging everyone to adopt the strategy and contribute to its delivery in any way that they can. We want to promote the city as a centre for innovation that is open, accessible and trusted, but we cannot do this alone – we all have a role to play in the city's success.

Leeds' digital sector is growing and thriving with the city being the home for an ever increasing number of start-ups and small/medium enterprises, as well as larger tech companies such as BJSS, TPP and Emis, and the digital divisions of Sky and Channel 4. To support this growth, it's important that we have a skilled workforce that can fill job vacancies, encourage more business investment, and provide greater opportunities for all.

This digital strategy supports our key priorities focusing on improving the health and wellbeing of everyone, achieving our carbon zero ambitions, and ensuring we all benefit from the city's growth and prosperity. No single organisation can achieve this alone; it must be a joint effort. I hope therefore that you can contribute to the delivery of this strategy and support our ambition of Leeds being the best city in the UK to live.

Leonardo Tantari

Chief Digital Information Officer

Leeds Integrated Digital Service

I started my role of CDIO for Leeds City Council and the NHS Clinical Commissioning Group (CCG) six months into the pandemic.

This was a personal challenge for me, as I was unable to meet my new colleagues face to face. Whilst the two organisations were trying to get to grips with managing Covid 19 in the new, ever changing reality and pressures they were under.

Like any other major city, we're currently facing challenges on many levels that we must confront. Expectations continue to rise against a backdrop of ever increasing financial pressures.

The use of digital technology to support in the delivery of our services offers many opportunities that we encourage and embrace for Leeds.

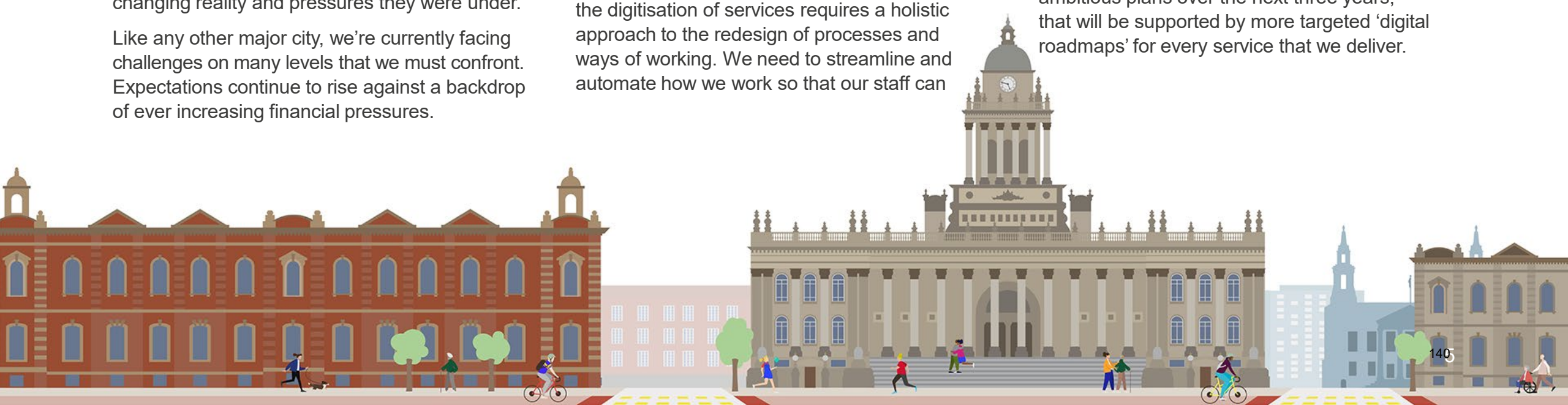
This is not just about moving our services online however, far from it. We must transform how we work. It is important to note that reaching the level of world-class digitisation we intend to achieve, will take more than simply deploying new technology. Bringing the digital services of the council and CCG together to create the Leeds Integrated Digital Service is the start of this digital transformation enabling us to provide a more joined up digital offer for the people of Leeds.

Any benefits expected to be realised from the digitisation of services requires a holistic approach to the redesign of processes and ways of working. We need to streamline and automate how we work so that our staff can focus on delivering the best services to our customers rather than on dealing with red tape and bureaucracy.

We will invest in our staff to ensure they have the right digital skills to deliver those services and be equipped to support the people of Leeds effectively.

We're on a journey to transform the delivery of our services through better use of technology and effective data use. We will increasingly be able to collect data in real-time and utilise mobile technology to deliver personalised services when and where they are needed.

This strategy maps out at a high-level, our ambitious plans over the next three years, that will be supported by more targeted 'digital roadmaps' for every service that we deliver.



Jason Broch

Chief Strategic Clinical Information & Innovation Officer

Leeds

As part of a developing Integrated Care System, the West Yorkshire Health & Care Partnership has created an environment encouraging organisations to come together and join up their services, by ensuring that places, like Leeds, are empowered to do what's right for the people who live there.

In Leeds, we take a 'place-based' approach that focuses on integrating healthcare and council services in every community across the city – each of which have their own individual strengths and challenges. We believe supporting organisations, both statutory and third sector, in place, is the best way to achieve the best outcomes for local people.

As doctors, nurses, pharmacists, physiotherapists, social workers and many other clinicians work closer across their historic organisational boundaries, there will be a need for digital solutions to, not only support and enable this new way of working, but join up information to ensure that the services provided is focussed on the needs of local communities.

As a GP, I know how important it is to have all the information needed, to make good decisions with patients and it is also important that people have access to information in a way that means they can care for themselves and their families in the best way possible.

It is important that people can access services, whether this is through new digital processes or the freeing up of traditional access capacity as a result of more people using digital methods, for example, the automation of some back-office functions can help free up staff enabling them to be more focussed on care.

Crucially, the way people connect with our services needs to be clear and easy, whilst making sure people unable to access digitally are not excluded. Our strategy underpins an inclusive approach to tackling health inequalities.

Leeds is a centre for developing health technologies and by supporting this, we can encourage job growth and inward investment in line with the ambitions of our Health and Wellbeing strategy.

Executive summary

This strategy has been written to underpin Leeds' Best City Ambition and the three key initiatives that support it:

Health and wellbeing

Leeds will be a healthy and caring city for everyone.

Inclusive growth

Leeds will have an economy that works for everyone.

Zero carbon

Leeds will have made rapid progress towards carbon neutrality, reducing our impact on the planet and doing so in a fair way.

Getting the basics right

Before we move on to the ambitions of the strategy, it is important to note that these initiatives would come to nothing unless we have the right foundations in place.

We therefore start by summarising the key underpinning initiatives that we will put into place to ensure people are not left behind as me move towards our digital-first (but not digital only) approach to delivering services.

It needs acknowledging however, that some people could be left behind as we begin to operate more digitally, either through a lack of skills, access to devices, connectivity or even lack of motivation. Therefore, the starting point of this strategy is to ensure that this negative impact is minimised through a robust approach to digital inclusion.

Each of these foundations underpin everything we do and provide the basis of how we intend to use existing and emerging technologies to serve the people of Leeds.

Better collection, management, and use of data that facilitates the delivery of improved, personalised services

The delivery of 21st century connectivity and infrastructure that provides the backbone for world-class service delivery

Digital inclusion is complex, we will continue to work with people to ensure equal opportunity to develop skills and access digital tools, technology and services that are the right for them

Life-long learning that ensures people continually have the right skills to get online, access digital services, and do their job effectively

Scrutiny and sense checking to ensure that any use of data or introduction of new technology or digital service is sound, and ‘the right thing to do’

Our digital ambitions

We have mirrored the 'life course approach' used in the Best City Ambitions to clearly articulate the impact of our plans for digital at every stage of a person's life from early years to older age – Starting well, Living well, Working well and Ageing well.

Starting well

Using modern data technologies and techniques we will analyse population health and other data to understand and what determines a person's health and life chances from birth through to old age. This will help us to reduce inequalities and design impactful services for the people who need them the most.

We will achieve this by:

- Using data to identify and eliminate inequities
- Introduce new ways to stay healthy including education and services
- Ensuring that all children have the opportunity to access and use technology

What this means for Leeds:

- Better outcomes for children
- Improved life opportunities
- Improved parent and child health

Living and ageing well

We will utilise new technologies to deliver health and wellness services tailored for individuals and ensure that peoples information follows them through their journey regardless of the organisation they are interacting with. We will help people to stay healthy using innovative tools such as wearable monitors, augmented reality apps or coaching tools.

We will achieve this by:

- Ensuring information can be shared between partner organisations, adhering to rigorous information governance policies and procedures
- Making services easier to find and access
- Using automation technology to make services better
- Launching new ways for people to stay healthy using technology

What this means for Leeds:

- Better access to services
- Improved health and wellbeing
- More effective public services
- Services delivered closer to home

Working well

We will build on existing collaboration by improving information flow between organisations and supporting the city's inclusive growth ambitions. Our thriving digital community, modern infrastructure and skilled workforce will attract new and established businesses to Leeds.

We will achieve this by:

- Investing in infrastructure to support the services we deliver
- Supporting our vibrant digital economy that creates inclusive growth
- Taking a #TeamLeeds approach to dealing with cyber threats
- Building and coordinating an innovation network that is accessible to all

What this means for Leeds:

- Inclusive growth and more opportunities for business and employment in Leeds
- New ideas that improve services
- People will be able to build digital skills
- Confidence that personal data is protected

Priorities and approach

It has not been written from the perspective of any particular organisation, but rather from a ‘whole city’ one where everyone can play a part in delivering some of the priorities outlined.

The strategy takes a ‘person-centred’ approach, that is, people are at the heart of everything we do. When we talk about ‘people’, we are referring to those who access services, live, work, study and visit our great city.

We see the strategy as a key enabler to improve outcomes for everyone. For this reason, a ‘Life Course’ approach was taken when developing the Best City Ambition that clearly articulates the opportunities and challenges at every stage of a person’s life from early years to older age – starting well, living and ageing well and working well. We have harnessed this approach for the Digital Strategy to outline how digital can support everyone throughout their lives.

For the purposes of this strategy, we have combined living and ageing well.

Underpinning the Best City Ambition, Leeds has three main ‘pillars’ focusing on Health and Wellbeing, Inclusive Growth and Zero Carbon. This digital strategy will support the delivery of these key strategies.

