Leeds Health & Care Partnership

NHS West Yorkshire Integrated Care Board

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

Tuesday 14th March 2023, 13:15 – 16:30
(Private pre-meet for members 13:00, public meeting 13:15)
HEART: Headingley Enterprise & Arts Centre, Bennett Rd, Leeds LS6 3HN

AGENDA

No.	Item	Lead	Page	Time
LC 62/22	**Welcome, Introductions**	**Rebecca Charlwood** Independent Chair	-	13:15
LC 63/22	**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 64/22	**Minutes of the Previous Meeting** - To approve the minutes of the meeting held 13th December 2022	**Rebecca Charlwood** Independent Chair	8	
LC 65/22	**Matters Arising** - To consider any outstanding matter arising from the minutes that is not covered elsewhere on the agenda	**Rebecca Charlwood** Independent Chair	-	
LC 66/22	**Action Tracker** - To receive the action tracker for review	**Rebecca Charlwood** Independent Chair	22	
LC 67/22	**People's Voice** - To share a lived experience of health and care services	**Hannah Davies** Chief Executive of Healthwatch Leeds	-	13:25
LC 68/22	**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	-	13:40
LC 69/22	**Place Lead Update** - To receive a report from the Place Lead	**Tim Ryley** Place Lead	24	13:50
ROUTINE REPORTS				
LC 70/22	**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	-	14:05
LC 71/22	**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	45	
LC 72/22	**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	-	

No.	Item	Lead	Page	Time
LC 73/22	**Risk Management Report** - To receive and consider the risk management information provided	**Tim Ryley** Place Lead	47	14:20
FINANCE				
LC 74/22	**Finance Update at Month 10 (January) 2022-23** - To receive the financial position update	**Visseh Pejhan-Sykes** Place Finance Lead	64	14:35
	BREAK 14:50 – 15:00			
ITEMS FOR DECISION/ASSURANCE/STRATEGIC UPDATES				
LC 75/22	**NHS Operational Planning 2023/24** - To receive and consider the Draft Operational Plan for 2023/24	**Tim Ryley** Place Lead	73	15:00
LC 76/22	**Leeds Health and Wellbeing Strategy Refresh** - To consider and provide feedback on the current draft of the strategy	**Tony Cooke** Chief Officer, Health Partnerships Team	83	15:20
LC 77/22	**Urgent Decision: Practice Proposal - The merger of Fountain Medical Centre and Morley Health Centre** - To ratify the decision taken 8th February 2023 by the Chair and the Place Lead	**Sam Ramsey** Head of Corporate Governance and Risk	130	15:40
FORWARD PLANNING				
LC 78/22	**Sub-Committee Annual Reports and Terms of Reference** - To review the annual reports and amended Terms of Reference for each of the Sub-Committees	**Sam Ramsey** Head of Corporate Governance and Risk	141	15:45
LC 79/22	**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	-	16:00
LC 80/22	**Forward Work Plan** - To consider the forward work plan	**Rebecca Charlwood** Independent Chair	192	
LC 81/22	**Any Other Business** - To discuss any other business raised and not on the agenda	**Rebecca Charlwood** Independent Chair	-	
	Date and Time of Next Meeting The next meeting of the Leeds Committee of the WY ICB will be held at 1.15 pm on Wednesday 5th July 2023.	**Rebecca Charlwood** Independent Chair	-	-

The Leeds Committee of the ICB 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 82/22	**Confidential Minutes of the Previous Meeting** - To approve the minutes of the confidential meeting held on 13 December 2022	**Rebecca Charlwood** Independent Chair	N/A	16:05
LC 83/22	**Intermediate Care Programme Proposal** - To consider and approve the programme proposal **Exempt under the provisions of the Freedom of Information Act 2000 (Section 43.2)**	**Jenny Cooke** Director of Population Health Planning	N/A	16:10

Leeds Committee of the West Yorkshire Integrated Care Board - Register of Interests, March 2023

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
	Caroline Baria	Interim Director, Adults and Health, LCC	Nil Declaration					
	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	Non-Financial Professional Interests	Direct	01/09/2015	Ongoing	Declare any relevant potential or perceived interest at relevant meeting
			Wellspring Multi-Academy Trust Voluntary Trustee / Vice-chair	Non-Financial Professional Interests	Direct	01/09/2015	02/11/2022	Declare any relevant potential or perceived interest at relevant meeting
			Wellspring Multi-Academy Trust Voluntary Trustee / Chair	Non-Financial Professional Interests	Direct	02/11/2022	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	George Winder	Chair of Leeds GP Confederation.	GP Partner Oakwood Lane Medical Practice	Financial Interests	Direct	01/01/2013	Ongoing	Declare any potential or perceived conflict of interest at relevant meetings or workshops.
			Clinical Director, Seacroft PCN	Financial Interests	Direct	01/07/2019	Ongoing	Declare any potential or perceived conflict of interest at relevant meetings or workshops.
			Chair of Leeds GP Confederation	Financial Interests	Direct	01/01/2023	Ongoing	Declare any potential or perceived conflict of interest at relevant meetings or 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.
Dr	Keith Miller	Interim Associate Medical Director	GP Partner, Vesper Road and Morris Lane Surgery, Leeds	Financial Interests	Direct	04/01/2022	Ongoing	Declare any potential or perceived conflict of interest at relevant meetings/workshops.
			Spouse is an Advanced Clinical Practitioner working in Emergency Department of LTHT (LGI and SJUH sites) – currently seconded to Health Education England for leadership fellowship till August 2023	Indirect Interests	Indirect	01/01/2004	Ongoing	Declare any potential or perceived conflict of interest at relevant meetings/workshops.
Professor	Phil Wood	Interim Chief Executive - LTHT	Chair of Northeast and Yorkshire Genomic Medicine Service Partnership Board	Non-Financial Professional Interests	Direct	01/02/2023	Ongoing	Declare any potential or perceived conflict of interest at relevant meetings/workshops.
			Honorary Professor in Healthcare Leadership, University of Leeds	Non-Financial Professional Interests	Direct	01/02/2023	Ongoing	Declare any potential or perceived conflict of interest at relevant meetings/workshops.

	Rebecca Charlwood	Independent Chair, Leeds Committee of the WY ICB	Spouse is a Professor of HRM in the management department of the Leeds University Business School	Indirect Interests	Indirect	01/09/2019	Ongoing	Declare any potential or perceived conflict of interest at relevant meetings/workshops.
Dr	Ruth Burnett	Executive Medical Director Leeds GP Confederation and Leeds Community Healthcare NHS Trust	GP at Crossley Street Surgery, Wetherby – not employed or partner, done as CPD	Non-Financial Professional Interests	Direct	01/01/2017	Ongoing	Declare any potential or perceived COI if relevant agenda items
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

Leeds Health & Care Partnership

NHS West Yorkshire Integrated Care Board

Draft Minutes

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

Tuesday 13 December 2022, 1.15pm – 4.30pm

Thackray Museum of Medicine, Beckett Street, Leeds LS9 7LN

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 (joined remotely)	**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 (joined remotely)	**SMu**	Chief Executive, Leeds & York Partnership Foundation NHS Trust (LYPFT)	✓	
Julian Hartley	**JuH**	Chief Executive, Leeds Teaching Hospital NHS Trust (LTHT)		✓
James Goodyear (deputising for Julian Hartley)	**JG**	Director of Strategy at LTHT	✓	
Dr Chris Mills	**CM**	Chair, Leeds GP Confederation	✓	
Cath Roff	**CR**	Director of Adults & Health, Leeds City Council (LCC)		✓
Caroline Baria (deputising for Cath Roff)	**CB**	Deputy Director, Integrated Commissioning, Adults & Health, LCC	✓	
Victoria Eaton	**VE**	Director of Public Health, LCC	✓	
Shanaz Gul	**SG**	Third Sector Representative		✓
Francesca Wood (deputising for Shanaz Gul)	**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	✓	

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Members	Initials	Role	Present	Apologies
Additional Attendees				
Sam Ramsey	**SR**	Head of Corporate Governance & Risk, ICB in Leeds	✓	
Manraj Khela	**MK**	Head of Health Partnerships	✓	
Harriet Speight (minutes)	**HS**	Corporate Governance Manager, ICB in Leeds	✓	
Kirsty Turner (Item 55)	**KT**	Associate Director of Primary Care, ICB in Leeds	✓	
Esther Ashman (Item 52) (joined remotely)	**EA**	Associate Director Strategy, WY ICB	✓	
Hannah Davies (Item 43)	**HD**	Chief Executive, Healthwatch Leeds	✓	
Anna Chippindale (Item 43)	**AC**	Community Project Worker, Healthwatch Leeds	✓	
Helen Lewis (Items 51,57 and 61)	**HL**	Director of Pathway Integration, ICB in Leeds	✓	
Stephen Blackburn (Item 53) (joined remotely)	**SB**	Innovation Relationship Manager, Integrated Digital Service in Leeds	✓	

Members of public/staff observing – 0

No.	Agenda Item	Action
38/22	**Welcome and Introductions** The Chair opened the meeting of the Leeds Committee of the West Yorkshire Integrated Care Board (WY ICB) and brief introductions were made.	
39/22	**Apologies and Declarations of Interest** Apologies had been received from Cath Roff, Julian Hartley and Shanaz Gul. Caroline Baria was deputising for Cath Roff, James Goodyear was deputising for Julian Hartley 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. The register of interests had been included with the full paper pack and the Chair noted that all partners had an inherent professional financial conflict in relation to Item 61.	
40/22	**Minutes of the Previous Meeting – 22 September 2022**	

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No.	Agenda Item	Action
	The minutes were approved as an accurate record. **<u>The Leeds Committee of the WY ICB:</u>** a) **Approved** the minutes of the previous meeting held on 22 September 2022.	
41/22	**Matters Arising** There were no matters raised on this occasion.	
42/22	**Action tracker** The Committee noted the completed actions set out in the action tracker and that in reference to action 7, the Partnership Executive Group would continue to inform the Place Lead Updates.	
43/22	**People's Voice** The Chair introduced Hannah Davies and Anna Chippindale from Healthwatch Leeds who provided a summary of recent work undertaken by the People's Voice Partnership relating to digital access to health services, including two Healthwatch reports – 'Digitising Leeds: Risks and Opportunities for Reducing Health Inequalities in Leeds' and 'Digital Inclusion in Leeds: How Does It Feel for Me?' The key messages included: - Digital can offer fantastic advantages to people, however such provisions should aim to enhance rather than replace traditional forms of access in recognition that not all services would be suited to entirely digital access - As a city and wider, there is a good understanding of digital exclusion parameters and how social factors impact these, but there is a gap in terms of analysis of which services work best for people - There is a clear link between the digital agenda and personalised care, people need to be involved in development of services and be provided with choices around how they access and receive support to ensure that certain groups are not excluded by the shift to digital services Members were also advised of two specific examples of limitations of using digitalised systems in Leeds. The first, a patient who had tried to call the enquiry line to access sexual health services but was not able to connect and advised to use online services but was unable to navigate the system on the website. The second example related to the recently launched Leeds Teaching Hospitals Trust (LTHT) Patient Hub App, for which it was reported that there is no demographic data collected for users and patient experience analysis undertaken received the views of 51 people despite 100,000 appointments having been booked using the Patient Hub App.	

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No.	Agenda Item	Action
	James Goodyear (JG) advised that LTHT routinely collect user data for all patients and would seek clarification following the meeting regarding the data specifically related to the Patient Hub app. It was confirmed that all traditional booking routes remain available alongside the app. JG agreed with the need to engage with the public to develop services. John Beal (JBe) highlighted the varying availability of online booking systems between GP practices and sought clarity on whether there is a standardised offer that should be available across all. Dr Jason Broch (JBr) advised that all GP practices work in a similar way and aim to provide a system offer, however the biggest challenge is finding a mechanism that matches capacity and demand at individual practices, because if all appointments were made available online, people who are digitally literate would be likely to be able to book quickly, excluding those who are not. Jo Harding (JoH) also informed the Committee that West Yorkshire has been successful in its bid to take part in the National Experience of Care Pilot, which allow the Leeds system to be engaged in the methodologies and will provide dedicated resource for understanding people's experiences of digital services. Tim Ryley (TR) welcomed the report and highlighted that people's experiences of digital are key, however must be considered alongside the other factors, particularly finance and delivering overall improvement across healthcare. JBr highlighted that a significant part of the digital agenda is broader digital infrastructure, which could set the foundations for improved accessibility in the future, as technology advances, to a more diverse group of people. This could include, for example, voice lead access through artificial intelligence technology that also provides translation for those with English as an additional language. The Chair welcomed the report and the link to the Digital Strategy (refer. Item 54), recognising the exciting opportunities that new technologies bring to healthcare, but also that in difficult and emotional times for patients and their families, human interaction is crucial for true understanding of needs and identifying the appropriate route of support and care. **ACTION –** That the two Healthwatch reports – 'Digitising Leeds: Risks and Opportunities for Reducing Health Inequalities in Leeds' and 'Digital Inclusion in Leeds: How Does It Feel for Me?' – be circulated to Members following the meeting. *Chris Mills (CM) joined the meeting at 13:35 during discussion of this item.*	**HS**
44/22	**Questions from Members of the Public** There were no questions received from members of the public.	