Health and Wellbeing

In 2030, Leeds will be a healthy and caring city for everyone: where those who are most likely to experience poverty improve their mental and physical health the fastest, people are living healthy lives for longer, and are supported to thrive from early years to later life.

Inclusive Growth

In 2030 Leeds will have an economy that works for everyone, where we work to tackle poverty and ensure that the benefits of economic growth are distributed fairly across the city, creating opportunities for all.

Zero Carbon

In 2030 Leeds will have made rapid progress towards carbon neutrality, reducing our impact on the planet and doing so in a fair way which improves standards of living in all the city’s communities.

Whilst the strategy is focused on Leeds, its people, and services, it is written in the context of national policies and strategies that focus on the wider challenges facing the UK and which will have a significant impact on our plans. Notable documents that will influence the approach taken in Leeds are:

NHS Long Term Plan

10-year strategy that identifies how digital technologies will support people in and out of hospital, giving them more control over their own health and wellbeing.

NHS England – 'what good looks like'

Framework that builds on good practice to provide guidance for the safe and secure digitisation of health and care services.

A plan for digital health and social care

Policy paper directed at leaders in the health, social care and technology sectors focusing on laying the digital foundations that will deliver faster, more effective and more personalised care.

Data saves lives – reshaping health and social care with data

That explains how the NHS will 'use data to bring benefits to all parts of health and social care – from patients and care users to staff on the frontline and pioneers driving the most cutting-edge research.'

National Data Strategy

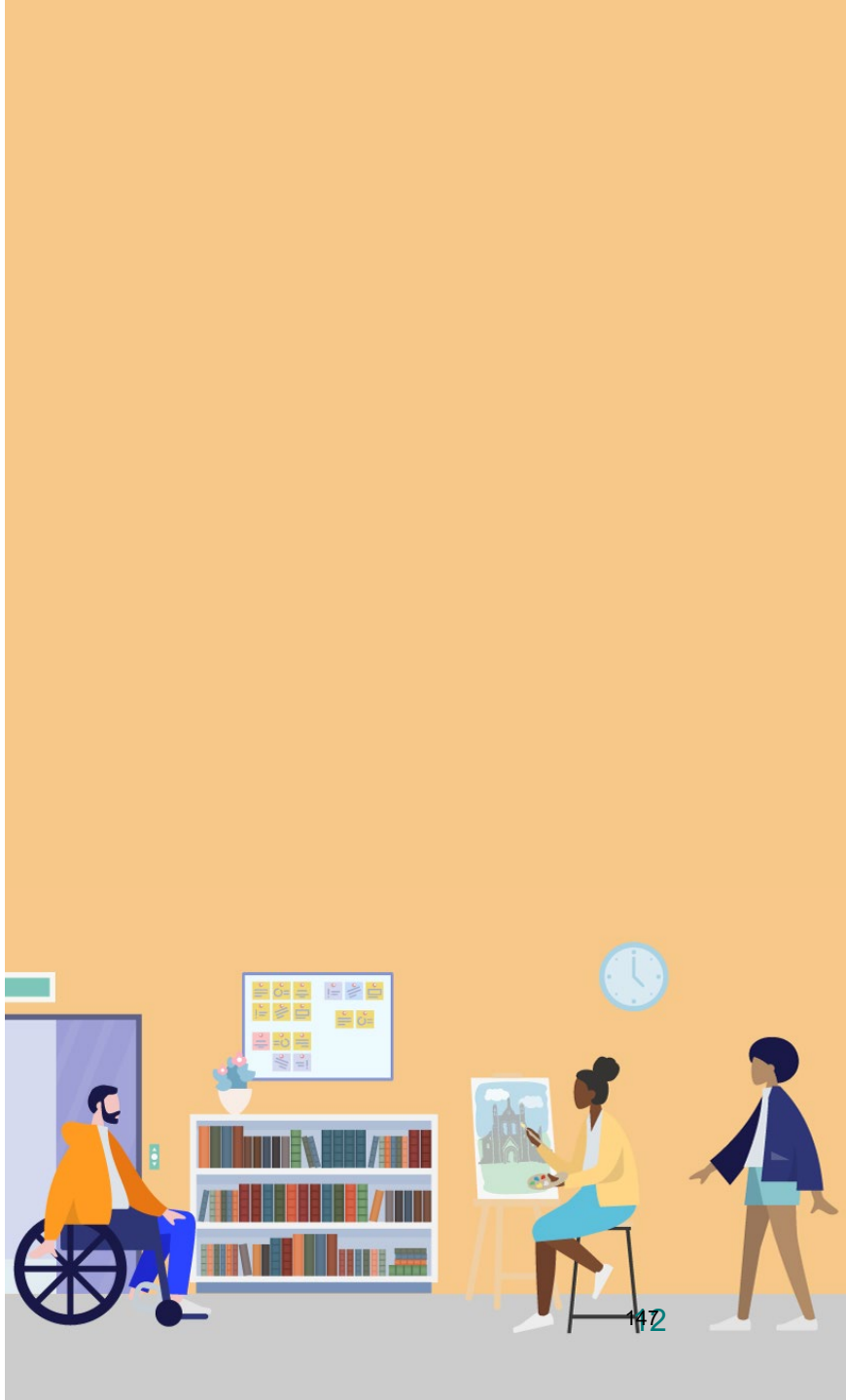
Sets to 'unlock the power of data' and 'sets the framework for how [the country] will invest in data to strengthen [the] economy and create big opportunities… in the future.'

UK Innovation Strategy

Focusing on how innovation supports businesses to innovate by making the most of the UK's research, development and innovation system.

Technology Code of Practice

That outlines a set of principles that support designing, building and buying new technology such as defining user needs, making use of open standards, and taking a cloud first approach.



Better use of data and technology can radically improve how services are delivered in Leeds.

There are of course challenges that will need addressing to realise a more sustainable, equitable Leeds that we all aspire to, however these should be viewed in relation to the opportunities that exist that will enable people, businesses and communities to prosper.

This summary highlights some of the key challenges and opportunities that will be investigated as part of the delivery of this strategy.

Challenges	Opportunities
Reducing digital exclusion	Building on the 100% Digital Leeds programme to support skills, connectivity, motivation and access to devices
Workforce and skills shortage	Collaborate to deliver a citywide skilled workforce that makes Leeds the no.1 destination for the digital sector
Access to devices and connectivity	Deliver world-class infrastructure, shared work spaces and equitable access to devices
Data sharing between services/organisations	Deliver shared infrastructure and improved joined-up working
Access to funding	Work closely with national government on policy and idea development
Achieving Leeds' zero carbon ambitions	Promoting the city as a Living Lab for GreenTech innovation
Acceptance of new digital technologies and digital services	Promote the city as a centre of innovation excellence that champions co-produced innovation and idea development
Narrowing the gap between rich and poor	Strengthen partnerships with the third sector and enterprise to deliver inclusive growth
Data and technology are used ethically as not to disadvantage anyone	Ensure robust governance procedures in place and leverage support and expertise from across the city

Digital foundations

Whilst we have significant ambitions for digital services and technologies in Leeds, it is also important that we get the basics right.

These foundations set the baseline for which the rest of the strategy is built on and will ensure that our ambitions are grounded, achievable and inclusive.

Better collection, management, and use of data that facilitates the delivery of improved, personalised services

The delivery of 21st century connectivity and infrastructure that provides the backbone for world-class service delivery

Digital inclusion is complex, we will continue to work with people to ensure equal opportunity to develop skills and access digital tools, technology and services that are the right for them

Life-long learning that ensures people continually have the right skills to get online, access digital services, and do their job effectively

Scrutiny and sense checking to ensure that any use of data or introduction of new technology or digital service is sound, and 'the right thing to do'

Data underpins everything we do. It is a valuable resource that has the power to revolutionise how businesses are run and services are delivered.

It's important however, that when collecting, using, storing, disposing, or sharing personal data, it is managed appropriately and within an information governance framework that instils confidence and protects people's data.

Leeds have done well in promoting the publication and use of open data and being home to numerous data analysis and consultancy companies. Building on this cements Leeds as the UK's leading 'data city'.

We will work closely with the West Yorkshire Integrated Care System to better understand how data can help improve health and care outcomes for the people of Leeds and help us tackle unequal outcomes and access to healthcare services.

What this means for Leeds:

- Improved data intelligence, decision making and service delivery.
- Utilisation of data for research and innovation that powers new medical treatments and the direct care of individuals.
- The ability for everyone to analyse and interpret data.
- Data driven planning and improvement of services.
- Increased amount of publicly accessible that supports innovation.
- Improved understanding of population health that drives understanding, decision making and the proactive targeting of services.
- Assurance that people have confidence that their personal data is being managed appropriately.
- Access to the data and information that services need.
- Access to comprehensive information about the people using services without having to rely on people to 'fill the gaps' and explain multiple times.

Connectivity and infrastructure

Protecting our data and information is of paramount importance. We will ensure that data and systems are protected from any security threats whether they be cyber or physical, deliberately intended or otherwise. It is therefore important that we have the infrastructure in place to deal with external threats.

Through investment in world class connectivity and infrastructure platforms, service delivery can be transformed to enable more people to access services digitally, where and when they want them.

We will follow a 'Cloud First – Multi-Cloud' approach to derive best value for money, best technological approach, and the highest security standards.

We will take an open standards approach for all software developments in Leeds to ensure the maximum potential for systems integration and interoperability.

What this means for Leeds:

- Confidence that personal data is protected and can be shared safely and securely between organisations and departments.
- Services will be available 24/7.
- Everyone has the right skills to keep data safe and secure.
- Relevant people have the skills to prevent, detect and respond to Cyber incidents.
- The option for homes and businesses to connect to fast, full fibre broadband.
- Access to reliable digital services supported by leading edge cloud and infrastructure technologies.
- The ability to pilot and launch new digital initiatives using a scalable cloud platform.
- Access to connectivity that supports Internet of Things devices and encourages innovation.
- People can access Wi-Fi in GP practices, hospitals and council buildings.
- Assurance that digital services can be accessed by everyone who needs them.

100%
Digital Leeds digital inclusion programme.

Digital inclusion is a key ‘enabler’ to delivering many of the strategic priorities of the council and the wider city. It is a spectrum rather than a binary indicator and people will move along that spectrum as their life changes and society changes around them.

The barriers to digital inclusion for many people are complex and link to wider factors beyond the common issues of lack of skills, motivation or access to a device. We will address these barriers to ensure that everyone in Leeds has equal opportunity to use digital tools, technology and services in the right way for them.

We will work with trusted partner organisations to take a person-centred, holistic approach to develop sustainable, long-term solutions that increase digital inclusion in all communities across the city.

What this means for Leeds:

- Stronger digital inclusion infrastructure across the city.
- Prioritise the groups and communities that are further away from equal opportunity of access.
- Digital inclusion challenges tackled at scale by bringing together organisations in a place or serving a particular community.
- Increased access and accessibility so that people have more options to get online and use digital tools and technology, either independently or with support.

Case study

The 100% Digital Leeds team leads on digital inclusion for the city. It has a vision that everyone in Leeds has equal opportunity to use digital tools, technology and services in the right way for them.

Digital inclusion

To achieve this, the team works with hundreds of organisations, settings and colleagues across the council, third sector, and health and care to identify, prioritise and support the most digitally excluded people and communities in Leeds.

They use their experience and expertise to coordinate, connect, amplify and accelerate digital inclusion across the city.

They are strengthening the digital inclusion infrastructure to address challenges at scale by bringing together organisations in a place or by serving a particular community.

They bring together teams and organisations with shared priorities, based in the same areas of the city, serving similar Communities of Interest or working towards common goals.

BARCA Leeds

Person A is a 34-year-old male who has been in and out of prison for most of his adult life. He was released from prison in November and gifted a Community Calling smartphone by BARCA in December 2021.

The device has allowed him to get online without having to visit the library or Job Centre meaning he could more regularly and proactively check his emails. He has been able to apply for a budget advance through the Department for Work and Pensions, find and secure housing, and complete a Peer Mentor course. Not having to rely on Pay As You Go calls and data has allowed him to reconnect with and regularly contact his family and support services.

This has allowed him to rebuild and maintain a positive support network including detoxing from methadone, meeting Probation requirements, and avoiding reoffending, all of which have allowed him to stay out of prison for the longest period of his adult life.”

Hamara Healthy Living Centre

“Working with the 100% Digital Leeds team has been so beneficial for our community. The support they have given Hamara as an organisation on the Digital Health Hub project has been invaluable.

Being a Digital Health Hub has helped so many of our community members to get online and bid for properties, apply for benefits and sign up to the NHS app.

We have empowered people to do these tasks themselves and often at home thanks to our device lending scheme.

Our next step is introducing health management apps to those with long term health conditions and creating a space in the café where the community can come in and use the devices while enjoying a cuppa or meal. We have also recruited Digital Champion volunteers who speak community languages to support our English class to become more digitally included.”

Whether you're at school starting to do basic coding, in employment working with data and technology, or getting online for the very first time, technology doesn't stand still. It's therefore important that we maintain our skills throughout our lives.

Through this life-long learning approach, we will ensure that everyone in Leeds has the skills to access services in a way that suits their needs. Digital channels will be accessible, well designed and so easy to use that they become most people's preference.

We recognise however, that not everyone will want to access services via a digital channel all of the time. It is for this reason that we take a 'Digital First but not Digital Only' approach, meaning that others complimentary means of accessing services will always be available, such as, face-to-face and by telephone.

What this means for Leeds:

- Improved services over digital channels that are supported on any device.
- More people can access services through a digital channel.
- Greater opportunities for people to develop their digital skills throughout their life.
- Improved employment opportunities for everyone.
- A skilled workforce that attracts investment from businesses and the availability of high-earning, high-skilled jobs.
- Greater numbers of graduates choosing to remain in the city.
- Digital skills are improved through participation.

Data is easier to collect than ever and technology is developing so quickly that it is often difficult to keep pace with.

It's therefore important that as these new technologies become more widely used, we have thorough understanding of their impact. Just because something can be done using technology, doesn't mean it should be.

Leeds is already a champion of 'tech for good' and we will improve this by embedding strong governance procedures and by drawing upon data and digital ethics expertise from across the city. This will provide additional support and scrutiny that will ensure Leeds is regarded as the best destination for anyone who wants to deliver services ethically and equitably.

What this means for Leeds:

- Robust governance structures are in place to ensure that the use of data and introduction of new technology is done so ethically and equitably.
- People can be confident that services will be delivered that can be accessed by anyone.
- Personal data with be handled safely and securely and only shared with those who need to access it.
- Risks are assessed to identify the impact on people, place and infrastructure of the introduction of new digital services and data use.

Starting well

Child Friendly Leeds programme that sets the vision for Leeds being the best city in the UK for children and young people to grow up in. With this in mind, this strategy supports the priorities outlined in the Children and Young People's Plan ensuring that people have the best possible start in life.

We will use modern digital technologies to understand the challenges associated with population health and education and how this affects individuals from birth through to old age. Understanding health and economic conditions prevalent across the city will help us to reduce inequalities and provide more relevant and impactful services to families across Leeds.

We will work increasingly with schools and colleges to encourage children and students to get involved in innovation work that helps develop their digital skills and get them interested in the technology sector and the breadth of opportunities it offers.

We will achieve this by:

- Engaging in the Maternity Transformation Programme recognising the important role that digital technology can play in transforming maternity services.
- Supporting a better start for all children in Leeds through better access to services that understand their requirements.
- Collecting and analysing data about the population of Leeds, their needs, and their health, that support the design and commissioning of services and health initiatives.
- Using high quality health intelligence to inform improved decision making and responses to health protection incidents.
- Analysing data that supports the identification and reduction of inequalities that disadvantage people in early life.

What this means for Leeds:

- Improved outcomes for children.
- Reduced numbers of young people not in education, employment or training.
- Improved number of children engaging in learning and improving digital skills.
- Improved physical activity through utilising digital channels.
- Improved life skills and readiness for work.
- Increased numbers of people taking up employment in the digital and technology sector.

Starting well

Case study

The Covid-19 pandemic was a challenge that no-one expected or had previously dealt with on such a scale. Technology enabled many people to continue working from home, whilst understanding the data assisted with monitoring progress and decision making.

Continuing healthcare services throughout the Pandemic

COVID-19 response

Throughout the pandemic, the **Integrated Digital Service** (supporting digital services for Leeds City Council and the Leeds NHS Clinical Commissioning Group) supported GP practices and Primary Care Networks to help them adapt to new ways of working, allowing them to maintain services in the unprecedented circumstances presented by Covid.

At the start of the pandemic additional equipment was delivered to GPs including 600 laptops, 500 webcams and 800 headsets.

This additional equipment enabled practices to continue to work, provide a safe working environment for staff and allow patient services to be maintained. Throughout 2021/22, the team continued to support the increased demand for more online consultations, ongoing testing requirements and new Covid outbreaks.

Blood pressure monitors

In early 2021, the Leeds NHS Clinical Commissioning Group took part in the national blood pressure **monitoring@home** programme. 2,800 monitors were distributed to GP practices to share with their patients with a confirmed diagnosis of hypertension.

Following training, patients monitored their blood pressure at home and submitted their results for review by their GP, reducing the need for patients to visit their GP practice, freeing up GP resources traditionally employed to take readings, allowing continuous monitoring if needed, and enabling healthcare professionals to change or adapt medications as necessary.

Leeds office of data analytics

The new **Office of Data Analytics** (ODA) was created out of situation where data was held in siloes across the various health and care providers, resulting in it being very difficult to understand the full picture of what was happening to groups of people across the city. It combines data from a multitude of sources helping to reveal the single version of the truth as to what is happening to cohorts of populations.

The Public Health Intelligence team has been at the forefront of the ODA's Covid response. The team was fundamental in setting up and delivering test and trace reporting for local measures and guiding outbreak test teams in the early days of the pandemic, along with a wide range of internal and external reporting on infections and vaccination provision, especially to those most vulnerable, or at risk of inequalities of access.

Living and ageing well

We will implement leading edge digital solutions that enable real-time monitoring and communication to support the shift towards enabling proactive self-care, and help people to manage their own health and wellbeing better.

We will ensure a joined up approach across the eleven Population and Care Boards to use data to understand population health and the challenges and inequalities being faced by the people of Leeds. This intelligence will support partners to define and deliver effective services and support, including messaging that prevents the onset and progress of disease and helps people to stay healthy.

We will use modern digital services to deliver primary and community care closer to people's homes in a way that is better for the people of Leeds and those delivering the service.

We will achieve this by:

- Building and information sharing approach that is person-centred to ensure their data and information can, legally and securely, follow them regardless of which organisation and/or service they are engaging with.
- Implementing intelligent and automated processes that make services more efficient, convenient and joined up.
- Ensuring the approaches taken in this strategy are reflected at a regional level.
- Introducing new technologies such as wearable devices that supports independent living, clinical service delivery at home, wellness programmes and healthier habits.
- Continuing to work with GP practices and other care settings to develop online and video consultations.
- Introducing digital technologies that provide the public with a range of personalised preventative interventions.
- Using data to identify people who may benefit from innovative health and care services.

What this means for Leeds:

- More people can find the services they need, when they need them, and access them through a digital channel and device of their choice.
- Improved efficiency of services through automation.
- Improved understanding of people's wider determinants of health.
- Improved personalisation of services, ensuring services are delivered at the right time and in the right location/setting.
- More people are enabled and confident to access their information and contribute to their records.
- Improved access to the information that services require, when and where they need it, including real time data.
- Increasing numbers of people receiving healthcare services previously delivered in hospital, closer to where they live.
- Improved independent living, self-care and self-management.

Case study

The use of Virtual Reality (VR) has been trialled with people living with dementia and carers as part of the Dementia Pathfinders programme.

Using virtual reality to assist people living with dementia

VR headsets were loaned to care homes and carers groups to trial how they might enhance the existing dementia programme by offering residents the chance to experience new virtual reality, immersive environments.

The trial reviewed the Google Cardboard and Oculus GO headsets that have different price levels, to test their suitability and effectiveness, and were conducted in both individual and group settings utilising apps mainly focused on meditation, relaxation, world travel and wildlife.

Images included both static and moving content which led some people to experiencing slight motion sickness. Some adjustments to the headsets were made to ensure users had more control over them leading to this being improved.