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No.	Agenda Item	Action
45/22	**Place Lead Update** TR provided an overview of the report, highlighting that the national picture continues to change, however NHS England remain focused on narrowing the route of targets and pressures, which in time, supported by the Independent Review of Integrated Care Systems to be led by Rt Hon Patricia Hewitt, will provide more freedom to accelerate key ambitions in Leeds, particularly around tackling health inequalities. TR highlighted that Winter Plans were in place, however the winter period remains hugely challenging for the system. This would be discussed further through agenda item 51/22 Winter Plan 2022/23. It was also noted that the £500m Winter Discharge Fund had been announced, equating to £8m for Leeds. TR highlighted that the funding will be essential to support improvement around system flow. TR also referenced other significant system challenges within the report including children and mental health, which he noted should remain prominent in discussions alongside the current winter pressures, as well as an update on work that had taken place between the Chief Officers in the Leeds system over the last six months to further develop the common narrative that underpins the partnership in Leeds. JBe noted that out-of-area placements for children with mental health needs were reducing and queried whether this was the same for adults. Sara Munro (SM) advised that Red Kite View, a new Children and Young People's Mental Health Inpatient Unit in Leeds, had provided additional beds and as a result the number had dropped from 30 out-of-area placements at the beginning of 2022 to just three. SM advised that the numbers were fluctuating for adults and remain challenging to reduce through the winter period. The Chair sought assurance from the NHS Trust representatives around plans in place to manage the expected strike action due to take place in coming weeks. JG advised that LTHT were working closely with staff to agree the derogations for which services will be deemed essential and will therefore continue to run. Members were also advised that an incident management command structure had been set-up to ensure the delivery of essential services during the period of action. TS advised that similar activity to that described by JG would take place at Leeds Community Healthcare Trust (LCH), and added that the three NHS Trusts in Leeds and others regionally were working closely together to build resilience across the system. **The Leeds Committee of the WY ICB:** a) **Considered** and **noted** the contents of the report; and b) **Advised** on the content of future Place Lead Updates	
46/22	**Quality and People's Experience Sub-Committee Update**	

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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: - 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. In reference to the mortality indicators, JG advised that a mortality review group at LTHT routinely monitors the data and learning from deaths reviews are completed and submitted where appropriate. Victoria Eaton (VE) also highlighted the need for analysis as a Leeds system of the excess deaths within the population, as well as deaths recorded at hospitals, recognising that nationally there is growing concern around excess deaths. It was highlighted that there had been more than 22,000 excess deaths in the last six-month period and varying debate around the causal factors of the increase. The Chair noted that a future discussion around mortality rates following analysis would be welcomed. **The Leeds Committee of the WY ICB:** a) **Received** the update.	
47/22	**Delivery Sub-Committee Update** The Chair of the Sub-Committee, Yasmin Khan (YK), 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 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	

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<tr><th>No.</th><th>Agenda Item</th><th>Action</th></tr>
<tr><td></td><td>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.

In reference to cancer performance data, JG acknowledged that cancer waiting times remain a challenge, with particular issues around skin, lung and urological cancers, however improvements have recently focused on the diagnostic part of the pathway for patients to reduce the need for treatment. JG also noted that the total waiting list for LTHT had reduced, which had been a significant challenge following backlogs from the pressure's experiences throughout the Covid-19 pandemic.

<u>The Leeds Committee of the WY ICB:</u>

a) Received the update.</td><td></td></tr>
<tr><td>48/22</td><td>Finance and Best Value Sub-Committee Update

The Chair of the Sub-Committee, Cheryl Hobson (CH), 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 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 Leeds is 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</td><td></td></tr>
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No.	Agenda Item	Action
	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. Thea Stein (TS) reflected that all 'alert' points within each of the Sub-Committee assurance reports and the Place Lead Update (Refer. Item 45) were heavily focused on hospital activity in Leeds, and noted that future reports should also reflect community, general practice. and mental health pressures. TR welcomed the feedback and noted that the other sections of the assurance reports include detail around other pressures, however recognised that the reporting process and membership for each of the Sub-Committees requires reflection as part of the 12-month governance review to ensure that discussions in meetings are representative of the entire partnership, and that 'alert' sections within reports reflect positive messages, as well as pressures to be escalated. **The Leeds Committee of the WY ICB:** a) **Received** the update.	
49/22	**Risk Management Report** The Place Lead provided an overview of the report, highlighting that the risks rated as 'high' should be the most prevalent topics of discussion throughout meetings of the Leeds Committee. TR noted that although most of the 'high' rated risks had formed part of discussion in earlier items, children and adults' mental health had not which required reflection within the forward plan. Sam Ramsey (SR) also provided an update regarding the request from members to introduce a risk around workforce for Leeds. SR advised that the workforce risk sits with organisational boards, and the Leeds One Workforce Strategic Board (LOWSB) have oversight of the Leeds workforce risk profile. Members recognised that the line of responsibility is clear, however agreed that the risk should also be monitored separately within Leeds. **ACTION** – To add a system risk around workforce to the risk register. TR to draft wording to ensure it is included appropriately.	**SR/TR**

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	In reference to the common risk across WY regarding mental health capacity, TS and SM reflected that the risk scoring may be too low considering current pressures and requested that this be reviewed. **ACTION** – To seek further detail from the mental health capacity risk scoring from the risk owner and provide update in a future report Cheryl Hobson (CH) queried the consistency of approach to risk rating across West Yorkshire, noting that risks are rating higher in Leeds than all other Places. Members were advised that the Risk Management Operational Group with representation from across WY consider the ratings across place and ensure that the levels are appropriate, however also noted that the Leeds represents one third of WY, and therefore the impact is inevitably higher, which is therefore reflected in the risk rating. **The Leeds Committee of the WY ICB:** a) **Received** and **noted** the High-Scoring Risk Report (scoring 15+) as a true reflection of the ICB's risk position in Leeds, following any recommendations from the relevant committees; b) **Received** and **noted** the risks directly aligned to the Leeds Committee of the ICB scoring 12 and above; and **c)** **Noted** in respect of the effective management of the risks aligned to the Committee and the controls and assurances in place.	 **SR**
50/22	**Finance Update at Month 7 (October) 2022-23** Visseh Pejhan-Sykes (VPS) provided an overview of the report, advising that there had been significant dialog across WY around the remaining gap in funds in Leeds, however additional social care resources had recently been made available across the Leeds partnership (refer. Item 45), along with underspend from other Places across WY, and had therefore improved the position in Leeds, expected to result in a balanced position for Leeds. It was emphasised, however, that many allocations are non-recurrent, which therefore will not impact the underlying position for 2023/24, which highlights a key challenge for planning in the medium-term. CH advised that a similar discussion had taken place at the Finance and Best Value Committee on 1st December 2022 and members were clear that the medium-term financial plan will be key in supporting the underlying position in Leeds, as well as considerations of workforce, and that this work should commence as soon as possible. Chris Mills (CM) noted that the Leeds partnership had invested significantly in support from Newton Europe to develop a significant cultural shift in assumptions about investments in the future. CM queried whether there is level of capacity in the system to sustain significant behavioural and systematic change required. TR advised that ongoing work with Staten Island, New York, has shown a different	

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	approach of understanding how finances and workforce move around a system, alongside systematic behavioural change, and colleagues are working to understand how a similar model could work in Leeds. **The Leeds Committee of the WY ICB:** d) **Noted** the month 7 year to date and forecast financial position; e) **Noted** the additional key risks that may crystallise later in the year; and f) **Discussed** the next steps as we close the 2022-23 financial year and prepare for the 2023-24 planning round in the new calendar year. ***The meeting adjourned for a comfort break at 2:50 p.m. until 3:00 p.m.***	
51/22	**Winter Plan 2022/23** Helen Lewis (HL) introduced the report, providing an overview of the three key elements to winter planning - expanding capacity, improving productivity, and preventative healthcare. HL also added that industrial action expected to take place in coming weeks was also a key consideration in planning, with daily dialog between partners to ensure resilience. Caroline Baria (CB) advised the Committee that the care sector, particularly nursing care homes, were experiencing significant financial challenges and workforce issues, and whilst LCC were working to support, this should be flagged as a risk for the winter period. In reference to workforce pressures, TS informed the Committee of a recent analogue hyper local recruitment drive for LCH that had been very successful, reaching people who want to live and work within their community and support local people. Members recognised the whole-system approach required to accelerate preventative work, a key component of the plan, and the value of public health campaigns around vaccinations and proactive activity around the impact of cold weather throughout the challenging winter period. **The Leeds Committee of the WY ICB:** a) **Noted** 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.	
52/22	**Refresh of the West Yorkshire Partnership's Five-Year Strategy - Working Draft** Esther Ashman (EA) provided an overview of the report and draft strategy, advising that the strategy had been developed by the Strategy Design Group, which includes representation from all Places in WY, and represents the complexity of the system.	

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	EA noted that the final version of the strategy will be published in March 2023, following feedback and approvals. JBe commented that the strategy inaccurately describes patients being able to register with NHS dentist practice, as NHS patients are not tied to a specific practice in the same way as GP practices. EA confirmed that the strategy would be updated to reflect this. TR commented that the draft strategy provides a helpful framework, however, does not provide clarity on responsibilities at Place to deliver. TR requested that the strategy be updated to reflect subsidiarity and identify areas of responsibility. CM queried whether the strategy will include a commitment to timeframe for sharing data across NHS organisations and was advised that this element was in development and will be reflected in the forward plan. EA welcomed the feedback from members and committed to continuing to engage with places through the Strategy Design Group and the Health and Wellbeing Board. **The Leeds Committee of the WY ICB:** a) **Noted** the work that has been undertaken across the Partnership as part of the refresh of the strategy; b) **Supported** the proposition to further build the ‘integrated care experience’ into the way in which we work to deliver the strategy; and c) **Commented** on the current draft of the strategy, noting the further work to be undertaken as part of its development.	
53/22	**Leeds City Digital Strategy** Stephen Blackburn (SB) provided an overview of the report and strategy, advising that the strategy had been written from a ‘whole city’ view rather than from any specific organisation's perspective to encourage participation in its delivery. The strategy outlined priority areas that would be taken forward by the Integrated Digital Service with a focus on improving service delivery and realising efficiencies. The Chair sought the Committee’s views as to whether they felt they had been sufficiently involved in the development of the strategy and if they felt ownership of the ambitions and priorities set out. TS commented that LCH had not been involved to the extent they would have liked to have been, however recognised the barriers to this, but otherwise considered the strategy to be elegant and interesting. TS noted that the consensus from the LCH team was to further consider the basics prior to focusing on innovation projects. Referring to the earlier discussion during the People’s Voice item (Item. 43), JBe noted that the Healthwatch insight reports have indicated that various groups are excluded from digital, and therefore it is crucial that the strategy considers the	

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	impact of digital exclusion on health inequalities, as well as the benefits of digital inclusion. Francesca Wood (FW) also noted that the third sector are key partners in delivering services for some of the most vulnerable groups and should be prioritised along with other front-line services for this work. CM commented that the strategy lacked key capabilities around sharing of data across systems, and suggested the strategy be amended to reflect the inter-organisational communication. JoH advised that the recently published National Nursing Strategy includes several recommendations around digital that have clear expectations for local delivery, which are not currently reflected and should therefore be incorporated into the strategy. SM noted that the strategy should be clear around the cost of fully realising the digital ambitions set out. Members welcomed the strategy, however agreed that the strategy required supportive action plans, developed in consultation with partners, to realise some of the broader ambitions set out and provide information on how work will be funded. SB agreed to take comments away and build on the strategy further prior to final publication. **The Leeds Committee of the WY ICB:** a) **Supported** the approach being outlined in the digital strategy, the digital transformation approach, and the innovation programme. b) **Approved** the strategy and agreed that it can be published, subject to amendments suggested during discussions.	
54/22	**Clinical & Professional Leadership (CPL) in the Leeds Health & Care Partnership** JBr provided a brief overview of the report and proposals, highlighting that the arrangements had been developed to mirror clinical leadership structures at WY ICB level. JBr advised that since CPL is still developing, the paper should be seen as a position statement with an opportunity to influence the developing structures and functions. Members were supportive of the developments to date, however requested that as part of the next steps, consultation takes place with each of the partner organisations to ensure clinician and other professional voices are reflected across the system. **The Leeds Committee of the WY ICB:**	

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	a) **Reviewed** 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) Agreed** to consider further with partner organisations to answer in detail the remaining recommendations within the report.	
55/22	**Practice Proposal: The Merger of Sunfield and Hillfoot Practices and subsequent closure of Sunfield Medical Centre** Kirsty Turner (KT) introduced the report, advising that the Primary Care Board had considered the proposals in detail and recommended to the Committee to support the merger and subsequent closure as set out in the report. The Committee were assured by the report and the detail that had been considered by the Primary Care Board and agreed to approve the recommendation. **The Leeds Committee of the WY ICB:** a) **Approved** 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.	
56/22	**Leeds Joint Working Agreement (JWA) with Astra Zeneca for Improving Asthma Outcomes** Helen Lewis introduced the report, advising members that previously, NHS Leeds CCG followed the policy in relation to joint working and it had been proposed that whilst harmonisation of commissioning policies is undertaken across WY (which will include the review and update of the Joint Working Policy / approaches collaboratively across WY), the Leeds 2020 policy is utilised in the interim. 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. The report outlined 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. **The Leeds Committee of the WY ICB:** a) **Approved** the recommendation that the Leeds place enters into a Joint Working Agreement (JWA) with AstraZeneca for the Improving Asthma Outcomes project as described within the paper.	
57/22	**Items for the Attention of the ICB Board**	

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	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.	
58/22	**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.	
59/22	**Any Other Business** The Chair thanked Julian Hartley and Cath Roff on behalf of the Committee for all their work to support the Leeds Health and Care Partnership and wished them well in their future endeavours. The Chair also thanked Dr Sue Proctor for her time as the Chair of LYPFT and welcomed the new Chair of LYPFT, Merran McRae to the role.	
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.	
	The Leeds Committee of the WY ICB resolved that representatives of the press and other members of the public be excluded from the remainder of the meeting, having regard to the confidential nature of the business to be transacted 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.	

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Action Tracker

Leeds Health & Care Partnership

Leeds Committee of the WY ICB

LC 66/22

Action No.	Meeting Date	Item Title	Actions agreed	Lead(s)	Accountable body / board / committee	Status	Update
11	**13/12/2022**	**People's Voice**	That the two Healthwatch reports – 'Digitising Leeds: Risks and Opportunities for Reducing Health Inequalities in Leeds' and 'Digital Inclusion in Leeds: How Does It Feel for Me?' – be circulated to Members following the meeting.	**Harriet Speight**	**LCICB**		**Complete** Circulated reports 15/12/22
12	**13/12/2022**	**Risk Management Report**	To add a system risk around workforce to the risk register. TR to draft wording to ensure it is included appropriately.	**Tim Ryley/Sam Ramsey**	**LCICB**		**Complete** A workforce risk has been added and detail is included in the risk report at Item 72/22
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.