The trial provided people living with dementia and carers the opportunity to escape reality and enjoy experiences such as National Geographic, visit places across the world they'd never seen before and take virtual museum tours exploring arts and culture.

Carers expressed how they enjoyed exploring different places and experiences and explained that they it appeared to relieve symptoms of their loved one's dementia such as agitation and disorientation.

Supporting digital inclusion

The work supported the wider 100% Digital Leeds work focusing on improving digital inclusion across the city.

It comprised carers and people with dementia, staff, volunteers and stakeholders that resulted in 81 carers and 91 staff and volunteers trained as Digital Champions.

Leeds is building a digital sector that competes on the world stage. To do this, it needs to be diverse. Having the full social spectrum represented within the sector will lead to a wide range of benefits for the city, allowing Leeds to unlock the true potential of the digital and technology sector.

We will build on existing collaboration between our different workforces in all sectors by improving information flow between organisations and supporting the city's inclusive growth ambitions.

A thriving digital community, modern infrastructure and skilled workforce will attract new and established businesses to invest in Leeds improving opportunities for the city and people of Leeds.

Building on established innovation work in Leeds, we will develop a co-ordinated innovation network and community that offers a fair and robust innovation management approach, supporting the qualification, testing and dissemination of new initiatives.

We take a people-centred approach to service design and ensure that associated business change programmes and training are delivered alongside service implementation.

- Building a co-ordinated innovation network that focuses on co-creation, allowing people to bring their ideas forward through a consistent and agile approach that promotes qualification, testing, learning and scaling.
- Embedding a culture of openness to change, embracing digital technology and ensuring benefits of change are measured and managed on an ongoing basis.
- Sharing of, and learning from best practice.
- Identifying funding opportunities at a local and national level that supports an ambitious innovation programme and helps grow the technology community and facilitates collaborative working.
- Exploring opportunities for new ways of working and the development of a digital blueprint for shared buildings to encourage improved and seamless access to collaborative space and allow people to work more flexibly.
- Identifying new innovation opportunities for the city to lead on such as GreenTech.
- Promoting creativity alongside technology and innovation.

What this means for Leeds:

- Inclusive growth that includes everyone and leaves no one behind.
- Access to open data that facilitates innovation.
- Access to an innovation platform that enables enterprise and entrepreneurs to collaborate.
- A skilled workforce across the entire city.
- More job opportunities in the technology and digital sectors.
- An attractive city for businesses to invest and thrive.
- Everyone has the opportunity to participate in the improvement and development of services and helping to tackle some of the challenges facing the city.
- The delivery of new, innovative digital services and solutions are prioritised and accelerated.
- People have the skills and capabilities to be able to work in new ways as the business landscape changes.
- A city that is recognised for its creative digital sector, cultural opportunity and diversity.

Working well

Case study

Innovation is thriving in Leeds, from grassroots community led initiatives such as Leeds Digital Festival – UK's largest tech festival, to Nexus Leeds, a state-of-the-art innovation hub located at the heart of the University of Leeds. World leading R&D, health innovators and tech unicorns have made Leeds their home.

Innovation through collaboration

We have benchmarked ourselves internationally through working with **Massachusetts Institute of Technology** on their **Regional Entrepreneurship Acceleration Program** (MIT REAP).

Recognising the significance of our innovation assets, we have worked closely with key stakeholders to refresh our innovation vision 'to stimulate innovation which drives and delivers measurable impact towards a healthier, greener and inclusive future for Leeds and the world'.

The **Innovation Arc** concept is central to this vision. Set across 150 hectares of the city centre and involving partners such as Leeds Beckett University, University of Leeds, Leeds Teaching Hospitals NHS Trust and Leeds City Council - it will stitch together some of the most significant innovation assets in the North of England to become a driving force for innovation and emerging digital technologies.

A part of Leeds Teaching Hospitals NHS Trust, the **Innovation Village** will be a cornerstone of the Innovation Arc and one of the most exciting UK investment opportunities focusing on research, innovation and technology in health and life sciences.

Nexus Leeds is a magnet for high-growth innovation talent from across the globe. Their member businesses have already demonstrated economic impact by creating 176 new jobs, raising over £27.8m of private investment, and being awarded £18m in collaborative research funding with the University.

British Library North represents a £95m investment which will magnify its impact in the North by opening up access to a new generation of researchers at Boston Spa and a new public space in Leeds. The expansion compliments their network of Business & IP Centres, which in Leeds offers innovation and digital advice for entrepreneurs.

Ingenuity is an exciting new real-world smart city innovation testbed located in South Leeds. It has been successful in receiving £1.7m of levelling up funding and will be developed by Munroe K at White Rose Park.

Supporting local businesses to use digital technology and unlock growth is critical. **AD:VENTURE** and **Digital Enterprise** offer a range of free support for SMEs in the region. Additionally, the **Innovation@Leeds** grant scheme enhances the city's core business offer to support innovative entrepreneurs, reach more diverse communities and build the city's innovation profile.

The city's expertise in the professional and finance sectors is fuelling innovation in FinTech, LegalTech and Green Finance that is strengthened further by the presence of the Bank of England, UK Infrastructure Bank and the Financial Conduct Authority.

Conclusion

We have directly linked our plans to Leeds' Best City Ambition and the city's key strategies focusing on:

1. **Health and wellbeing**
2. **Inclusive growth**
3. **Zero carbon**

This ensures that any initiatives we undertake are directly aligned to the things that matter to the people of Leeds regardless of where they live, work and play.

Our ambition is clear – we want Leeds to be the best place to live in the UK that is supported through innovative use of data and technology and be a leading light in solving challenges faced by the whole country.

Ambition is important, but it is of little value unless we get the basics right and provide a good foundation on which to build more advanced initiatives.

Therefore, our immediate focus will be on ensuring that core programmes around digital inclusion, digital skills, data use, and digital ethics are underway and able to underpin our other programmes.

Innovation will be key to delivering our digital transformation ambitions. We will take a co-ordinated approach across the city to ensure we have a connected innovation ecosystem where we can all play a part and contribute.

We will build on the momentum generated from the launch of the Innovation Arc to increase collaboration and promote Leeds as a centre of digital innovation.

We will develop digital roadmaps and plans to achieve the strategic ambitions across the life stages of starting well, living and ageing well, and working well. Ensuring these are in easy to understand, accessible formats.

We want to ensure that the people of Leeds are involved and informed of our progress and ideas throughout the life of the strategy. To do this, we will be launching a new website (digitalleeds.com) to release updates, news articles, papers and plans as well as ways of engaging with us and our projects should you wish to be involved.

This strategy has been a joint effort and we'd like to thank everyone who has contributed to it through attending workshops, providing feedback, sense checking and design.

Whilst this list is not exhaustive, we'd like to make a special mention to the following for their support and contribution.

- Forum Central
- Information Commissioner's Office
- Leeds Academic Health Partnership
- Leeds City Council
- Leeds Community Healthcare NHS Trust
- Leeds GP Confederation
- Leeds Healthwatch
- Leeds Local Medical Committee
- Leeds Office of the NHS West Yorkshire Integrated Care Board
- Leeds Teaching Hospitals NHS Trust
- Leeds and York Partnership Foundation NHS Trust
- Voluntary Action Leeds
- Yorkshire and Humber Academic Health Science Network

If you have an idea, want to get involved, or just want more information, please contact us via email:

hello@digitalleeds.com

Leeds City Council

Leeds Health & Care Partnership

NHS

#TeamLeeds

Meeting name:	Leeds Committee of the West Yorkshire Integrated Care Board
Agenda item no.	LC 54/22
Meeting date:	13 December 2022
Report title:	Clinical & Professional Leadership in the Leeds Health & Care Partnership
Report presented by:	Dr Jason Broch, Chief Strategic Clinical Information & Innovation Officer
Report approved by:	Clinical & Professional Executive Group (CPEG)
Report prepared by:	Dr Jason Broch, Chief Strategic Clinical Information & Innovation Officer

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

Previous considerations:

This report has been considered and approved by the Clinical & Professional Executive Group (CPEG) on 13 November 2022.

Executive summary and points for discussion:

The Leeds Health and Care (Place Based) Partnership Integrated Care Board (ICB) Committee is established as a committee of the West Yorkshire ICB (WY ICB), in accordance with the ICB's Constitution, Standing Orders and Scheme of Delegation.

Integral to the Health & Care Partnership is visible, robust clinical & professional leadership.

The Leeds Health and Care Partnership have a shared bold ambition: Leeds will be the best city for health and wellbeing. Our clear vision is Leeds will be a healthy and caring city for all ages, where people who are the poorest improve their health the fastest.

We have also agreed a number of partnership principles.

Clinical & Professional leadership (CPL) is a term used to express several functions and is often described separately to the rest of system leadership. In the Leeds Health & Care Partnership, CPL is seen as integral to good system leadership and this paper seeks to outline how this supports the work of the partnership. This paper does not seek to describe how CPL works within each partner organisation but will highlight the evolving joint working and seek to assure the Leeds Committee of the ICB about the robustness of clinical involvement in system leadership supporting its ambitions.

Since CPL is still developing, this paper should be seen as position statement with an opportunity to influence the developing structures and functions.

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 WY ICB is asked to:

a) **Review** the information in this paper in the understanding that the Leeds H&CP is still developing and as part of that so are the structures and governance for CPL
b) **Consider** what it requires from the developing CPEG meeting to support decision-making and risk management
c) **Consider** what it may want from the WY Clinical & Professional forum or how it would like to influence it
d) **Consider h**ow it interacts with the Leeds Clinical & Professional Forum and how it can be developed to be a key hub for Clinical and Professional engagement and leadership and
e) **Consider** how it would like to be informed about innovation and influence the work of the Clinical Senate

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. Leeds Clinical & Professional Executive Group Terms of Reference
2. Leeds Clinical & Professional Forum Draft Terms of Reference
3. Leeds Clinical Senate Draft Terms of Reference

These are included within the supporting information section of the overall report pack.

Acronyms and Abbreviations explained

1. ICB – Integrated Care Board
2. CPEG – Clinical & Professional Group
3. CPL – Clinical & Professional Leadership
4. LAHP - Leeds Academic Health Partnership
5. PEG – Partnership Executive Group
6. LCPF - Leeds Clinical & Professional Forum

What are the implications for?

Residents and Communities	None directly arising from this report.
Quality and Safety	The report highlights clinical leadership to drive the improvement of quality and safety across the Leeds system.
Equality, Diversity and Inclusion	None directly arising from this report.
Finances and Use of Resources	None directly arising from this report.
Regulation and Legal Requirements	None directly arising from this report.
Conflicts of Interest	None directly arising from this report.
Data Protection	None directly arising from this report.
Transformation and Innovation	Challenges and opportunities for transformation and innovation are highlighted throughout the report
Environmental and Climate Change	None directly arising from this report.
Future Decisions and Policy Making	The details in this paper outline the developing structures to support joined-up clinical & professional leadership across the partnership.
Citizen and Stakeholder Engagement	None directly arising from this report.

1. Introduction

6.1. The Leeds Integrated Care Board (ICB) Committee is established as a committee of the West Yorkshire ICB (WY ICB), in accordance with the ICB's Constitution, Standing Orders and Scheme of Delegation.

6.2. **Integral to the Health & Care Partnership is visible, robust clinical & professional leadership.**

6.3. The Leeds Health and Care Partnership have a shared bold ambition: Leeds will be the best city for health and wellbeing.

6.4. Our clear vision is: Leeds will be a healthy and caring city for all ages, where people who are the poorest improve their health the fastest.

6.5. We have also agreed a number of partnership principles:

- We start with people – working with people instead of doing things to them or for them, maximising the assets, strengths and skills of Leeds' citizens, carers and workforce.
    - Have 'Better Conversations' – equipping the workforce with the skills and confidence to focus on what's strong rather than what's wrong through high support, high challenge, and listening to what matters to people
    - 'Think Family' – understand and coordinate support around the unique circumstances adults and children live in and the strengths and resources within the family
    - Think 'Home First' – supporting people to remain or return to their home as soon as it is safe to do so.
- We deliver – prioritising actions over words. Using intelligence, every action focuses on what difference we will make to improving outcomes and quality and making best use of the Leeds £.
    - Make decisions based on the outcomes that matter most to people
    - Jointly invest and commission proportionately more of our resources in first class primary, community and preventative services whilst ensuring that hospital services are funded to also deliver first class care
    - Direct our collective resource towards people, communities and groups who need it the most and those focused on keeping people well.
- We are Team Leeds – working as if we are one organisation, being kind, taking collective responsibility for and following through on what we have agreed. Difficult issues are put on the table, with a high support, high challenge attitude.
    - Unify diverse services through a common culture

- Be system leaders and work across boundaries to simplify what we do
- Individuals and teams will share good practice and do things once

7. Clinical & Professional Leadership (CPL)

7.1. Clinical & Professional leadership (CPL) is a term used to express several functions and is often described separately to the rest of system leadership. In the Leeds Health & Care Partnership, CPL is seen as integral to good system leadership and this paper seeks to outline how this supports the work of the partnership. This paper does not seek to describe how CPL works within each partner organisation but will highlight the evolving joint working and seek to assure the Leeds Committee of the ICB about the robustness of clinical involvement in system leadership supporting its ambitions.

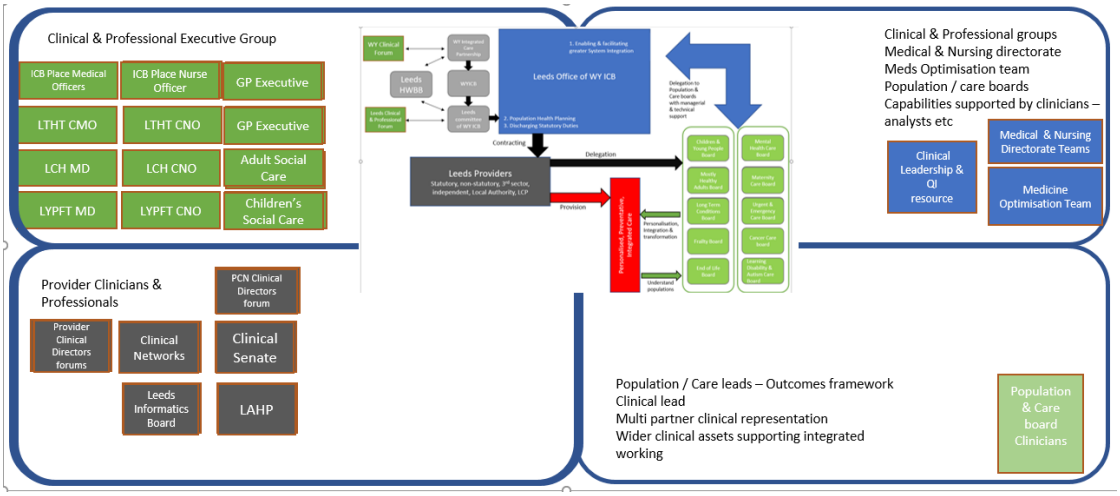
7.2. **Since CPL is still developing, this paper should be seen as position statement with an opportunity to influence the developing structures and functions.**

7.3. Since the establishment of WY ICB as a statutory body, Leeds has been empowered through the Leeds Committee of the ICB with statutory duties. This provides a solid bedrock for integration of services and a transition to the use of population health management to focus services around people in a more proactive and personalised way. This requires partners in the Leeds HCP to be able to share resources, data and leadership.

7.4. The transformation of services that follows on from this integration requires system leadership from clinicians & professionals, clinical & professional engagement & expert advice from Clinicians, professionals & academic.

7.5. Whilst an option would have been to design how this would work from the establishment of the ICB, Leeds took a more developmental approach.

7.6. A key principle is that since Leeds, as a place, is so big (larger than some whole Integrated Care Systems), our clinical leadership should mirror that of an ICS and be able to connect as appropriate to the wider West Yorkshire system. It is also key that there should be clarity on why a group of clinicians and professionals are meeting, so the governance and Terms of Reference of each group has been evolving through real work. As such the model depicted in this paper is a ‘moment in time’ based on our current requirements and ways of working but will continue to develop to ensure both effectiveness and value for money.



The above diagram demonstrates where Clinical & Professional Leadership sits in the overall governance of the Leeds Health & care partnership.

7.7. Clinical & Professional accountability ultimately sits at board level in each partnership organisation. Each separate organisation remains accountable for its own statutory duties and contractual obligations. Of course, the associated risks and their management are not always within the individual organisations ability to completely control. It is also the case that actions of partner organisations can help control a risk or potentially make it worse. The Clinical & Professional Executives can collectively discuss and understand the system nature of risk management through the Clinical & Professional Executive Group (CPEG). There have been monthly meetings where issues have started to be explored. Whilst not being decision-making, the members of this group are involved in advising and making decisions. The meeting enables the ability to discuss key issues and understand how teams are involved in decision-making. Terms of Reference (Appendix A), which have been developed based on the discussions that have taken place to date. CPEG can help with coordination of wider clinical leadership and can act as a senior clinical advisory group to PEG and the Leeds Committee of the ICB going forward. This group is also represented on the WY Clinical & Professional Forum, coordinated by the Medical & Nursing directors of the WY ICB.

7.8. CPEG is continuing to develop and review the value it offers, as the partnership develops.

7.9. **The Leeds Committee is asked to consider what it requires from this senior group of Clinical Leaders in Leeds to support decision-making and risk management.**

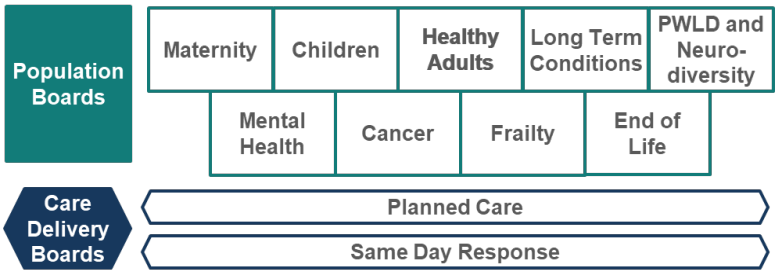
7.10. This paper will not detail the subcommittee function for quality assurance, but it is clear that clinical involvement is paramount.

7.11. At West Yorkshire ICB level, the Clinical & Professional directorate is led by the medical & nursing directors. It is still developing but is continuing to hold a WY Clinical & Professional forum on a monthly basis, facilitating discussions about areas that are either not delegated to place or are brought by place to work on together. Key areas, at present, are policy alignment work and leadership development.

7.12. **The Leeds Committee is asked to consider what it may want from the WY Clinical & Professional forum or how it would like to influence it.**

8. Collaboration & Engagement

8.1. In order to deliver the 'Healthy Leeds Plan' and the ambitions of the Health & Wellbeing strategy, Leeds has developed a Population Health Management (PHM) approach. The population is split into population segments, which are groups of people with similar needs. This facilitates a data-informed, proactive & personalised approach. Key to this are Population and Care Delivery Boards, which are expected to take an holistic view of their population's needs and take decisions on how resources in the city are used in accordance with these needs.



8.2. A principle behind the design of these boards is that they have strong clinical / professional leadership. The Leeds office of the WY ICB, under the remit of the Leeds Committee of the WY ICB is instrumental in supporting the development of these boards and has a rich offer to support the development of the clinical and professional leads. The boards are attended by delegated representatives from partner organisations of the Leeds HCP.

8.3. The Leeds Clinical & Professional Forum (LCPF) brings together leaders from primary and secondary care including mental health and social care to develop innovative ideas to improve outcomes, tackle health inequalities and improve the effectiveness and efficiency of services. The chairs and clinical leads from the population health and care boards will also be supported through this group, as well as a more focussed meeting to

support their development. It is a unique space for Clinical and Professional Leaders to connect with each other. The LCPF is a safe space for leaders from different clinical, professional and specialist backgrounds to come together and share problems, debate issues and develop innovative solutions, capitalising on the diversity of views and experiences and mirrors the forum at a West Yorkshire level.

8.4. **The Leeds Committee should consider how it interacts with the Leeds Clinical & Professional Forum and how it can be developed to be a key hub for Clinical and Professional engagement and leadership.**

9. Academic partners and innovation

9.1. Partners across Leeds Health & Social Care along with the universities form the Leeds Academic Health Partnership (LAHP) need to focus on innovation, research and academic support to real world pressures and problems. It is equally important that there is joint work and development of leading clinicians and academics in the city. This is facilitated by the Clinical senate (Appendix C).