Updated: February 2023

Action No.	Meeting Date	Item Title	Actions agreed	Lead(s)	Accountable body / board / committee	Status	Update
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.
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**		**Complete** Place Lead Update at Item 45/22 includes local context and priorities
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
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

Leeds Health & Care Partnership

NHS West Yorkshire Integrated Care Board

Meeting name:	Leeds Committee of the West Yorkshire Integrated Care Board
Agenda item no:	LC 69/22
Meeting date:	13 March 2023
Report title:	Place Lead Update
Report presented by:	Tim Ryley, Place Lead, ICB in Leeds
Report approved by:	N/A
Report prepared by:	Tim Ryley, Place Lead, ICB in Leeds

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

Previous considerations:

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

Executive summary and points for discussion:

The report provides members of the Leeds Committee with national context and a summary of the winter and performance challenges including a brief update on the major programme to redesign Intermediate Tier services. Whilst performance has improved in a number of areas there remain real challenges around access to mental health, neuro-diversity diagnosis, waiting times and emergency department and system flow pressures. The financial challenges for next year are significant and planning work is still underway to address these.

The report also describes ongoing developments across West Yorkshire and the Leeds Health & Care Partnership as we seek to strengthen how we work including a governance and operating model review.

There are a number of areas of success to note including early delivery in some areas of the Intermediate Tier programme, improved ambulance turn-around times at LTHT, continued development of admission avoidance work and a number of pieces led by the Long-Term Conditions Programme board.

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

☒ Improve healthcare outcomes for residents in their system

☒ Tackle inequalities in access, experience and outcomes

☒ Enhance productivity and value for money

☒ Support broader social and economic development

Recommendation(s)

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

a) **Note** and **consider** the report
b) **Advise** on future content

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. Letter to Forum Central
2. Report: Celebrating our work on Atrial Fibrillation (AF) in Leeds

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

What are the implications for?

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

1. National Context and Impact

1.1 The national picture remains challenging. Whilst strikes by nurses at the time of writing are suspended, there is continued action by ambulance workers, therapists, and junior doctors. This continues to put significant pressure on services despite good local working relationships between unions and local NHS organisations.

1.2 Whilst Leeds and the West Yorkshire ICS will deliver financial balance in this current year, there are very significant risks going into 2023-24. These are reflected nationally and also in Leeds. These may, if not reduced prior to final planning submissions at the end of the month, draw significant regulatory attention.

1.3 Nationally the NHS focus remains on a few key areas: reducing the elective backlog including prompt treatment for cancer, improving urgent care including ambulance times, A & E performance and discharge, and primary care (GP) access. Clearly these are important issues for the public and in the run up to the next general election will remain a high political priority.

1.4 Whilst the worst of the pandemic is behind us Covid has not disappeared, and we continue to face smaller waves that are not insignificant in their impact on service delivery. In addition, there is evidence of an increase in mortality more widely nationally and we are working alongside Public Health colleagues to identify the local issues. In addition, there continues to be a big increase in demand for all services and in particular in Mental Health. These are to be expected post-pandemic consequences.

1.5 The national Hewitt Review of ICS continues and through various people in Leeds and West Yorkshire we continue to feed into that. We are still awaiting publication of the findings.

2 Winter Challenges and Current Position

2.1 This Winter has been among the toughest the NHS has experienced. Alongside a Covid spike, seasonal influenza came early and with an extremely high spike during December. This put immense pressure on the Leeds System in all parts of the NHS, Social Care and Third Sector. High sickness levels, strikes and holiday period were all factors that made the last few weeks of December particularly difficult.

2.2 We should as a Leeds Committee note our thanks and appreciation to all clinical and professional colleagues who, alongside operational managers, continued to operate the NHS, Social Care and the Third Sector. Our winter plans were stretched sometimes almost beyond breaking point.

2.3 In part due to the very early and high speak in influenza, the period since the middle of January has felt quieter than might have been expected. However, it

is really important that we do not normalise current levels of, for example, surge beds open in LTHT or ambulance times. The system remains under significant pressure with high levels of demand and acuity.

2.4 There are a number of positive features of our system despite all the challenges. We continue to build on the pioneering work of virtual wards for example and LTHT are among the very best performing on ambulance handovers (LGI top and St James 5th in England).

2.5 Colleagues are planning a review of arrangements for Winter to understand what lessons can be learned for the future.

3 Performance Challenges

3.1 In most areas performance is improving and given the challenges of the last few years this needs to be noted.

3.2 There remain a number of areas of concern including:

3.2.1 We perform well on most mental health performance indicators. However, there are very significant pressures in all areas with very high demand for services. This continues to mean more people than we would like to have to be treated out of area and waiting lists are longer than we would wish. This is for both children and adults.

3.2.2 One particular concern is the waiting times for neurodiversity (autism, ADHD etc) particularly among children. One in eight children in Leeds is seeking a diagnosis and this is often the route to get additional support in the education system. We do not have the capacity to meet this demand. This is a wider national issue and is being looked at both within Leeds and through a West Yorkshire lens.

3.2.3 We continue to make good progress on reducing the longest waits for elective surgery and at the same time there are real challenges to reducing this at the pace being asked of us for next year. Colleagues in the West Yorkshire Association of Acute Trusts (WYATT) are working together to maximise the opportunities. The continued pressures in the unplanned system and strikes present significant barriers to increasing levels of activity.

3.2.4 We continue to see performance below our desired standards in the A&E departments. This has the risk of poor experience and poor outcomes for people attending. This is a whole system problem and as well as work LTHT are doing internally, partners are working together to improve flow (see below). The Same Day Response Board is also addressing attendances with increased capacity in Same-Day Primary Care, working with the ambulance service to reduce unnecessary conveyance, and there is also work in areas such as the virtual wards. The system is planning in 2023-4 to hit the nationally set improvement trajectory in this area.

4 Intermediate Care Programme

4.1 We have been concerned for some time by the numbers with no reason to reside in a hospital setting and the consequences on them as individuals in terms of deconditioning and loss of independence, and the impact on flow through the hospital, especially the Emergency Department.

4.2 As a result, we have developed a system flow programme of work and now an Intermediate Care transformation programme. Despite the many challenges over winter, unlike most areas in West Yorkshire and England, the proportion of beds at LTHT has reduced from 22% to 17-18% and we have reduced length of stay of those individuals considerably, meaning a reduction in lost beds days from circ. 7000 in Sept to circ. 4,800 in Feb.

4.3 However, we want to go further and are in the process of finalising the next and major phase of transformation. A Programme team and programme directors are being put in place and we are just finalising the contractual agreements with external partners to support this. This will be an 18 month to two-year programme, but we anticipate significant benefits within this financial year.

4.4 The benefits are much broader than reducing no reason to reside and include seeing far more people supported to live at home rather than go into care settings, increased independence derived from enhanced rehabilitation in our remaining community beds and efficiency benefits which we can use to support increased elective activity and securing community and council services.

5 Development of the ICS and Leeds Health & Care Partnership

5.1 The Leeds Health & Care Partnership want to welcome Professor Phil Wood to the role of Chief Executive at Leeds Teaching Hospitals Trusts (LTHT) and Caroline Baria as Interim Director of Adult Social Care within Leeds City Council (LCC). Both are already colleagues, and we look forward to continuing to work with them in their new roles.

5.2 The West Yorkshire ICB are undertaking a review of both the Governance Arrangements and their Operating Model over the next three or four months. This will be informed by learning from within our own system and the outputs from the Hewitt Review. The NHS has also set challenging running cost reductions for 2024 onwards which will require a response. This will have implications and present opportunities for the wider ICS including place-based arrangements.

5.3 The Accountable Officer (Leeds) has been asked to step out of Leeds until July to lead the design element of this work. Arrangements are being put in place to cover from across the ICB Team in Leeds and the Leeds Health & Care Partnership.

5.4 As part of this we will be reviewing the Leeds Health & Care Partnership arrangements including the Leeds Committee of the ICB and the sub-committees in a way that aligns to the broader changes in the operating model.

5.5 We continue to develop relationships with the Staten Island Provider Performing System in New York. The Staten Island PPS provides HealthCare to 550,000 people who are mainly on Medicare and Medicaid federal funded programmes. The system is internationally renowned for its value-based and population health led approach. We have drawn-up a set of key lines of enquiry and discussing exchanges of insight. The key lines of enquiry are based around a number of foundational building blocks critical to integrated systems including business intelligence, leadership, governance, and financial models. We will bring back more to the committee at our next meeting.

5.6 An important and valued member of the Leeds Health & Care Partnership are colleagues in the Third Sector. The sector is facing a considerable challenge financially given both the cost-of-living crisis (demand and inflationary pressures) and tightening statutory sector funding availability. West Yorkshire ICB have agreed a set of principles on how we should work with the sector going forward. The statutory partners in Leeds have met and written to Forum Central describing how we will seek to apply these principles and to welcome further conversations (see Appendix 1).

6 Other Leeds Health & Care Partnership News

6.1 Leeds has declared itself a Marmot City. Under the leadership of Public Health in Leeds City Council we will be working together to look to how we best address collectively, wider determinants of health and address the inequalities in health outcomes. Michael Marmot and his team will be working closely with us in this endeavour. The Leeds Health & Wellbeing Board will provide oversight of this work and all partners in the wider health system (along with many others) will want to play our part in what is an exciting opportunity.

6.2 The Long-Term Conditions Population Board have been overseeing a piece of work on reducing stroke through the early identification, appropriate monitoring, and treatment of individuals with Atrial Fibrillation. This has had a significant positive impact building on initial pilot work initiate with us by NHSE. Colleagues from the city medicines optimisation team, pathway integration team and primary care working with providers have reduced the risk of stroke for many people. This demonstrates a strong population-based piece of work (full report Appendix 2).

6.3 The Long-Term Conditions Programme Board have also been working with Leeds Academic Health Partnership (LAHP) to submit a bid for research funding. It is envisaged, if successful, the National Institute for Health and Care Research (NIHR) Systems Engineering Innovation hubs for Multiple long-term Conditions (SEISMIC) Programme will bring our Engineering and Physical Sciences Research Council (EPSRC) and NIHR research communities together with NHS Leeds services, to improve the real-world experiences and quality of life for people with Multiple Long-Term Conditions (MLTCs). This will also increase equality and equity in the design and delivery of health and care services. Work has already been undertaken in Leeds to segment the population and provide a detailed understanding relating to a geographical and

ethnicity perspective. Alongside this there is a well-established partnership board with all members at the table focussed on this population which has put us in a strong position. The LAHP noted the wider opportunities such an approach may bring us.

6.4 During this last year the Core20plus funding was used to support some small-scale projects in a number of areas to address health inequalities. We were able to move the money-out quickly and as a result we are now in the process of evaluating progress. An evaluation report will follow in the next couple of months and initial findings are extremely positive.

7 The Leeds Committee of the ICB are asked to:

a) **Note** and **consider** the report

b) **Advise** on future content

8 Appendices

1. Letter to Forum Central
2. Report: Celebrating our work on Atrial Fibrillation (AF) in Leeds

Leeds Health & Care Partnership

NHS West Yorkshire Integrated Care Board

1st Feb 2023

Dear Pip,

In response to your email of 19th January 2023

I have had a conversation with all the statutory partners about our commitment to supporting the Third Sector in Leeds following PEG in October. We are very aware of the pressures the sector is under from the cost-of-living crisis, inflation, and demand. We would all want to restate the value we place on the contribution of the sector to the health of the population in general and in the specific work you do alongside us in the delivery of services.

You will be aware that the NHS and Leeds City council are also facing challenges in demand including backlogs and have significant financial constraints. However, we are aware that these demands would be made worse if the Third Sector was not able to function.

We have considered the 7 recommendations set out below and approved by the ICS. In broad terms we collectively support these and will communicate these to colleagues in our organisations working with you.

However, there are three ***important caveats*** to this broad support:

1: This agreement of the recommendations is not carte-blanche and each specific grant or contract holder will need to discuss the specific application of these recommendations in each case with the relevant individuals. There will be some instances in the specifics where these may be more difficult to implement (Principles 1-3).

So, for example, statutory organisations have strict rules about funding upfront for services and require accountable officers to sign-off such agreements. We would not be able to do this if viability of a provider was a concern. Similarly, whilst providers might want to use shortfalls in recruitment to increase wages the long-term consequences need to be understood and mutually agreed. These will be case-by-case conversations and we will be mindful of not creating unhelpful precedents.

2: In agreeing changes to what is delivered statutory organisations will be looking to work with Third Sector colleagues to identify innovative ways the outcomes envisaged in funding arrangements could still be delivered even if the details are changed (Principle 2). This will be a pre-requisite for any conversations, and again will be case by case.

3: We would want to see that the Third Sector itself is able to articulate how it is seeking to rationalise either in organisational terms or through bringing together support functions. It is in this context we can look at the role of Anchor Institutions in partnering arrangements (Principle 5) as well as addressing the other principles. We envisage this being part of wider transformation of the Third Sector landscape and look forward to working with you on that.

Whilst Recommendation 1 has challenges as referenced above, we would want to iterate our commitment to prompt payment and would ask that any issues with this are drawn to our attention.

Whilst we are broadly supportive of these immediate recommendations and will seek to apply them with the caveats above; we are cognisant that there are wider and longer-term issues that we will need to collectively address and look forward to working with you on these. I will look to find time through PEG to identify the best way to take these forward.

Kind regards

Tim Ryley

Place Lead (Leeds)

Cc: Cath Roff, Caroline Baria, Dr Phil Wood, Dr Sara Munro, Thea Stein.

ICB Key recommendations for support to the Third Sector:

1. Provide statutory grant/contract payments upfront to support cash flow and no longer provide payment in arrears

2. If inflationary uplifts are not possible, provide greater flexibility in use of funding already allocated to VCSE organisations (e.g. vacancies funding to pay salary uplifts or cover increased energy costs)

3. Minimise reporting requirements/onerous re-tendering processes where possible – saving staff time to focus on delivery

4. Explore funding mechanisms and opportunities across WY ICB - including winter pressures funding, resilience funding and creative use of vacancies funding within statutory organisations - to invest in maintaining VCSE services in line with local plans and priorities

5. Explore or accelerate the role of Anchor Institutions (including Community Anchor organisations / larger VCSE organisations) in partnering with and supporting their local small and micro VCSE organisations

6. Bring together funding offers in Place where possible to simplify and streamline processes for the VCSE sector (particularly grassroots with less bidding capacity)

7. Plan and communicate now regarding recommissioning services due to end in March 2023 – can contracts be extended? Or if contracts are being finished, give notice to organisations now to minimise staff destabilisation.

Leeds Health & Care Partnership

NHS West Yorkshire
Integrated Care Board

Long Term Conditions Population Board	**Agenda item:**	
DATE OF MEETING: 23rd February 2022	**Category of Paper (✓)**	
ICB in Leeds Lead: Lindsay McFarlane, Head of Pathway Integration, Long Term Conditions Emily Turner, Advanced Pharmacist, Pathways and Inequalities	**Decision and Approval**	
Paper Author: Lindsay McFarlane, Head of Pathway Integration, Long Term Conditions Emily Turner, Advanced Pharmacist, Pathways and Inequalities	**Position Statement**	
Paper Title: Celebrating our work on Atrial Fibrillation (AF) in Leeds	**Information**	✓
	Discussion	✓

This paper has previously been reviewed or advice sought by:

(please ✓ as applicable)		Name of advisor:
Finance		
HR		
Governance		

Other - please note any other forums this paper has been sighted at
e.g.: Quality Performance Cttee, Integrated Commissioning Executive (ICE), Clinical Commissioning Forum, Council of Members, Commissioning for Value

Alignment to populations in the Health Leeds plan (please indicate Y where there is a link):

Healthy Populations		Maternity		Children and Young People (Mental Health)		Children and Young People (Long Term Conditions)	
Children and Young People (SEND)		Long Term Conditions	Y	Mental Health		LD and Autism	
Cancer		Frailty		End of Life		All of these populations	
Not applicable							

Specify Healthy Leeds Strategic Indicators where applicable (as listed in template guidance):

Health Outcome Measures	Improve Healthy Life Expectancy and narrow the gap Reduce Potential Years of Life Lost (PYLL) avoidable causes & rates of early deaths and narrow the gap Reduce premature mortality for those with LD and SMI and narrow the gap
System Activity Metrics	**Primary/Community Services:** Increase proportion of people being cared for in P/C services **Hospital Care:** Reduce rate of growth in non-elective bed days and A&E attendances Reduce number of face to face appointments in hospital
Quality Experience Measures	Improve the experience for those using Primary Care services Improve the experience for those using Hospital services Improve the experience for those using Community services Person Centred Co-ordinated Care Experience – P3C-EQ

1. Background / Context to this paper - The Why?

Within Leeds stroke prevention in Atrial fibrillation (AF) has been a key priority for a number of years and significant work has been undertaken locally. This paper, produced in collaboaration with stakeholders involved in the Leeds Anticoagulation and Thrombosis Task and Finish Group, aims to summarise work undertaken to date to improve anticoagulations rates in AF, the strategic context, impact and learning of this work, and make recommendations for future approaches.

Atrial fibrillation (AF) is an irregular and often very rapid heart rhythm (arrhythmia) that can lead to blood clots in the heart. Symptoms of AF include palpitations, chest pain, tiredness, shortness of breath, finding it harder to exercise and dizziness or feeling faint.

The pillars of AF management are focused on detection of AF, ensuring the condition doesn't affect quality of life, protection against stroke and perfecting treatment to gain maximum benefit from stroke risk reduction and symptom control.

AF increases the risk of stroke, heart failure and other heart-related complications. AF increases the risk of stroke 5 fold. Stroke caused by AF tends to be severe with 20% being fatal and 60% being disabling with significant associated health and social care and societal costs. AF patients at high risk of stroke should be prescribed anticoagulant medicines if safe to do so, which reduce the risk of stroke by 60-70%. Where patients on anticoagulation still have strokes they are less significantly severe with less associated disability. Stroke prevention in AF is a key priority within the NHS Long Term Plan and the national target is for 90% of people with AF who are known to be at high risk of a stroke to be adequately anticoagulated by 2029.

Anticoagulant medicines include the direct oral anticoagulant (DOAC) medicines and warfarin, which was the mainstay of AF stroke risk reduction therapy in to the mid-2010s when DOACs came on to the market. Since around 2017-2018 DOACs have become the first line therapy option for stroke-risk reduction in AF in clinical practice. There have been steady increases in DOAC prescribing and reductions in warfarin prescribing.

Every year in Leeds about 280 (The Sentinel Stroke National Audit Programme, 2021-2022) people get admitted to hospital with a stroke due to AF. More than two thirds of these people, despite being known to have AF before their stroke, are not receiving anticoagulation of any sort. Data tracking the percentage of AF patients prescribed an anticoagulant is inconsistent with sources showing variations from 72% to 93% of high-risk AF patients being anticoagulated in Leeds. In April 2022 a more accurate data source become available and is now being used to track changes in anticoagulant prescribing against the national target. At the time of writing, 83% of high risk AF patients in Leeds are prescribed an anticoagulant.

Preventative work on anti-coagulation prescribing to avoid stroke forms a core priority within our Stroke Priorities commitments due to be published in 2023 (priorities previously reviewed and agreed by the Long Term Conditions Population Board in late 2022).

2. Long Term Conditions Population Board – Prioritisation of AF; a plotted timeline

Historical context

Historically anticoagulation for AF has been managed predominantly by secondary care in Leeds because warfarin was the main therapy option until the mid-2010s and required very regular blood monitoring and dose changes. Management of warfarin continues to be undertaken by Leeds Teaching Hospitals (LTHT). While warfarin prescriptions are written and supplied by general practice, there is limited primary care input into warfarin monitoring and management. When DOACs became a therapy option in the early 2010s, Leeds Area Prescribing Committee chose to make these medicines restricted to be prescribed by general practice only upon recommendation by secondary care. This was due to the limited experience of general practice in managing anticoagulation (and associated challenge from general practice to prescribing DOACs), and cost concerns. This created an unintentional impact of Leeds not adopting DOAC roll-out as quickly as other areas. As more patients were started on DOAC and experience in primary care increased, the classification was changed in 2015 to allow prescribing in primary care for patient's who met certain criteria and where prescribers had undertaken necessary training.

Stroke risk reduction

2019

From early 2019-2021, the former NHS Leeds CCG became an AF demonstrator site working with NHS England. Leeds received national funding and was tasked with reviewing people with non-valvular AF through the utilisation of pharmacist-led virtual clinics, and where appropriate initiate an anti-coagulant or switch the patient, if appropriate from warfarin to a DOAC.

This project began to facilitate a strong working relationship between Pathway Integration, the Medicines Optimisation team and Leeds Teaching Hospitals, Pharmacy teams.

Patients were either reviewed virtually by a pharmacist (employed by the CCG Medicines Optimisation team) or by pharmacists employed within PCNs using an agreed template with complex cases discussed with the consultant pharmacist (LTHT). Shadowing opportunities with pharmacists with more experience in anticoagulation were also provided.

Methods of delivery within each PCN varied: some pharmacists completed the whole process; some pharmacists completed the virtual reviews and then discussed each case with a GP before speaking to the patient; other pharmacists completed the virtual reviews and left it for the GP to review and initiate.

Over the course of 2019 and early 2020, 3359 patient reviews were reviewed with 323 people placed on anti-coagulant. The results are outlined below.

Results

Baseline	Number of virtual reviews undertaken	Number of patients anti-coagulated following virtual review	Number of patients not anti-coagulated (medical reason)	Number of patients not anti-coagulated (patient choice)	Number of patient AF excluded	Unknown outcome
3,359	3168	323	1709	617	455	64

During this work, the Leeds CCG formed its ‘DOAC task and finish group’, which we have recently renamed/revamped and is now called the ‘Anticoagulation and Thrombosis Task and Finish’ group. This group includes representatives from system partners including primary care.

Several learning points from the developer project were taken forwards to support development of a sustainable model of care. Specifically:

- Provision of accessible clinical support
- Robust education and training pathways
- Development of integrated care models with a focus on relationships
- Utilisation of the new PCN pharmacy workforce (pharmacists and pharmacy technicians)

2020

In April 2020, as the Covid pandemic took hold, the Leeds system made the decision to further expedite switching patients on warfarin to DOACs in line with best practice, to avoid attendance at warfarin clinics for International Normalised Ratio (INR) monitoring for Clinical Extremely Vulnerable (CEV) patients for regular blood test monitoring. The rate of switching is demonstrated by **Figure 1,** along with the overall increase in levels of anti-coagulation across the city as a result of collaborative efforts in 2019/2020.

Figure 1: Quarterly patient numbers: Anticoagulation

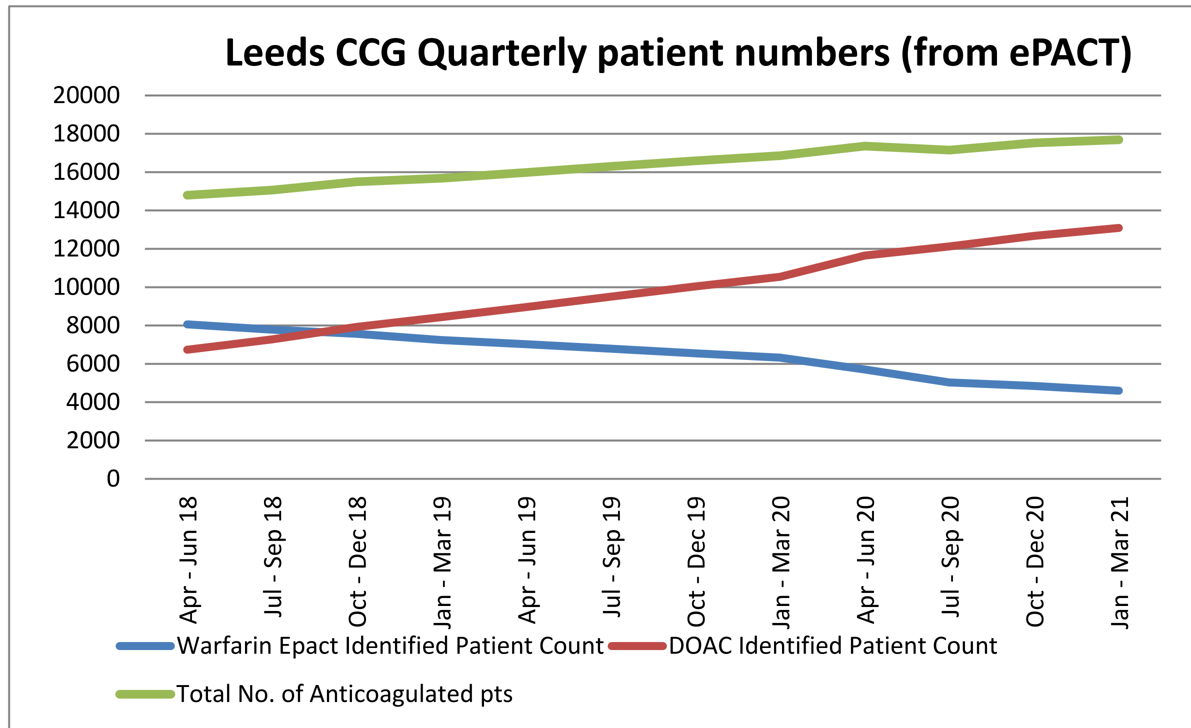
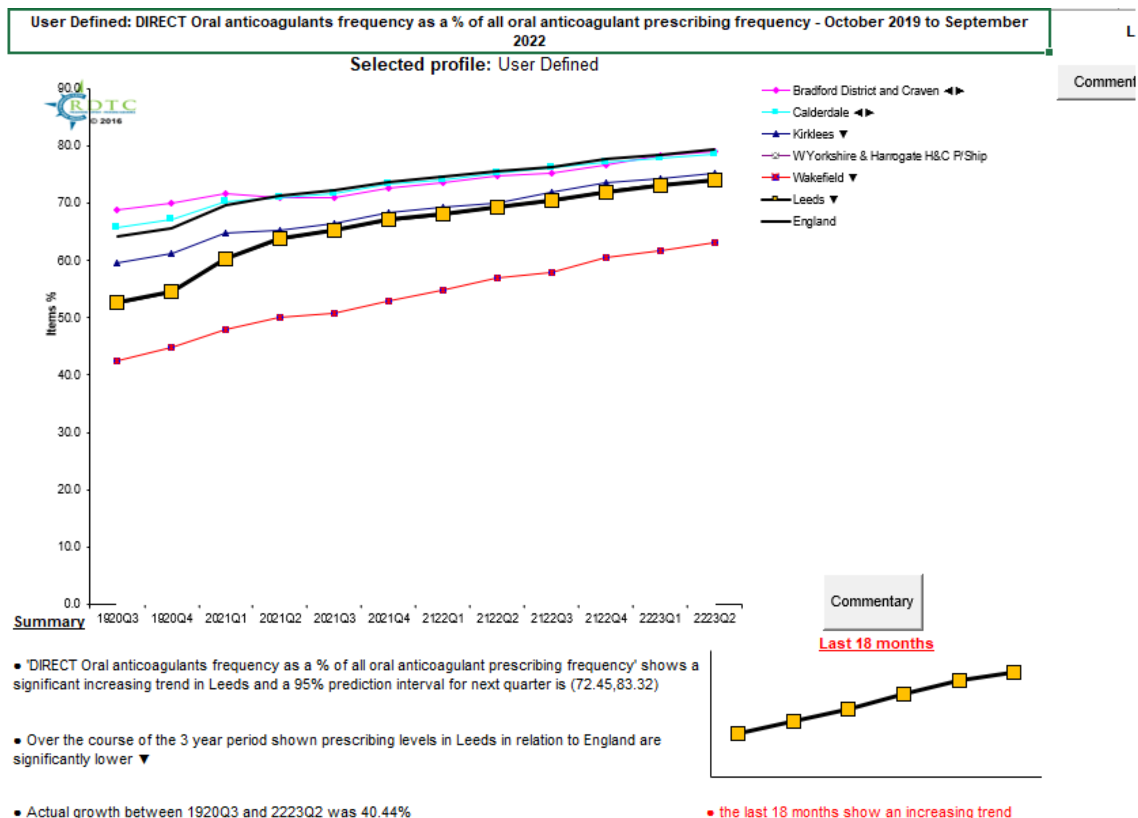


Figure 2 overleaf shows that the activities outlined brought Leeds (black line with yellow squares) in line with the ICB average, but Leeds remains significantly below the national average (black line) for DOAC prescribing.

Figure 2: DOAC frequency as a % of all oral anticoagulant prescribing



2021

To support primary care with the immediate management of additional follow-up/six-month review in primary care of people on anti-coagulants the following supporting initiatives were implemented and continue to be provided:

- Access to LTHT Advice and Guidance
- Amber Drugs Payment Scheme amended to increase payment for DOACS
- Education and training on DOACs via TARGET sessions

During 2021, Leeds Teaching Hospitals also implemented a project focusing on the anticoagulation of domiciliary patients with AF. 104 people were reviewed with 38% switched to DOAC, saving 824 appointments per year, i.e., phlebotomy and dosing appointments.