9.2. The Clinical Senate exists as an independent clinical and academic reference group for the Leeds Health and Care Partnership with a focus on quality improvement, research and innovation. Independent of governance responsibilities, the Clinical Senate provides opportunities for members to work in a space that will encourage thinking which is collaborative, novel and without boundaries, facilitating the ambition for Leeds to be a Research City for All. The Clinical Senate brings a unique combined clinical and academic perspective to challenges that face our health and social care system, our populations, and our city. The Senate is particularly concerned with ensuring that quality improvement, research and innovation efforts are correctly steered in relation to population health needs in an equitable manor, in line with the priorities of the Leeds Health and Care Partnership.

9.3. **The Leeds Committee should consider how it would like to be informed about innovation and influence the work of the Clinical Senate**

10. Next Steps

10.1. The details in this paper outline the developing structures to support joined-up clinical & professional leadership across the partnership. The paper does not detail some of the clinical involvement in Committee

assurance mechanisms or within partner organisations, where it is key in engagement of the front line.

11. Recommendations

The Leeds Committee of the WY ICB is asked to:

a) **Review** the information in this paper in the understanding that the Leeds H&CP is still developing and as part of that so are the structures and governance for CPL
b) **Consider** what it requires from the developing CPEG meeting to support decision-making and risk management
c) **Consider** what it may want from the WY Clinical & Professional forum or how it would like to influence it
d) **Consider h**ow it interacts with the Leeds Clinical & Professional Forum and how it can be developed to be a key hub for Clinical and Professional engagement and leadership and
e) **Consider** how it would like to be informed about innovation and influence the work of the Clinical Senate

12. Appendices

Leeds Clinical & Professional Executive Group Terms of Reference

Leeds Clinical & Professional Forum Draft Terms of Reference

Leeds Clinical Senate Draft Terms of Reference

Meeting name:	Leeds Committee of the West Yorkshire Integrated Care Board
Agenda item no.	LC 55/22
Meeting date:	13 December 2022
Report title:	Practice Proposal: The Merger of Sunfield and Hillfoot Practices and subsequent closure of Sunfield Medical Centre
Report presented by:	Gaynor Connor, Director of Primary Care and Same Day Response
Report approved by:	Gaynor Connor, Director of Primary Care and Same Day Response
Report prepared by:	Victoria Annakin, Senior Manager Primary Care Integration

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

Previous considerations:

In August 2022 Primary Care Board provided approval for Hillfoot Surgery and Sunfield Medical Centre to commence a period of engagement with a view to merging the practices on 1 April 2023 and subsequently closing Sunfield Medical Centre thereafter.

A period of engagement was undertaken between September and October and the outcome of the engagement and subsequent business was presented to the Primary Care Board on 3 November 2022.

At the meeting on 3 November 2022, Primary Care Board reviewed the business, engagement feedback and recommended approval for Sunfield Medical Centre and Hillfoot Surgery to merge the two practices ahead of the closure of Sunfield Medical Centre in April 2023.

Executive summary and points for discussion:

The ICB in Leeds has received an application from the partners of Sunfield Medical Centre and Hillfoot Practice, located in LS28 setting out a proposal to merge the two practices together under a single contract ahead of the closure of Sunfield Medical Centre in April 2023.

Sunfield Medical Centre is operated by a sole practitioner who owns the building and plans to retire from April 2023. The proposal is to merge the practices from April 2023 ahead of the closure of Sunfield Medical Centre shortly after thereby transferring patients registered with Sunfield Medical Centre to Hillfoot Surgery on 1 April 2023. This arrangement will allow the smooth transition of care for patients to a local practice ensuring continuity of care and appropriate access to a GP practice, within the current boundary, ahead of the closure of the Sunfield Medical Centre. The alternative would be to close the surgery and disperse the registered patient list according to their postcode, however the proposal to merge would minimise disruption to patients, ensuring access to a GP remains in place.

The engagement identified several key themes, including:

- Getting an appointment with the right healthcare professional
- Having friendly practice staff
- Being able to make an appointment on the same day
- General sadness about the closure the practice
- Concerns about accessing online services during the change and in the future
- Concerns about local practices' ability to provide services and personalised care to increased numbers of people
- Patients accessing Hillfoot Surgery via public transport
- Car parking and estates
- Access to a pharmacy

The Primary Care Board reviewed the attached proposal and agreed that in the interest of securing a smooth transition for patients the proposal should be supported.

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 WY Integrated Care Board is asked to:

1. **APPROVE** the proposal for Sunfield Medical Centre and Hillfoot Surgery to merge the two practices ahead of the closure of Sunfield Medical Centre in April 2023 as recommended by the Primary Care Board.

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

The proposal aims to support overall resilience in general practice thereby supporting increasing patient experience and outcomes.

Appendices

1. Practice Business Case
2. Engagement report

These are included within the supporting information section of the report pack.

Acronyms and Abbreviations explained

1. PMS – Personal Medical Services (Contract for General Practice Service)
2. GP – General Practitioner
3. ICB – Integrated Care Board
4. PGM – Policy Guidance Manual (for consideration of matters relating to General Practice services)

What are the implications for?

Residents and Communities	There will be reduced choice for patients in the area through the proposal but ultimately the aim is for improved overall accessibility and range of services on offer for patients previously registered at Sunfield through increased workforce and improved facilities.
Quality and Safety	The aim is for improved overall accessibility and range of services on offer for patients previously registered at Sunfield through increased workforce and improved facilities.
Equality, Diversity and Inclusion	None identified
Finances and Use of Resources	None identified although future estate needs will need to be considered
Regulation and Legal Requirements	The proposal has been managed in accordance with the Policy Book
Conflicts of Interest	None identified
Data Protection	None identified
Transformation and Innovation	None identified
Environmental and Climate Change	None identified
Future Decisions and Policy Making	None identified
Citizen and Stakeholder Engagement	Patient and stakeholder engagement report is attached outlining a number of themes which need to be addressed

Practice Proposal: The Merger of Sunfield and Hillfoot Practices and subsequent closure of Sunfield Medical Centre

1. SUMMARY OF PROPOSAL

1.1 The partners of Sunfield Medical Centre (B86058) and Hillfoot Practice (B86011) have submitted a business case (Appendix A) setting out a proposal to merge the two practices together under a single contract ahead of the closure of Sunfield Medical Centre in April 2023.

1.2 This paper aims to present the overall business case and summarise the engagement the practices have completed to support their application.

1.3 The original application to commence engagement was approved at the Primary Care Board in August 2022 and the results of the engagement and final business case were approved by the Primary Care Board in November 2022.

1.4 The main driver for the application is due to the retirement of the single-handed GP at Sunfield Medical Centre and the need to ensure sustainable primary care provision to the registered practice population.

1.5 As the only GP on the contract for the provision of GP services at Sunfield this will result in the closure of the practice following his retirement in April 2023. The GP and a previous partner own the practice building and plan to sell this following his retirement meaning there will no longer be a GP practice at Sunfield from the April 2023.

1.6 The proposal is to merge the practices from April 2023 ahead of the closure of Sunfield Medical Centre shortly after thereby transferring patients registered with Sunfield Medical Centre to Hillfoot Surgery on 1 April 2023. This arrangement will allow the smooth transition of care for patients to a local practice ensuring continuity of care and appropriate access to a GP practice,

within the current boundary, ahead of the closure of the Sunfield Medical Centre. The alternative would be to close the surgery and disperse the registered patient list according to their postcode, however the proposal to merge would minimise disruption to patients, ensuring access to a GP remains in place.

1.7 To allow the single GP to take 24-hour retirement, one of the GP partners at Hillfoot has been added to the PMS contract for Sunfield to continue provision of services until the approval of the merger of the 2 practice contracts in April next year. Hillfoot Surgery are offering to support the GP at Sunfield in his transition to full retirement by using their GPs to provide the required additional clinical sessions during that period.

1.8 The practices anticipate that the merger and subsequent closure of Sunfield this will provide continuity of care and stability for registered patients, provide economies of scale with the opportunity to invest in developing services, provide increased access to specialist clinicians and the opportunity for patients to join a thriving practice within the current boundary catchment area.

2. PRACTICE INFORMATION

2.1 Sunfield Medical Centre and Hillfoot Surgery are in Pudsey in the West of Leeds. There is 1.6mile distance between the two practices with public transport available between the two sites. Neither practice has a branch surgery or site. Sunfield has a list size of 4196 and Hillfoot has a lost size of 7071. Roughly 20% of Sunfield's registered list live out of area (approx. 800 patients) which is a historic arrangement with some patients living as far away as Robin Hoods Bay.

2.2 Both practices hold a PMS contract and use SystmOne as their clinical system. Both practices own their own estate.

2.3 Sunfield Medical Centre is run by a single-handed GP Partner, along with a fixed share business partner. The GP partner applied to take a 24-hour retirement at the end of this July which was approved by the CCG in May 2022.

2.4 There is a Wells Pharmacy situated next door to Sunfield Medical Centre, with a lease in place until 2025. The Primary Care Team and NHSE are working with the Pharmacy which has been informed of the planned closure of Sunfield Medical Centre who are in the process of assessing and reviewing future options for the provision of services from the Pharmacy.

3. PATIENT AND STAKEHOLDER ENGAGEMENT

3.1 The engagement process started on 5 September to 10 October 2022 (5 weeks)

3.2 The practices led on the engagement and a variety of activities and methods were used to seek the views of as many registered patients at both practices.

3.3 Both practices held an initial meeting with both their respective PPGs to seek their views on how we should communicate the proposals and ensured this feedback was fed into the agreed engagement process

3.4 The proposed changes were outlined on both practice websites with a link to an online survey.

3.5 Both practices printed copies of the survey and made these available at both surgeries to ensure those unable to access the survey online were still able to provide feedback

3.6 A letter outlining the proposed changes was posted to all registered patients (1 per household) which included details of the survey, how to submit any questions and details of the 3 planned public events. The letter was translated into Urdu and Punjabi and sent to households for whom this was their first language

3.7 The practices organised and held an online event where people could find out more about the proposed changes, providing opportunity for patients to ask questions, which was well represented with patients from both practices.

3.8 The practices organised and held 2 public events at Pudsey Civic Hall for people to attend to find out more about the proposed changes, providing opportunity for patients to ask questions.