In April 2021 a new AF anticoagulation project was initiated aiming to to sustainably reduce the anticoagulation treatment gap through extensive upskilling primary care pharmacy teams in managing anticoagulation for AF and the development of system-wide clinical leadership.

In 2021 the project developed a multi-modal education approach and set up a virtual clinical discussion service ran by specialists in the Medicines Optimisation (MO) team and LTHT anticoagulation team. By the end of 2021 these had been piloted in five PCNs.

Through our collaborative working, efficiencies have been delivered within LTHT; i.e. a reduction in warfarin patients managed in clinics / housebound patient benefits as detailed within this paper. Resources released have been reinvested to support the long-term provision of the above discussion service for primary care. Complex warfarin patients remain under LTHT care.

2022

Between Jan-Apr 2022 the AF anticoagulation project was rapidly rolled out to all nineteen PCNs and the discussion service was running on a weekly basis. Simultaneously a piece of work was completed to create a digital solution to allow pharmacy teams to identify patients on inappropriate doses of DOACs and those who weren't being monitored appropriately (international data shows 10-25% of patients on DOACs for AF are on the wrong dose). Plans are in place for this support to continue long term to support sustainable changes.

In Jan 2022 an NHSE commissioning agreement came in to place making edoxaban the most cost-effective DOAC for AF stroke risk reduction. A member of the Leeds MO team led an ICS system-wide piece of work to support PCNs and practices to action the national request to switch patients from other DOACs on to edoxaban where clinically appropriate.

NHSE added 3 IIF indicators to the PCN DES in April 2022:

- CVD-05: Percentage of patients on the QOF Atrial Fibrillation register and with a CHA2DS2- VASc score of 2 or more (1 or more for patients that are not female), who were prescribed a direct-acting oral anticoagulant (DOAC), or, where a DOAC was declined or clinically unsuitable, a Vitamin K antagonist
- CVD-06: Number of patients that are currently prescribed Edoxaban, as a percentage of patients on the QOF Atrial Fibrillation register with a CHA2DS2-VASc score of 2 or more (1 or more for patients that are not female) and who are currently prescribed a direct-acting oral anticoagulant (DOAC)
- SMR-03: Percentage of patients prescribed a direct-acting oral anti-coagulant (DOAC), who received a renal function test and have a recording of their weight and Creatinine Clearance Rate, along with a recording that their DOAC dose was either changed or confirmed (not changed)

The workup undertaken in the AF anticoagulation project was prepared for this and enabled PCNs to make significant progress on these indicators to improve the approriateness and safety of anticoagulation for stroke risk reduction in AF. **Figures 4 and 5** below show progress made against CVD-05 and CVD-06 indicators as a city from April 2022, compared to the rest of West Yorkshire.

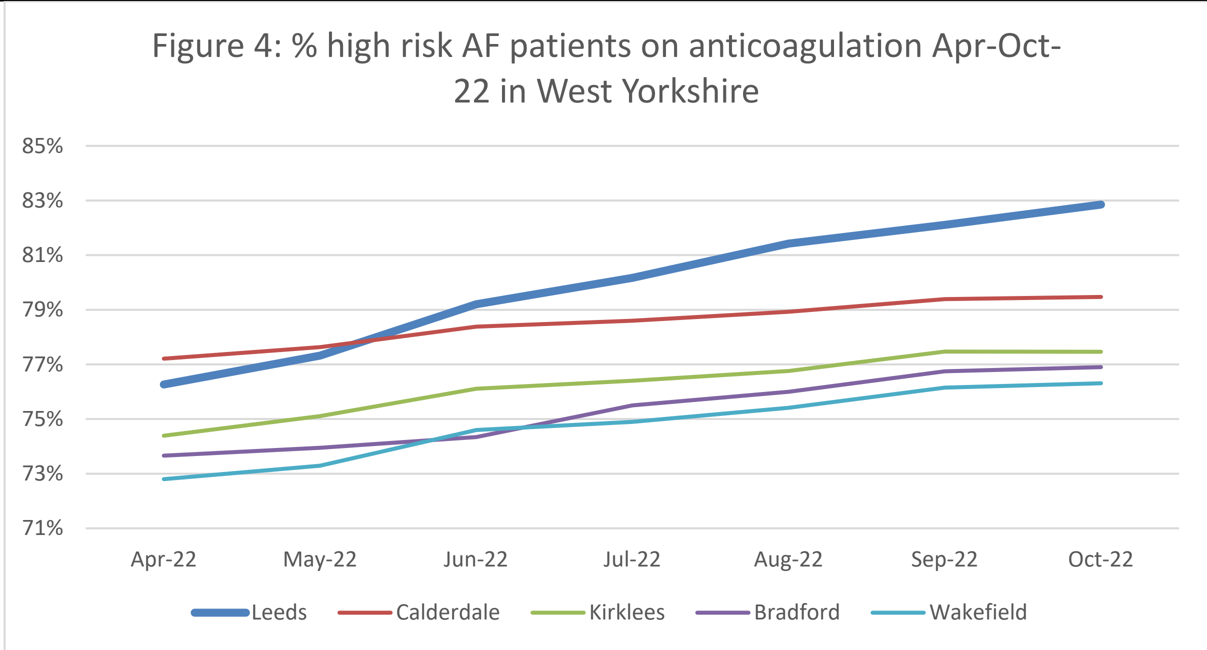


Figure 4 demonstrates a significantly faster and more intense increase in anticoagulation rates in Leeds compared to the rest of West Yorkshire highlighting the impact of the work undertaken to support primary care in managing anticoagulation for AF. As of October 2022 18 out of 19 PCNs were meeting the lower threshold for this indicator (70%) equalling a payment of up to £13,200 per PCN (list size adjusted). These figures account for an additional ~1200 patients anticoagulated in a 7 month time span.

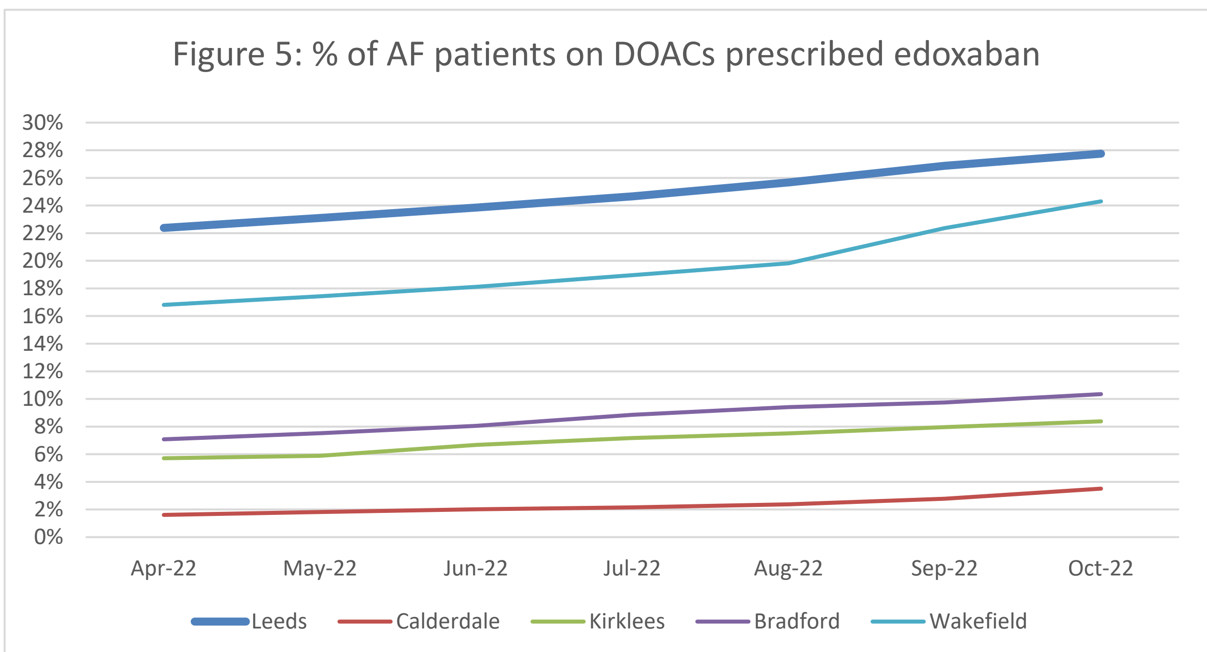


Figure 5 demonstrates the differences in increased edoxaban usage across West Yorkshire; Leeds had a higher baseline because prior to April 2022 engagement work was encouraging switching and a 1st line choice of edoxaban. As of October 2022 16 of 19 PCNs had hit the lower threshold for IIF payments (25%) equalling a payment of up to £13,200 per PCN (list size adjusted)

An additional 331 patients have been switched to the correct dose of a DOAC since April 2022 and 5390 patients on DOACs are now being monitored to guidelines who weren't in April 2022. DOAC monitoring is an area CQC are looking at when inspecting practices giving an indication of the safety implications of missing monitoring.

Only 1 of 19 PCNs was meeting the SMR-03 lower threshold (50%) in October 2022 however this is thought to be a coding issue which is being resolved. The significant improvements in monitoring show that the work is being done. SMR-03 is worth up to £2600 per PCN.

Alongside this we have worked with industry providers to benefit from national initiatives to provide additional support to PCNs in managing stroke risk reduction. In May 2022 an exploration in to patient experiences of care for AF was undertaken and contributed to future strategy.

Linked to our work on AF and also wider work on lipids, a medicines adherence research project was commenced in 2022, to understand the views and thoughts of people that take oral anticoagulants and lipids in Leeds. The project was funded by the former Leeds CCG, with research status approved by the Health Research Authority following a lengthy approvals process that commenced in 2021. The project aims to engage with 3500 people. The information currently being collated will help us understand the problems or barriers people face on anticoagulants to help us improve our service offers and achieve better outcomes of treatment, by improving patient education and staff training.

2023

We are currently working up a joint working agreement with Daichii Sankyo for a project looking at developing consensus guidelines and an MDT approach for the management of anticoagulation for AF in people living with frailty (expanding our focus to other population groups). Alongside the guideline development we aim to review 1000 patients within this project to ensure clear, appropriate, safe and effective anticoagulation decision making for this population.

Economic benefits

Economic modelling for stroke risk reduction is complex. A Stroke Association economic analysis based on 2015 prices estimated that treating 89% of high-risk AF patients with anticoagulation would save £2bn over 5 years. Taking an estimate of Leeds contributing 1% of the population that is £20m for Leeds over 5 years. If we just maintain our anticoagulation rates at 83% that is £18.65m over 5 years.

The total societal cost of AF-related stroke is £56,847 in the first year and £30,768 in subsequent years conditional on survival. Research estimates that 40% of stroke survivors live 5 years and 18% live 15 years. We need to treat 34 patients with a DOAC to prevent 1 stroke. Just accounting for the additional measured 1500 patients anticoagulated since 2019 we have prevented at least 44 strokes saving an additional ~£2.4m following the first year of stroke alone. The long term impacts of this work will have much higher cost saving benefits due to the effects on clinical leadership and ownership of anticoagulation by a large professional group sat in primary care.

The NHSE national commissioning of DOACs agreement provides rebates to ICBs for every edoxaban prescription. The work we have undertaken to support edoxaban usage is likely to result in a financial rebate of approximately £1 million in 2022/23.This rebate has and will help offset increases in the overall prescribing budget, whilst also allowing us to focus on increasing edoxaban usage. This work has also supported primary care, with >£500,000 expected to be paid directly to PCNs in Leeds from NHSE for AF-related IIF indicators 22/23.

Detection of AF

Our priority has been to evaluate the MDT approach and provide this permanently in Leeds to support medicines optimisation of anticoagulation. The remaining gaps in AF care are in detection of AF and symptom management. The national target for AF detection is 85% of the expected prevalence by 2029. In May 2021, the then Public Health England estimated 3800 people in Leeds are undiagnosed with AF and we need to find 950 to reach the 85% target. In June 2022 our prevalence of AF as a city was 1.88%; the national prevalence is 2.35% showing we are behind in detection. Our recorded prevalence is lower in areas of high deprivation. The stroke association estimate a screening programme for AF would save £223m over 5 years ~£2.2m for Leeds.

Work has started on the detection agenda. Detecting AF through opportunistic pulse checks is essential, with significant education provided with primary care on the importance of AF detection in Leeds. In April 2022, all GP practices were provided with training via Target education sessions. Improvements in knowledge of AF, continuous messaging and clinical leadership from the anticoagulation work in primary care is also expected to have had consequencial positive impacts on detection. We have been engaging with a research project (FIND-AF) looking at using AI and point of care technology posted to peoples homes to detect AF in people at high risk that is working with 3 PCNs in Leeds.

An AF detection task and finish group has been formed under the CVD steering group and is due to start work in March 2023 at a face to face event in collaboration with the national AF Association. Scoping for making this task group a West Yorkshire wide group has also been discussed. This group will also explore symptomatic and rhythm management in AF which was highlighted as an area for improvement in our patient engagement work.

3. Conclusions

Board members are asked to acknowledge the significant amount of work completed to date jointly between the medicine's optimisation, pathway integration and provider teams.

LTHT have contributed significant resource to develop these integrated ways of working and support left-shift. This programme of work demonstrates exemplar matrix team working. It should be acknowledged that transformational work of this nature, that ultimately addresses prevention and delivers long term population health benefits takes time.

The project management function delivered by the medicines optimisation team must be recognised.

In terms of next steps, board members are asked to consider the recommendations detailed in **section 4.0.**

4. Recommendations

- Through our collaborative working, efficiencies have been delivered within LTHT; i.e. a reduction in warfarin patients managed in clinics / housebound patient benefits as detailed within this paper. Resources released have been reinvested to support the long-term provision of the discussion service for primary care. Complex warfarin patients remain under LTHT care. This re-alignment of resource is an example of a system efficiency and the learnings from this, must be replicated in other LTC programmes of work. We must continue to explore system efficiency across our service offers contributing to this priority as we explore future opportunities.
- Continue to explore opportunities for collaborative working agreements with pharma for further investment; similar to joint working agreements agreed for heart failure and asthma inhalers.
- Share learning and resource to support other places in the ICB to undertake similar work as long-term finances likely to be impacted if other areas are not benefitting from rebates and reduction in stroke incidences.
- Complete our medicines aherance research, publish and implement agreed recommendations.
- Proceed with our planned focused work on AF detection.