3.9 Additional text message reminders were sent out to all patients registered with a mobile phone halfway through the engagement period to encourage people to fill out the survey and provide feedback.

3.10 A total of 246 people actively engaged in the engagement process through either attending a meeting or submitting a survey. Most responses via the survey were from patients at Hillfoot (and most attendees at the public events were from patients at Sunfield.

3.11 The engagement identified several key themes, including:

- Getting an appointment with the right healthcare professional
- Having friendly practice staff
- Being able to make an appointment on the same day
- General sadness about the closure the practice
- Concerns about accessing online services during the change and in the future
- Concerns about local practices' ability to provide services and personalised care to increased numbers of people
- Patients accessing Hillfoot Surgery via public transport
- Car parking and estates
- Access to a pharmacy

3.12 An FAQ document was created and updated with responses to patients queries and concerns throughout the process. This was updated in response to responses to the survey and questions raised at the public events. A full

breakdown of the responses and assurances given to the concerns raised can be found in the full engagement report in Appendix B.

3.13 Although concerns and queries were raised throughout the engagement process, overall, the response to the proposal was accepted by patients. This was further validated by the assurances given by Hillfoot regarding workforce, availability of appointments, transition of online services and patient records and the option for patients to re-register elsewhere if more suitable.

3.14 The Engagement Report details the engagement process and outcomes and includes a key themes table which outlines the practice response to some of the patient concerns (see Appendix B)

4 FINANCIAL IMPLICATIONS AND RISK

4.1 As both practices hold a PMS contract there are no significant financial implications of the merger.

4.2 Finance colleagues will continue to be involved to pick up any issues with the closure of Sunfield Medical Centre following the merger of the practice contracts

5 COMMUNICATIONS AND INVOLVEMENT

5.1 Two meetings were held with local councillors who represented the patients at both Sunfield Medical Centre and Hillfoot Surgery.

5.2 The first meeting was held ahead of the engagement process, feedback from which helped to inform the design of it. For example, Councillors stressed the need to ensure patients are aware of alternative options if transferring to Hillfoot is not convenient for them. At the 2 public events patients were informed of the options available to them to register with another practice and emphasis was placed on patient choice and this not being something that they must sign up to.

5.3 The second meeting with Councillors was held to update them on the engagement process and the engagement activities carried out, the feedback from patients and the specific concerns raised, to provide assurance on the plans in place should the proposal be approved and to gain an understanding of any further queries or concerns. Councillors were assured of the process that had taken place as well as the assurance that Hillfoot Surgery have provided in relation to some of the concerns of patients.

5.4 In addition, engagement with other local GP practices within Pudsey, Bramley and Staningley also took place to ensure that capacity will be available to take on any new patients, should some of the patients at Sunfield decide not to transfer to Hillfoot. All local GP practices confirmed that they could receive new patients and were supportive of the proposal.

6. NEXT STEPS

6.1 Following approval, the Primary Care Team will ensure the merger is enacted in line with NHS England's Policy and Guidance Manual (PGM) (Part B, section 7.11).

6.2 The closure of Sunfield Medical Centre will be enacted in line with NHS England's Policy and Guidance Manual (PGM) (Part B, section 7.15) which sets out what commissioners should consider when deciding on practice closures.

6.3 The Primary Care team will use the standard checklist for practice mergers to ensure all aspects of the merger and closure are addressed. This covers formal patient and stakeholder communication, IT actions, and all other operational elements for consideration.

6.4 The Primary Care Team will work with the practices to develop and implement their mobilisation plan for the merger on the 1 April 2023 and subsequent closure of Sunfield Medical Centre. The Primary Care Team will also work with NHSE to incorporate considerations in relation to the Pharmacy at Sunfield.

7. RECOMMENDATION

The Leeds Committee of the WY ICB is asked to:

a) **Note** the feedback from patients and local stakeholders around the impact of the proposed changes at Sunfield Medical Centre and Hillfoot Surgery

b) **Approve** the proposal for Sunfield Medical Centre and Hillfoot Surgery to merge the two practices ahead of the closure of Sunfield Medical Centre in April 2023

8. APPENDICES

8.1 Appendix A - Business Case

8.2 Appendix B – Engagement Report

Meeting name:	Leeds Committee of the West Yorkshire Integrated Care Board
Agenda item no.	LC 56/22
Meeting date:	13 December 2022
Report title:	Leeds Joint Working Agreement (JWA) with Astra Zeneca for Improving Asthma Outcomes
Report presented by:	Helen Lewis, Director of Pathway Integration, NHS West Yorkshire Integrated Care Board – Leeds Based
Report approved by:	Lindsay McFarlane, Head of Pathway Integration, Long Term Conditions, NHS West Yorkshire Integrated Care Board – Leeds Based
Report prepared by:	Lindsay McFarlane, Head of Pathway Integration, Long Term Conditions, NHS West Yorkshire Integrated Care Board – Leeds Based Auzma Yousaf, Clinical Pharmacist, NHS West Yorkshire Integrated Care Board – Leeds Based

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

Previous considerations:

This proposal has been worked up and is supported by members of the Leeds Respiratory Steering Group, which includes membership from Leeds Teaching Hospital, Leeds Community Healthcare, Leeds and York Partnership NHS Foundation Trust and Primary Care. The Leeds Respiratory Steering group reports into the Leeds Long Term Conditions Population Board, who also supported this proposal on the 14th November 2022.

Executive summary and points for discussion:

This paper outlines the proposed Joint Working Agreement between the West Yorkshire ICB (Leeds Office) and Astra Zeneca which aims to transform asthma management in adults with poorly controlled asthma.

It is anticipated that the Joint Working Agreement will run from January 2023 if agreed, through to January 2024. We will work with four Primary Care Network (PCNs) to promote a SABA-free approach to asthma prescribing, utilising the Maintenance and Reliever Therapy (MART) regimen to use a single inhaler (further detail/definition provided in the main report). This proof-of-concept pilot will focus on adults with asthma who are identified as high users of SABA inhalers (6 or more inhalers per year), and/or using frequent (3 or more) courses of oral corticosteroids.

The expected outcomes of the project are to improve asthma control, reduce waste, improve self-management, and reduce environmental impact, as well as upskilling primary care in the use of MART regimes and asthma treatment guidelines.

The estimated financial value of the Joint Working Agreement totals £115,700. 40% from health and 60% from AstraZeneca when the workforce commitments/resources as outlined within this paper are considered as a monetary value.

In line with the Leeds ICB, Pharmaceutical and Related Industries Joint Working Policy (2020), proposals for joint working must be reviewed by the organisations Quality and Finance teams, and if supported (which this proposal is) taken to a Governing Body/Committee meeting for formal meeting approval.

It has been proposed that whilst harmonisation of commissioning policies is undertaken across West Yorkshire (which will include the review and update of the Joint Working Policy / approaches collaboratively across West Yorkshire), that we continue to utilise the Leeds, 2020 policy and therefore seek approval from the Leeds Committee of the ICB. The reviewed West Yorkshire Joint Working Policy is due to be presented to the West Yorkshire Integrated Care Board in January 2023 for approval. Future arrangements will follow the governance outlined within the updated policy.

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 WY ICB is asked to:

a) Approve the recommendation that the Leeds place enters into a Joint Working Agreement (JWA) with AstraZeneca for the Improving Asthma Outcomes project as described within this paper.

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

N/A

Appendices

Appendix 1: Exclusion / Out of scope

Acronyms and Abbreviations explained

1. SABA - short-acting beta2-agonist bronchodilator – A type of reliever inhaler
2. MART- Maintenance and Reliever Therapy. A single combination inhaler used regularly, for maintenance and breakthrough asthma symptoms. This avoids patients needing a second SABA inhaler as a reliever.
3. MDI - metered dose inhaler
4. ICS/LABA inhaler – A type of combined inhaled corticosteroid/long-acting bronchodilator inhaler
5. IIF – Investment and Impact Fund
6. JWA – Joint Working Agreement

7.	EQIA - Equality and Quality Impact Assessment
8.	DPIA – Data Privacy Impact Assessment
9.	PCN – Primary Care Network

What are the implications for?

Residents and Communities	This initiative will improve outcomes for adult asthma patients living in Leeds
Quality and Safety	An Equality and Quality Impact Assessment has been completed with no quality and safety concerns identified. The project will improve patient outcomes.
Equality, Diversity and Inclusion	An Equality and Quality Impact Assessment has been completed with no implications identified.
Finances and Use of Resources	The estimated financial resource is outlined within this paper and is supported by finance colleagues.
Regulation and Legal Requirements	This development and Joint Working Agreement complies with the Leeds ICB, Pharmaceutical and Related Industries Joint Working Policy (2020).
Conflicts of Interest	The Joint Working Agreement has been developed in line with the Leeds ICB, Pharmaceutical and Related Industries Joint Working Policy (2020) which addresses conflicts of interest. No conflicts of interest have been identified. Whilst prescribing recommendations are made to the GP practice, the clinician agreed by the GP Practice will be responsible for approving and making all prescribing decisions in line with local prescribing formula/guidelines.
Data Protection	A Data Protection Impact Assessment has been undertaken with no risks identified.
Transformation and Innovation	This agreement allows us to innovate and improve patient outcomes.
Environmental and Climate Change	Positive Impact – initiative aims to reduce avoidable carbon emissions through encouraging choice of lower carbon inhaler alternatives, where clinically appropriate (lowering Global Warming potential).
Future Decisions and Policy Making	The learnings and evaluation from this work will inform future commissioning intentions within the Leeds ICB.
Citizen and Stakeholder Engagement	Patient materials will be developed in collaboration with the ICBs communications and engagement team.

1. Main Report Detail

1.1 Excessive SABA use in asthma is considered to be a marker of poor asthma control and high risk for asthma attacks. Good asthma control may be described as needing to use a reliever (SABA) inhaler no more than twice a week, and so a 200-dose salbutamol pressurised Metered Dose Inhaler (pMDI) should last 50 weeks. Anything more than this indicates poor asthma control.

1.2 The 2014 Royal College of Physicians report 'Why asthma still kills: The National Review of Asthma Deaths (NRAD)' highlighted that 80% of deaths reviewed showed evidence of sub-optimal adherence, and 39% of cases had been prescribed at least 12 short-acting beta-2 agonists (SABA) in the 12 months prior to death.