5. Next Steps

We wish to share this exempler piece of work with the Leeds Office of the ICB EMT, Clinical Directors, the Leeds Long Term Conditions Board and partners across the West Yorksire ICS, to showcase successes to date and seek commitments on the recommendations as outlined above.

Leeds Health & Care Partnership

NHS West Yorkshire Integrated Care Board

LC 71/22

Committee Escalation and Assurance Report – Alert, Advise, Assure

Report from: Leeds Delivery Sub-Committee

Date of meeting: 23rd February 2023

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

Date of meeting reported to: 14th March 2023

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:
<u>Operational Plan</u> The sub-committee received an update on progress made in the operational planning round 23/24, including a self-assessment against the 31 National NHS objectives, in advance of consideration by the Leeds Committee meeting on 14th March 2023. Members were advised that these are national objectives and there are additional ambitions held by the Health and Care Partnership in Leeds. A significant amount of work had been undertaken by team to ensure that each objective is reported against in the most meaningful way. The sub-committee was supportive of the work undertaken to date and referred to the Leeds Committee for consideration.
Advise:
<u>People's Voices</u> The sub-committee received a 'How does it feel for me?' report and video from Healthwatch Leeds depicting Emma and Adam's experience of accessing healthcare services in the period between June 2021 and June 2022. Members welcomed the report and video as a powerful way to begin the meeting and recognised the '3 Cs' - communication, compassion, and co-ordination - as essential building blocks for good person-centred care. It was agreed that the reporting framework for the sub-committee should be developed to further integrate the '3 Cs' approach, to assure the sub-committee of work undertaken to support and promote. Members also expressed concern around the clinical pathways for dual-diagnosis as illustrated by Emma and Adam's story, and an update was requested to form part of the Mental Health Population Board bi-annual report scheduled for the next meeting.
Assure:

Population and Care Delivery Board Bi-annual Reports

The sub-committee received reports from the Children & Young People Population Board, Maternity Population Board, Healthy Adults Population Board, and the Same Day Response Care Delivery Board, which are part of the wider 11 Population and Care Delivery Boards that were set up across the Leeds Health and Care Partnership as the governance framework for the Healthy Leeds Plan and will report to each of the sub-committees to provide assurance on a bi-annual basis.

Members welcomed the first set of comprehensive reports, noting that the level of background context and range of supportive data provided was imperative to developing their understanding at this stage, and were therefore reasonably assured with the work undertaken to date. Members requested that clear measures and outcomes for each of the boards be included in future reports to evidence the difference their work is making to the populations they support. Members were advised that this work was still in progress but expected to be ready for inclusion in the next cycle of reports.

Delivery Performance Report

The sub-committee received a performance report that provided an overview of reported performance in Leeds against national and local measures and metrics. 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 throughout the challenging Winter period and anticipated periods of industrial action.

Risk Management

The sub-committee received the updated risk register and noted reasonable assurance in respect of the effective management of the risks and the controls and assurances in place. There was some discussion around the sustainability of third sector and potential impact to delivery of services in Leeds, and it was agreed that the third sector role in service delivery should be integrated in the existing risks held by the Population and Care Delivery Boards.

In reference to risk number 2018, members queried the number of control gaps for mental health services, and it was suggested that an update was provided on mitigation for demand through the Mental Health Population Board.

Sub-Committee Annual Report and Review of Terms of Reference

The sub-committee received an annual report outlining the activities and assurances provided since becoming established on 1 July 2022, and a summary of the self-assessment survey that was undertaken by members and attendees. Members agreed that the annual report and survey enabled the sub-committee to identify areas that require further improvements as the sub-committee becomes more established and membership evolves. The amends to the terms of reference were agreed and referred to the Leeds Committee for approval.

Leeds Health & Care Partnership

NHS West Yorkshire Integrated Care Board

Meeting name:	Leeds Committee of the West Yorkshire Integrated Care Board
Agenda item no.	LC 73/22
Meeting date:	14 March 2023
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) – 30 January 2023 (email)

Delivery Sub-Committee – 23 February 2023

Finance and Best Value Sub-Committee – 02 March 2023

Quality and People's Experience Sub-Committee – 07 March 2023

Executive summary and points for discussion:

This paper presents the ICB in Leeds High-Scoring Risk Report (scoring 15+) as at the end of the current risk review cycle (Cycle 4 2022/23).

Following review of individual risks by the Risk Owner and the allocated Senior Manager, all risks on the Leeds Place Risk Register were reviewed by the EMT of the ICB in Leeds and then by either the Delivery Sub-Committee, Quality and People's Experience Sub-Committee or the Finance and Best Value Sub-Committee. A number of risks are directly aligned to the Leeds Committee of the ICB, these risks are presented in this report for review by the Committee, risks scoring 12 and above are highlighted in the report.

The total number of risks during the current cycle and the numbers of Critical and Serious Risks are set out in the report.

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

☒ Improve healthcare outcomes for residents in their system

☒ Tackle inequalities in access, experience and outcomes

☒ Enhance productivity and value for money

☒ Support broader social and economic development

Recommendation(s)
The Leeds Committee of the West Yorkshire 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 sub-committees b) **Consider** whether it is assured in respect of the effective management of the risks aligned to the Committee and the controls and assurances in place.
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) 2. Appendix 2: West Yorkshire ICB Common Risks as of 17 January 2023 3. Appendix 3: Risk on a Page Report
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 4 of 2022/23) which commenced on 4 January and ends after the West Yorkshire ICB Board meeting on 21 March.

1.2 The last risk report provided an update on the risk position during risk cycle 2. Due to the WY ICB reporting cycle being bi-monthly and the ICB in Leeds reporting cycle being quarterly, risk cycle 3 was not reported to the ICB Leeds Committee. For completeness, this report sets out the changes to the risk position during risk cycles 3 and 4.

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

2. Leeds Place Risk Register

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

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

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

2.2 The West Yorkshire Risk Management Policy and Framework was reviewed in detail by risk management leads at the risk management workshop on 7 February and actions to update the framework, implementing lessons learnt from the operation of the first three risk cycles, agreed. The updated framework has been scheduled for the ICB Board on 21 March 2023.

2.3 All high scoring place risks and all risks common to more than one place is reported 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

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

  An extract of the West Yorkshire ICB Risk report (17 January 2023) showing the common risks is attached at Appendix 2.

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

- West Yorkshire ICB Quality Committee – 28 February 2023
- West Yorkshire ICB Finance, Investment & Performance Committee – 28 February 2023

And will be presented to the WY ICB Board on 21 March 2023.

2.5 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.

Work is underway with system partners to triangulate information and provide visibility of system partners high scoring risks. This will be shared with the Committee as part of the Risk Report at the next meeting.

Partner risk registers are also being consulted when populating the Population and Care Board risk register (see 2.6 below).

2.6 Work has commenced on completing the risk register for the Population and Care Boards and processes are being developed for review and reporting of risks to the boards.

The Risk Manager will act as a link between the place and the population and care board risk registers to ensure risks are included on the place risk register where appropriate, for example where a common risk has been included on other place risk registers or where a risk impacts more than one population and care board.

2.7 There are currently 26 risks on the Leeds Place Risk Register, one of which is marked for closure, leaving a total of 25 open risks.

2.8 An overview of the Leeds Place risks exposure during the current risk cycle (risk cycle 4) is provided at Appendix 3, the Risk on a Page Report. Information that can be found includes:

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

2.9 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 30 January 2023.

a) All aligned delivery risks were reviewed by the Delivery Sub-Committee on 23 February 2023.
b) All aligned quality risks were reviewed by the Quality and People's Experience Sub-Committee on 7 March 2023.
c) All aligned finance risks were reviewed by the Finance and Best Value Sub-Committee on 2 March 2023.

d) All risks aligned to the Leeds Committee are presented to the Committee in this report.

Feedback from the sub-committees may be provided through the Alert, Assure and Advise report or verbally at the Leeds Committee of the WY ICB.

2.10 **High Scoring Risks**

The last report to the Leeds Committee of the WY ICB provided an update on the risk position during risk cycle 2. The following changes have taken place since risk cycle 2:

Risk	**Cycle 2**	**Cycle 3**	**Cycle 4**	**Movement**
2158 – Prescribing Costs	12 (New)	12	16	Risk increased – Cost pressures on the prescribing budget are continuing to rise more than anticipated and financial impact for 22/23 has increased to >£3m. Total cost pressure for December was £788k compared to £148k in April and in the last 6 months prescribing spend has increased by 8%. This is mainly due to the impact of price concessions (temporary increases in the price of drugs granted by DHSC) which are almost impossible to mitigate. The cost pressure of price concessions has continued to rise to record levels (£629k in December 2022 compared to £142k in April 2022 and £67K in December 2021. The OECD estimate that inflation will fall back to 4.6% next year but due to delays in cost pressures being reflected in the drug tariff it is anticipated that the full impact of 22/23 inflation has not yet fully materialised.

Risk	Cycle 2	Cycle 3	Cycle 4	Movement
2014 – Leeds System Financial Position	20	20	9	Risk reduced due to improvement in positions of Specialised Commissioning & Yorkshire Ambulance Service which has resulted in funding released to back within the ICB system. Prescribing remains a significant issue (see risk 2158).
2016 – Risk of Harm – Elective / Cancer Waiting Lists	16	16	16	Static Risk - Clinical harm review process, first update report awaited and agreeing ICB Quality team links with LTHT. Numbers of long waiters continue to reduce in both Cancer and Elective long waiters. Links to the System Flow risk given that elective capacity is directly impacted upon by non-elective flows.
2017 – Risk of Harm – Long Term Conditions / Frailty / Mental Health Conditions	15	15	15	Static Risk – Pressures on the Mental Health system remain significant both in terms of demand and capacity. Workforce remains the key risk, and some services have exceptionally high vacancy rates, which is creating a knock-on effect on other parts of the system. System partners locally and across the ICB and the Mental Health Provider Collaboratives are working closely to mitigate risks, but these remain a real challenge both in our children's, working age and older adult services.
2018 – Risk of Harm - Mental Health Access	15	20	20	Risk increased in risk cycle 3 following discussion at the Leeds Committee meeting held in December 2022. The risk score was considered too low given the current pressures. 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%.

Risk	Cycle 2	Cycle 3	Cycle 4	Movement
2019 – Risk of Harm – System Flow	20	20	20	Static Risk - Current controls are still not sufficient to reduce the risks due to exceptionally high demand on the system. Recruitment and retention remain significantly challenging and limit the ability to create additional capacity

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

2.11 **Risks Aligned to the Leeds Committee**

2.12 There are six risks aligned to the Leeds Committee, which comprise 23% of total risks currently on the ICB Risk Register. Of these risks:

a) A risk relating to the Leeds system workforce has been added;
b) One risk is marked for closure; and
c) One risk has reduced from 12 to 9 and there is one open risk scoring 12 or above (see below).

Risk Number and Risk Title	Cycle 2	Cycle 3	Cycle 4	Movement
2013 Availability of Programme Management Resource	12	12	9	The recruitment freeze has now been lifted. This is allowing the BU to review all work in progress, identify where we have resource gaps and reprofile the structure to recruit to skill gaps. Conversations are on-going with the Health Care Partnerships Team to understand how we can share resource to allow key priorities and projects to be delivered. Two additional licences for PRINCE2 have been approved, this along with internally organised and run learning and development sessions, coupled with 121 coaching will deliver improved capability. A temporary programme manager has been appointed to increase capacity.
2225 Leeds System Workforce			12 (New)	Risk added to the risk register following agreement at the Leeds Committee of the WY ICB meeting in December 2023. The Workforce risk remains challenging across Leeds however there is collective confidence in the ability to jointly prioritise and respond to the challenges together.

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

The WY ICB Board meeting held on 17 January 2023 received an update on progress made on developing the BAF. To support the development of the BAF, a Task and Finish Group was established, which was made up of ICB Board members and partners, including Tim Ryley, Leeds Place Lead. The Task and Finish Group have overseen the linking of each principal risk to a lead director and lead committee/Board to ensure ownership of risks.

Each of the lead directors has populated the ICB core controls and assurances. The ICB Board approved the second phase, to populate the remainder of the BAF by the five places. The completed document is scheduled to be presented to the ICB Board in March 2023.

Once presented to the ICB Board on 21 March, further guidance will be provided to outline the process for how the ICB and the Place Committee of each of the five places will maintain the Assurance Framework and Risk Register through which risk management activities are prioritised and managed.

3. Next Steps

3.1 After the Leeds Committee meeting, the risks will be carried forward to the next risk review cycle which will commence after the WY ICB Board meeting on 21 March 2023.

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

4. Recommendations

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

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

b) **CONSIDER** whether it is assured in respect of the effective management of the risks aligned to the Committee and the controls and assurances in place.