1.3 The traditional management of asthma relies on a separate fixed dose controller/preventer inhaler (an ICS with or without a long-acting beta-2 agonist (LABA) or montelukast) with a separate reliever inhaler (a SABA). An alternative approach is to use a single combination inhaler for **maintenance and reliever therapy (MART)**, which involves the use of a combination ICS-formoterol inhaler used regularly, one inhalation, twice daily with an additional dose as necessary for relief of breakthrough asthma symptoms, rather than using a second SABA inhaler.

1.4 The proposed Joint Working Agreement between the West Yorkshire ICB (Leeds Office) and Astra Zeneca aims to transform asthma management in adults with poorly controlled asthma as defined by excessive use of short-acting beta2-agonist (SABA) reliever inhaler and/or frequent rescue courses of prednisolone through increased use of single inhaler Maintenance and Reliever Therapy (MART) using Symbicort® Turbohaler.

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

1.6 The Joint Working Agreement will involve pharmacist-led reviews with adults with a diagnosis of asthma, who remain uncontrolled (using at least 6 SABA inhalers per year, and/or requiring at least three courses of systemic corticosteroids per year). Exclusion criteria is included in **Appendix 1**. The pharmacist led reviews will consist of patient education, inhaler technique training and the optimisation of asthma treatment to:

1.6.1 Improve outcomes for adult asthma patients by addressing SABA over-reliance, increasing appropriate anti-inflammatory treatment, and implementing a maintenance and reliever therapy (MART) focussed strategy for appropriate patients to improve asthma control and avoid asthma attacks.

1.6.2 Reduce the environmental impact of adult asthma management through reduction in SABA over-reliance, as well as improving patient health, it is envisaged that this incentive will also enable reductions in unnecessary SABA prescribing (and therefore carbon emissions) by improving disease control.

1.6.3 Help GP practices meet IIF indicators ES 01 and ES 02, delivering on the NHS England and British Medical Association (BMA) ambitions to reduce avoidable carbon emissions through encouraging choice of lower carbon inhaler alternatives, where clinically appropriate (lowering Global Warming potential).

1.6.4 Provide education, training and awareness. Update training sessions will be provided to PCNs on asthma treatment guidelines. Interface Clinical Services will support practice staff to ensure a lasting legacy of this service by allowing practice healthcare staff to sit in on consultations to learn and understand the review process.

1.4. It is anticipated that the Joint Working Agreement will run from January 2023 if agreed, through to January 2024. Four PCNs have been recruited to work with, to promote a SABA-free approach to asthma prescribing, utilising the MART regimen to use a single inhaler. We will focus on adults with asthma who are identified as high users of SABA inhalers (6 or more inhalers per year), and/or using frequent (3 or more) courses of oral corticosteroids. These patients by definition have uncontrolled asthma and should be a priority for an asthma review to optimise their treatment. The PCN's in agreement to commencing the project in the new year are; LS25/26, Bramley, Middleton, Wortley (BWM), Holt Park and Woodsley.

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

1.5.1 AstraZeneca

AstraZeneca will provide the following support:

- AstraZeneca medical educator resource to support education, implementation, and project management
- Support of timely asthma reviews via Interface Clinical Services to run virtual pharmacist review clinic (pharmacists will work under the direction of Leeds ICB/practice clinicians, additional benefit of this specific service is that they have been upskilled in review and transition to SABA-free strategy and have conducted significant volume of reviews recently)
- Deploy Sentinel plus programme (implemented elsewhere in the country, i.e. Hull – structured, nurse supported, virtual support programme to optimise adherence, inhaler technique, asthma knowledge, and self-management in newly transitioned patients
- Provide Turbohaler Placebos and Turbohaler whistles to support inhaler technique.
- This support from AstraZeneca is offered as a non-promotional activity in line with the ABPI code of practice.

1.5.2 West Yorkshire ICB (Leeds Office)

- Consultant pharmacist (LTHT), ICB Pharmacist and Project Support (ICB) will be provided within current resources.
- The consultant pharmacist and ICB Pharmacist will be available to Practice/PCN Teams to provide an initial asthma update training session on asthma guideline-based treatment, MART therapy and non-pharmacological interventions. They will also mentor and provide advice and guidance support to ensure a successful implementation of this project. This support can be accessed on an ad hoc basis by email or telephone.
- A follow-up meeting will be arranged four weeks after the initial consultation between the Consultant Pharmacist, Toby Capstick and Advanced Pharmacist Auzma Yousaf with each practice and PCN to undertake case reviews and ensure the quality of asthma reviews. Initially these will be timetabled weekly and stepped down as each practice and PCN are confident with implementing the project. As this project will be rolled out continuously from practice to practice, across 20 practices (4 PCNs), these meetings will be scheduled weekly, and practices invited as and when the project commences in each practice
- Evaluation to include anonymised open prescribing data collated by the West Yorkshire ICB (Leeds Office). The Leeds Office will also lead on evaluation of patient and workforce confidence, and whether this increases a as result of this project. This will be considered via the utilisation of patient questionnaires.
- Long term (6, and/or 12 month) outcome evaluation to assess the impact of the project will be performed by the ICB project team.

Following the asthma review and consultation, changes to each patient's asthma treatment will be made within a defined protocol in line with the project scope and local Leeds ICB formulary:

- Interface Clinical Services, will make prescribing recommendations to the GP practice. **The clinician (GP/ Non-Medical Prescriber) agreed by the GP Practice will be responsible for approving and making all prescribing decisions**.

- The preferred inhaled drug for this project is Symbicort Turbohaler (which is a AstraZenica product and is included in our current Leeds Asthma Guidelines). Patients who decline this option or who cannot use this device, will be offered either Fostair NEXThaler or Fostair MDI (not AstraZeneca devices).

- Follow up review 4 weeks after the initial intervention- to be completed by the practice (MDT support will be provided to practices- see above).

- Local community pharmacies will be briefed about this project (via Community Pharmacy West Yorkshire), so that they know to keep stock of Symbicort Turbohalers to avoid delays in dispensing new prescriptions, and to support patients with inhaler technique training.

- Patients will be assessed prior to prescribing the inhaler (with use of placebo's by Interface pharmacists) whether the device is suitable for them. Only patients who have been assessed as being able to use the inhaler appropriately will be prescribed it. If the Symbicort device is unsuitable then alternative inhalers (such as Fostair) can be issued by the practice.

- Community pharmacists will also be encouraged to provide patient support through the New Medicines Service. Where a patient is changing device practice staff will be encouraged to send a SMS/email to the patient for an active referral for an NMS.

1.6 The estimated financial value of the Joint Working Agreement totals £115,700. 40% from health (West Yorkshire ICB, Leeds Office) and 60% from AstraZeneca when the above workforce commitments/resources are considered as a monetary value.

1.7 In line with the Leeds ICB, Pharmaceutical and Related Industries Joint Working Policy (2020), proposals for joint working must be reviewed by the organisations Quality and Finance teams, and if supported (which this proposal is) taken to a Governing Body/Commitee meeting for formal meeting approval. The Leeds Committee is asked to agree to this project, and that the Leeds ICB enter into the Joint Working Agreement with AstraZeneca. Please note that a Data Privacy Impact Assessment and Quality and Equality Impact Assessment have been completed for this project.

2. Next Steps

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

- Joint Working Agreement signed by all parties in January 2023.
- Evaluation developed during December and January 2023; evaluation to include anonymised open prescribing data analysed by the Leeds Office of the West Yorkshire ICB, focused on patient and workforce confidence, and whether this increases a as result of this project. This will be considered via the utilisation of questionnaires.
- First PCN commences reviews in January 2023.
- Additional PCNs will join throughout calendar year 2023.
- The project will be evaluated throughout the year with a final project summary report being published 6 months post project completion; July 2024.

3. Recommendations

The Leeds Committee of the WY ICB is asked to:

a) Approve the recommendation that the Leeds place enters into a Joint Working Agreement (JWA) with AstraZeneca for the Improving Asthma Outcomes project as described within this paper.

4. Appendices

Appendix 1: Exclusion / Out of scope

Appendix 1: Exclusion / Out of scope

- People who are thought to be unable to self-monitor their asthma symptoms and adjust MART treatment.
- People with severe asthma under specialist severe asthma services at LTHT, such as those receiving biologic therapy to treat asthma (e.g. omalizumab, benralizumab, mepolizumab, reslizumab, dupilumab).
- People who are unable to use inhaler devices effectively.
- People with unstable comorbidities, or pregnancy, that might affect the assessment of asthma control
- History of COPD
- People who are unable to read or understand information provided in the English Language, as there are no nationally available information in other languages. These patients can be offered MART therapy within existing Leeds asthma formulary but cannot be part of this project.

Leeds Health & Care Partnership

NHS West Yorkshire Integrated Care Board

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

ITEM	Dec 22	Mar 23	Lead
STANDING ITEMS			
Welcome & Introductions	X	X	Chair
Apologies & Declarations of Interest	X	X	Chair
Minutes of previous meeting	X	X	Chair
Matters Arising	X	X	Chair
Action Tracker	X	X	Chair
Questions from Members of the Public	X	X	Chair
Summary & Reflections	X	X	Chair
People's Voice	X	X	-
Place Lead Update	X	X	TR
Financial Position Update			VPS
Forward Work Plan	X	X	Chair
Items for the Attention of the ICB	X	X	Chair
GOVERNANCE ITEMS			
Sub-Committee Assurance Reports	X	X	Relevant Chairs
Committee Effectiveness		X	Chair
Risk Management Report	X	X	TR
Terms of Reference Review		X	SR
ITEMS FOR DECISION			
Clinical Leadership Arrangements	X		JB/SF
Winter Plan 2022/23	X		TR
West Yorkshire Health and Care Partnership Strategy	X		EA
Leeds City Digital Strategy	X		LT
Leeds Joint Working Agreement (JWA) with Astra Zeneca for Improving Asthma Outcomes	X		HL
Practice Proposal: The Merger of Sunfield and Hillfoot Practices and subsequent closure of Sunfield Medical Centre	X		KT
Operational Plan Update		X	VPS
Health and Wellbeing Strategy Refresh		X	MK/TC
Medium Term Financial Plan		X	VPS
Business Case: Community Diagnostics Centre		X	JBS/RA