5. Appendices

Appendix 1: Risk Register extract (High Scoring risks and risks aligned to the Leeds Committee)
Appendix 2: West Yorkshire ICB Common Risks as of 17 January 2023

Appendix 3: Risk on a Page Report

Appendix 1
ICB in Leeds Place Risk Register Extract

Risk ID	Date Created	Risk Type	Strategic Objective	Risk Rating	Risk Score Components	Target Risk Rating	Target Score Components	Risk Owner	Senior Manager	Principal Risk	Key Controls	Key Control Gaps	Assurance Controls	Positive Assurance	Assurance Gaps	Risk Status
High Scoring Risks (15+)																
2019	30/06/2022	Both Delivery and Quality and People's Experience	Improve healthcare outcomes for residents	20	(I4xL5)	12	(I3xL4)	Nicola Nicholson	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.	5 Additional wards open at LTHT Transfer of Care hub completely staffed and working 7 days Daily System Huddle in place to identify capacity and demand System Flow Programme refreshed and overseen by Accountable Officer Detailed winter plans developed and overseen by PEG through System Resilience Operational Group (SROG) & System Coordination Group informed by LTHT short-term COVID modelling Seasonal Activity Planning refreshed and additional capacity commissioned from November onwards, together with improvements in length of stay linked to improved processes System Escalation Actions and Processes revised continuously OPEL & System Pressures Reporting Regime Communications work with Public to suggest alternatives to ED Intermediate Care Redesign diagnostic phase complete and workstreams being established to implement short and medium term improvements 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 homefirst model. Additional Community Beds commissioned both on a block and ongoing spot basis. Bed Base Task Force working to improve the use of the community beds Further investment to improve the access to discharge services facilitated through the Hospital Discharge Fund	Key controls in place responding to high levels of demand. Current controls are still not sufficient to reduce the risks due to exceptionally high demand on the system	Health & Social Care Command & Control Groups: System Resilience Operational Group (Bronze), System Coordination Group (Silver) and System Resilience and Reset Assurance Board (Gold) Integrated Commissioning Executive Partnership Executive Group Quality and Performance Committee	Weekly meeting in place for services to report on capacity /demand Reviewed Silver Action cards Fortnightly reporting to Partnership Executive Group to update on System flow and Winter action plans fortnightly 'check in' meetings with System flow programme director to report on actions plan, overseen by Accountable officer as SRO and Chief Execs Weekly review and update of system winter plan at SROG	Opel reporting system under development for ASC but not yet finalised or shared. Recruitment and retention remain significantly challenging and limit the ability to create additional capacity	Static - 3 Cycle(s)
2018	29/06/2022	Both Delivery and Quality and People's Experience	Tackle inequalities in access, experience, outcome	20	(I4xL5)	12	(I3xL4)	Eddie Devine	Helen Lewis	There is a risk of increased rates of avoidable deteriorations in mental health, due to increased mental health demand, alongside insufficient capacity to provide access to proactive community mental health intervention and support , exacerbated further by sustained workforce recruitment and retention challenges; resulting in increases in numbers and severity of acute /crisis presentations, with consequent adverse impact on mental health presentations to ED and YAS, increased lengths of stay and reduced system flow in mental health beds, and increased numbers of out of area acute mental health and PICU bed days.	Workforce : Work to stabilise CMHTs due to high vacancy factor: including redeployment, Integrated VCSE workforce/recruitment plan progressing within the MH Trust, and additional options for stabilisation being worked through. Systematic review of MH pathways/contracts to optimize value of Mental Health Investment Standard spend through Mental Health Population Board in Leeds being progressed, commencing with Crisis pathway- incorporating formal evaluations of Oasis crisis house model, LYPFT crisis assessment unit and crisis café model provision in Leeds within this. Community Transformation: -Phased mobilisation of new model of integrated community mental health provision March23-March24 supported by integrated workforce expansion plan -Launch of grants funding scheme to target bespoke intervention and support for population cohorts at increased risk of health inequalities, led through Leeds Community Foundation Crisis Transformation Investment into range of crisis alternatives provision including helpline, Oasis crisis house, crisis cafes, crisis flats. Redesign of Crisis Service model addressing timely access to network of multiagency crisis support/intervention .Acute flow improvement including, MH Trust Acute Care Excellence quality improvement plan, . Discharge fund-Additional MH social worker resource funded Development of further plans informed by MH Trust self-assessment against Discharge Challenge criteria, including mental health multiagency discharge event. Integrated commissioning (ICB in Leeds and Leeds City Council) of range of community based mental health, wellbeing, and supported housing provision IAPT/Primary Care MH: Actions undertaken in Leeds Mental Wellbeing Service (reconfiguring the digital screening algorithm, introduction of "helpful conversations" practitioners to divert primarily social needs to the right support) have stabilised waiting times for access to psychological therapies - CBT step 3. LMWS has contracted with a new online CBT delivery partner Xyla to reduce numbers waiting- mobilisation progressing. trajectory has been shared which indicates , with the introduction of Xyla online therapy commencement of new recruited CBT therapist trainees from March , will result in the CBT waiting list numbers reducing to a manageable level of 800 by March 24	CMHT stabilisation plan (Feb 23) Review of MH crisis pathways to optimise value of investment (March 23) Evaluation of Crisis alternatives models Discharge Challenge plans Mobilisation of new model of integrated community mental health initially within 3 early implementer local care partnership/PCN sites for testing/refining prior to further phased roll-out (March 23) Access to IAPT talking therapies Developed workforce plans that fully mitigate capacity gap.	Waiting and access times to services monitored through performance metrics, Healthy Leeds Plan, and Mental Health Board Outcomes Framework.	Community Mental Health Transformation Mobilisation lead commenced in post, and phased mobilisation plan developed with anticipated timeframe of Q4 22/23 in early implementer PCN sites, Q2 23/24 phase 2 sites, and remainder Q3 23/24. In context of workforce challenges, some key access performance metrics are being maintained Access to Early Intervention in psychosis services in Leeds has made significant improvements and maintains performance above access target.	Mental health pressures remain consistently at OPEL 3E, Acute Mental Health out of area placements as of 26/01/23 12 acute, 6 PICU, 1 dementia Delayed transfers of care impacting acute capacity- increasing numbers of internal transfers of care to other pathways- low secure, and complex mental health rehabilitation pathways. Access to crisis assessment within 4 hours for urgent needs performance has remained consistently below target 50% CMHTs remains in business continuity due to significant vacancy factor. IAPT: 2,622 people on the waiting list and average step 3 /CBT waiting times at 18 months (Nov 22- last available data)	Static - 1 Cycle(s)
2158	13/10/2022	Finance and Best Value Committee	Enhance productivity and value for money	16	(I4xL4)	9	(I3xL3)	David Wardman	Gaynor Connor	There is a risk of increased prescribing costs due to inflation and supply disruption resulting in financial strain on the primary care prescribing budget.	Review prescribing budget and review all concession drugs and price changes on a monthly basis. If any actions can be undertaken to reduce the financial risk these are implemented. Messages are being shared with prescribers, pharmacies and patients to support cost-effective alternatives where possible. A prescribing QIPP plan is being implemented to offset prescribing growth We are working with primary care to improve the quality and number of structured medications reviews that can rationalise prescribing and improve cost effectiveness. We are implementing national recommendation on overprescribing to reduce unwarranted polypharmacy.	QIPP plans will take time to implement and may be offset with future price changes. Data on prescribing is released 3 months in arrears creating a lag in time to respond to any fluctuations in spend.	Review prescribing budget and review all concession drugs and price changes on a monthly basis with oversight from the Commissioning of Medicines Group. Any risks flagged with finance team as a cost pressure. QIPP plan implementation to be monitored weekly.	Monthly prescribing data	Data on prescribing is released 3 months in arrears	Increasing
2016	29/06/2022	Both Delivery and Quality and People's Experience	Tackle inequalities in access, experience, outcome	16	(I4xL4)	12	(I4xL3)	Joanna Bayton-Smith	Helen Lewis	As a result of the longer waits being faced by patients and limited capacity for treatments, there is a risk of harm, due to failure to successfully target patients at greatest risk of deterioration and irreversible harm, resulting in potentially increased morbidity, mortality and widening of health inequalities.	Joint working between ICB places and WYAAT trusts to maximise access to Independent Sector (IS) provision with a focus on increasing complexity and longest waiters. 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.	I	Frequent dialogue with ICB at Leeds and providers (LTHT/ LCH and community /IS providers) to identify and maximise opportunities to support with waiting lists. Development and implementation of roll-out plans for advice and guidance and PIFU are reviewed at LTHT Outpatient Board attended by ICB at Leeds Pathway Integration Lead. Monthly Corporate Performance reporting in place Planned Care Delivery Board oversight 2 x HI funded projects - Waiting well for Planned Care - to support people attending at A&E who are on a Planned Care waiting list and also a BI project to develop capacity and resources to enable us to focus on supporting people who are on multiple waiting lists across providers Priority work areas for the Planned Care Board including Targeted Interventions to support people on waiting lists and developing infrastructure / resource to support through Care Navigators / Support worker network. Plus a focus on range of products to support people whilst they are waiting including broadening engagement with the Patient Hub and addressing barriers to access services 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, Ongoing meetings with ICB at Leeds/ LTHT cancer team and wider partners. Implementation of actions enabled through TIF/ERF monies Implementation of initiatives funded through Cancer Recovery funding Clinical harm review process, first update report awaited and agreeing ICB Quality team links with LTHT.	Numbers of long waiters continue to reduce in both Cancer and Elective long waiters	tbc	Static - 3 Cycle(s)
2017	29/06/2022	Both Delivery and Quality and People's Experience	Tackle inequalities in access, experience, outcome	15	(I3xL5)	9	(I3xL3)	Lindsay McFarlane	Helen Lewis	There is a risk of harm to patients with LTC/frailty/mental health conditions due to the inability to proactively manage patients with LTC/frailty/mental health and optimise their treatments due to the impact of covid and other pressures 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. Collaborative Care and Support Plan 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 Additional Roles Reimbursement 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	Ability to address the pressures on the health and wellbeing of all staff across teams and recruitment plans at individual GP Practice level . Future model for health checks is currently being designed and consulted on	Static - 3 Cycle(s)
12+ Risks Aligned to the Committee of the ICB in Leeds																
2225	31/01/2023	Leeds Committee of the WY ICB	Improve healthcare outcomes for residents	12	(I3xL4)	6	(I2xL3)	Kate O'Connell	Tim Ryley	There is a risk of workforce and skill shortages due to the ability to recruit, retain and deploy our workforce effectively across our health and social care system, resulting in reduced quality and safety of services and non-delivery of improved outcomes.	The Leeds One Workforce Strategic Board (LOWSB) have oversight of the Leeds workforce risk profile providing 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) - Workforce plan and Skill-mix risk - Education & Development (Academy Steering Group) - Wellbeing risk - Absence & Employee Engagement (Wellbeing Community of Practice) Partner organisation boards have accountability for their individual statutory responsibilities in relation to workforce risks.	The Academy is currently developing a model which allows the risk profile to be tracked more systematically to improve visibility for partners.	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. Director of Leeds Health and Care Academy attends City Silver with the Chief Operating Officers to link workforce risk with operational issues.	Quarterly Academy Steering Group reports demonstrate continued positive and measurable impact across Leeds One Workforce Programme. Recent deep dives at Leeds Health and Wellbeing Board and its associated Scrutiny Board provided additional assurance. Collaborative projects assured through individual project steering groups and organisational impact across partners monitored through organisational workforce committees or equivalent.	The comparability of workforce planning data and insights remains challenging across the diversity of the health and social care sector in Leeds. This leaves a gap in assurance in the short term while working towards a longer term improvement. It has direct impact on the ability to accurately quantify the recruitment and retention challenge across Leeds and the impact of city-wide interventions.	New - Open

Appendix 2 Common Risks

Place	Risk	I	L	Score
Common risk re: Mental health services - capacity and demand				
Leeds (2018)	There is a risk of harm to patients with mental health conditions due to sustained increased demand impacting capacity to support a more responsive access to specialist mental health services, resulting in increased morbidity and widening of health inequalities.	4	5	20
Wakefield (2134)	There is a risk that older people with mental health problems do not receive optimum care due to the current configuration of inpatient services, resulting in extended length of stay and poorer outcomes	4	4	16
Calderdale (1864)	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 CCP Specialist Care/CHC team and to potentially increased costs for CCP.	3	2	6
Common risk re: Emergency departments - demand				
Leeds (2019)	There is a risk of harm to patients in the Leeds system due to people spending too long in Emergency Departments (ED) due to high demand for ED, 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.	4	5	20
Wakefield (2132)	There is a risk of patients not receiving timely care and overcrowding in ED due to imbalance between demand and capacity in urgent care services resulting in poor patient experience and outcomes.	4	4	16
Kirklees (2067)	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 - resulting in harm to patients and patient experience being compromised.	2	4	8

Appendix 2 Common Risks

Place	Risk	I	L	Score
Common risk re: Management of patients with long term conditions / frailty				
Leeds (2017)	There is a risk of harm to patients with LTC/frailty/mental health conditions due to the inability to proactively manage patients with LTC/frailty/mental health and optimise their treatments due to the impact of covid and other pressures on capacity and access resulting in increased morbidity, mortality and widening of health inequalities and increased need for specialist services.	3	5	15
Calderdale (1942)	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
Common risk re: Failure to meet Constitutional standards				
Leeds (2016)	As a result of the longer waits being faced by patients and limited capacity for treatments, there is a risk of harm, due to failure to successfully target patients at greatest risk of deterioration and irreversible harm, resulting in potentially increased morbidity, mortality and widening of health inequalities.	4	4	16
Kirklees (2066)	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), this may result in non-delivery of patient's rights under the NHS Constitution, potentially cause harm to patients, long waits and have detrimental impact on patient experience.	2	3	6
Calderdale (2162)	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
Wakefield (2129)	There is a risk of delays in people accessing planned acute care due to demand and the continued impact of COVID, resulting in poor patient experience/outcomes and non-compliance with the constitutional standards for waiting times.	4	5	20
Kirklees (2069)	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, resulting in a negative provider performance, patient experience & outcomes.	1	4	4

Appendix 2 Common Risks

Place	Risk	I	L	Score
Bradford District and Craven (2168)	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.	3	5	15
Common risk re: Financial position				
Leeds (2014)	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 not meeting the statutory duties.	3	3	9
Kirklees (2205)	There is a risk that the Kirklees Place will not achieve its financial control target due to financial pressures within the system, therefore impacting the wider WYICS. This is due to in part to several key elements including; economic uncertainty around the level of inflation, uncertainty around ERF income, pay award uplift, under delivery of efficiency programs, higher than planned agency costs and use of non-recurrent resources. The result of failure to deliver will be a risk to the achievement of the overall WYICS financial plan which could result in failure to deliver statutory duties, reputational damage and potential additional scrutiny from NHS England and a requirement to make good deficits in future years.	4	2	8
Calderdale (2148)	Calderdale System Financial Performance There is a risk that the Calderdale Cares Partnership part of the WYICS will not as a system deliver its planned financial position. This is due to in part to several key elements including; economic uncertainty around the level of inflation, uncertainty around ERF income, pay award uplift, under delivery of efficiency programs, higher than planned agency costs and use of non-recurrent resources. The result of failure to deliver will be a risk to the achievement of the overall WYICS financial plan which could result in failure to deliver statutory duties, reputational damage and potential additional scrutiny from NHS England and a requirement to make good deficits in future years.	4	3	12

Appendix 2 Common Risks

Place	Risk	I	L	Score
Calderdale (2126)	Calderdale Place (ICB) Financial Position 2022/23 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
Calderdale (2127)	2022/23 Running Costs Plan The risk is we fail to manage running cost spend within the ring-fenced allocation of £4.1m. This is due to general running cost pressures due to the annual pay award uplift being higher than expected and also contribution from place-based allocations to the central WYICB running cost requirement. Pay award inflation has not been funded by a corresponding increase in running cost allocations. Failure to deliver our running cost plan may result in the WYICB not achieving the key NHS England planning requirements and will affect the regulators assurance of the WYICB.	4	2	8
Calderdale (2163)	Calderdale Financial Strategy (future years) There is a risk that the Calderdale Cares Partnership part of the WYICS will not as a system develop a financial strategy to deliver a break-even position in future years. This is due to in part to the fact that the WYICB - Calderdale Place delegated budget has been deemed to be over its target allocation - in 22/23 this was circa £12m. In addition CHFT has in 22/23 planned for a significant deficit of circa £17m. The scale of these pressures will require a financial recovery plan to deliver a breakeven position in future years. The result of failure to deliver longer term financial balance will be a risk to the achievement of the overall WYICS financial plan which could result in failure to deliver statutory duties, reputational damage and potential additional scrutiny from NHS England and a requirement to make good deficits in future years.	4	3	12

Appendix 2 Common Risks

Place	Risk	I	L	Score
Bradford District and Craven (2171)	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

NHS
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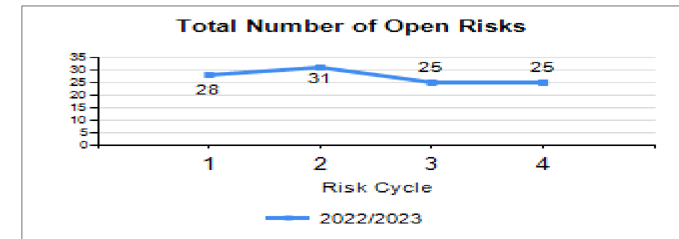
Integrated Care Board

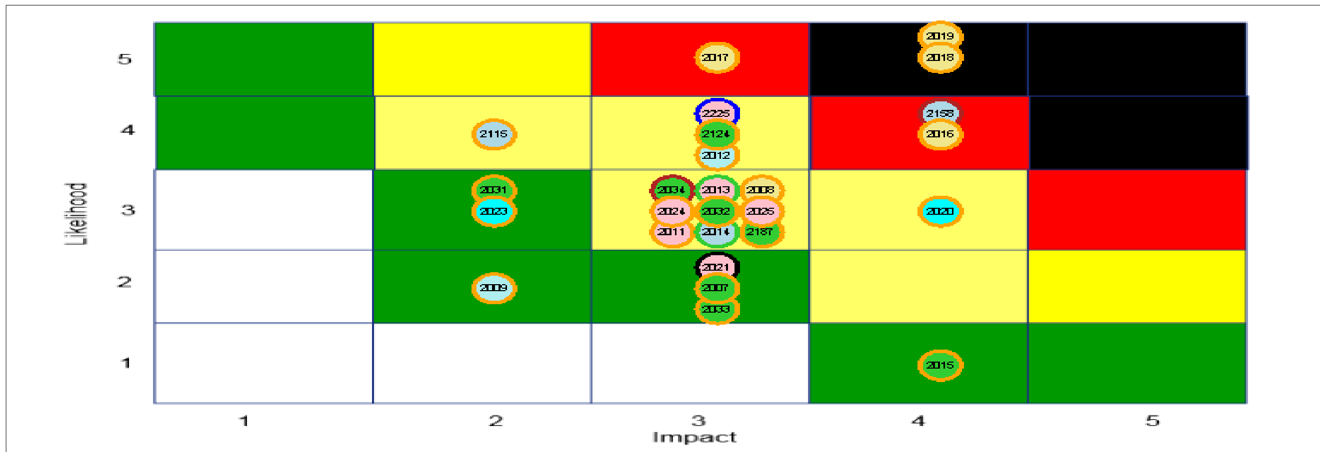
Risk Cycle 4: January – March 2023 – Appendix 3
Risk on a Page Report for the Leeds Committee of the West Yorkshire Integrated Care Board

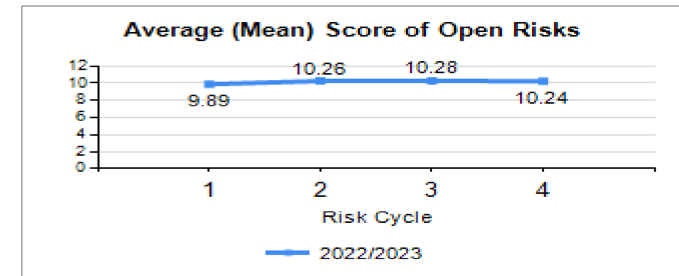
Total Risks	26 (1 closed)
Delivery	2
QPEC	2
Delivery and QPEC	5
Finance Best Value	3
Leeds Committee	6 (1 closed)
EMT	8

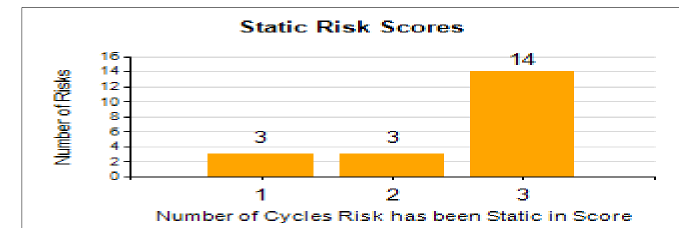
Movement of Risks	
New	1
Marked for Closure	1
Risk score increasing	2
Risk score static (1 cycle)	3
Risk score static (2+ cycles)	17
Risk score decreasing	2



Risk Overview







Key

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

- New Risk
- Closed Risk

- Risk Score Increasing
- Risk Score Decreasing
- Risk Score Static

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

Leeds Health & Care Partnership

NHS
NHS West Yorkshire
Integrated Care Board

Meeting name:	Leeds Committee of the WY ICB
Agenda item no.	LC 74/22
Meeting date:	14 March 202
Report title:	Finance Update at Month 10 January 2022-23
Report presented by:	Visseh Pejhan-Sykes, Finance Director Leeds Health and Care Partnerships
Report approved by:	Visseh Pejhan-Sykes, Finance Director Leeds Health and Care Partnerships
Report prepared by:	Gareth Winter, Head of Financial Resource Integration – Intelligence & Planning and Visseh Pejhan-Sykes, Finance Director Leeds Health and Care Partnerships

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

Previous considerations:

This report is a continuation of previous reports on the ICB in Leeds' financial position and in context of the overall NHS finances across Leeds as we approach the end of the 2022-23 financial year.

Furthermore an initial draft of 2023-24 financial plans was submitted for all NHS organisations across Leeds at the end of February 2023 with a further submission due at the end March 2023. There are still many unknowns, including most significantly, the level of pay awards likely to be agreed across the NHS, which render the initial plans only a very high level indication of the finances across, Leeds, West Yorkshire and the wider NHS. Nevertheless they serve to highlight some key emerging issues that would important for this Committee to note and debate.

Executive summary and points for discussion:

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

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.

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.

The Leeds Place collectively (Leeds Place of the ICB plus 3 NHS Providers) are currently forecasting 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.

The baseline position as we enter 2023-24 financial year is still projecting a significant and recurrent shortfall across NHS organisations in Leeds alone. The planning process is ongoing as part of the overall West Yorkshire system.

Currently across the Leeds system the initial plans suggest a financial gap of over £160m for NHS organisations alone. The WY gap is just under £294m. This represents 4.5% of the total NHS budget for 2023-24 across West Yorkshire and excludes any agenda for change settlements over and above 2% for 2023-24.

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

☐ Improve healthcare outcomes for residents in their system

☐ Tackle inequalities in access, experience and outcomes

☒ Enhance productivity and value for money

☐ Support broader social and economic development

Recommendation(s)

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

a) **NOTE** the month 10 year to date and forecast financial position.
b) **NOTE** the additional key risks that may crystallise later in the year.
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:

N/A

Appendices

1. Month 10 ICB of Leeds Summary Position
2. Non-Recurrent Turnaround Measures and its impact 2022/23
3. February 1st Draft Plan Submissions for the Leeds NHS System with detailed slides to be presented at the meeting in support of the latest financial planning position 2023-24

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 Context and Background information

1.1 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.

1.2 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.

1.3 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.

1.1 The Leeds Place collectively (Leeds Place of the ICB plus 3 NHS Providers) are currently forecasting 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. Even then, although the risks are potentially manageable across the wider Leeds and WY systems, many measures may continue to be non-recurrent.

1.2 The baseline position as we enter 2023-24 financial year is still projecting a significant and recurrent shortfall across NHS organisations in Leeds alone. The planning process is ongoing as part of the overall West Yorkshire system.

1.3 Currently across the Leeds system the initial plans suggest a financial gap of over £160m for NHS organisations alone. The WY gap is just under £294m. This represents 4.5% of the total NHS budget for 2023-24 across West Yorkshire and excludes any agenda for change settlements over and above 2% for 2023-24.

2 Key Points

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

	Planned Surplus £m
ICB In Leeds	6.4
LTHT	7.6
LYPFT	1.1
LCH	1.0
Leeds Total	**16.1**

2.2 As at month 10, the Leeds Place and West Yorkshire are still planning to meet their forecast plan but a number of risks emerged in year for LTHT and the Leeds Office of the ICB. LTHT and the Leeds Office of the ICB 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.

2.3 We are also pursuing all possible avenues to seek financial cover for risks that have emerged since the enacting the turnaround plan. Prescribing and Independent Sector Elective activity have increased significantly and are likely to be offset by national support in 2022/23.

2.4 Many 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.

2.5 Prescribing costs risks continue to rise and potential further increases in Independent Sector activity and Continuing Healthcare should be noted as the system looks to close the financial year.

2.6 Although the Leeds Place collectively (Leeds Place of the ICB plus 3 NHS Providers) are forecasting to meet their original planned surplus of £16.1m, the forecast plan for the Leeds place in 2023-24 is currently a deficit of £160m. This is due to the heavy reliance on non-recurrent measures by both LTHT and the ICB in Leeds to balance its 2022-23 finances. These have left both organisations depleted of any flexibilities to manage further in-year risks in future.

2.7 Given the fast changing and dynamic pace of the financial information being produced for the end of February submission, a set of slides will be presented to the meeting to share the details of the latest submissions.

3 Next steps

3.1 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.

3.2 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. 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.

3.3 The next submission of the financial plan will be for the end of March 2023. Depending on the scale of the gaps across systems and the changing position on pay settlements for NHS staff, it will be difficult to assess how much will be resolved and how much will remain to be determined by that date.

4 Recommendations

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

a) **NOTE** the month 10 year to date and forecast financial position.
b) **NOTE** the additional key risks that may crystallise later in the year.
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 10

RESOURCE	YTD Plan £000	YTD Spend £000	YTD variance £000	Annual Plan £000	Forecast Spend £000	Annual Variance £000
Allocation - Programme	1,191,446		-1,191,446	1,427,426		-1,427,426
Allocation - Primary Care Co-Commissioning	121,525		-121,525	144,227		-144,227
Allocation - Running Costs	11,388		-11,388	13,758		-13,758
Total Allocation	**1,324,359**	**0**	**-1,324,359**	**1,585,410**	**0**	**-1,585,410**
Expenditure						
Acute	656,081	659,289	3,208	786,710	790,874	4,164
Mental Health	167,606	168,393	786	201,156	201,496	340
Community	173,889	172,499	-1,391	208,969	205,448	-3,521
Continuing Care Services	51,238	55,051	3,814	61,493	62,815	1,322
Prescribing and Primary Care	134,123	136,072	1,949	160,279	163,220	2,941
Primary Care Co-Commissioning	122,507	123,052	545	145,714	150,632	4,918
Other	11,291	11,532	240	14,012	13,819	-193
Programme Reserves	-7,780	-7,345	435	-13,094	-16,730	-3,636
					-6,190	-6,190
Sub Total Programme	**1,308,956**	**1,318,543**	**9,587**	**1,565,239**	**1,565,384**	**145**
Running Costs	11,612	10,815	-797	13,758	13,612	-146
Total	**1,320,568**	**1,329,358**	**8,790**	**1,578,997**	**1,578,996**	**-**

Appendix 2 – Impact of 22-23 Non-Recurrent Measures to Hit Planned Position, Further Risks and Other Considerations

	£m
Planned Surplus for 22-23	**6,413**
Use of Non-recurrent Balance Sheet Flexibilities	-13,312
Slippage on schemes in Year	-10,513
One Off Windfall on National Insurance Rate Change	-1,700
Non-recurrent Allocations – some likely to be repeated in 23-24	-12,708
In year Cost pressures (S117, CHC, Prescribing, IS) Covered by in Year Support	-10,053
Further Risks Potentially in M11 &12 (S117, CHC, Prescribing, IS)	-3700

Appendix 3 – February 1st Draft Plan Submissions for the Leeds NHS System

	2022/23	2023/24
February 2023 Plans	£m	£m
LTHT	7.6	(156.4)
LCH (potentially improve by £4.5m allocation not accounted for)	1.0	(12.5)
LYPFT (excludes further risks for out of area patient activity)	1.1	(2.6)
Leeds Place of the ICB	6.4	(34.9)
ERF & COVID, discharge, Ockenden and capacity funding "unallocated" share for Leeds (54.3m less 8m committed spend for Ockenden and Discharge costs and ERF out of WY only)		46.2
Leeds Place TOTALS	16.1	(160.2)
WYICB TOTAL (4.5%)	0.0	(293.6)

Leeds Health & Care Partnership

NHS West Yorkshire Integrated Care Board

Meeting name:	Leeds Committee of the West Yorkshire Integrated Care Board
Agenda item no.	LC 75/22
Meeting date:	14th March 2023
Report title:	NHS Operational Planning 2023/24
Report presented by:	Tim Ryley, Place Lead
Report approved by:	Jenny Cooke (Director of Population Health Planning) / Helen Lewis (Director of Pathway Integration)
Report prepared by:	Catherine Sunter (Head of Population Health Planning) / 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:

The Delivery Sub-Committee (23rd February 2023) received an update on progress made in the operational planning round 23/24, including a self-assessment against the 31 National NHS objectives, in advance of consideration by the Leeds Committee meeting on 14th March 2023. Members were advised that these are national objectives and there are additional ambitions held by the Health and Care Partnership in Leeds. A significant amount of work had been undertaken by team to ensure that each objective is reported against in the most meaningful way. The sub-committee was supportive of the work undertaken to date and referred to the Leeds Committee for consideration.

Executive summary and points for discussion:

- An update on the progress of the NHS operational planning cycle for 2023 / 24
- By exception, details of areas where further work will be undertaken to meet plans for 2023/24
- Local plans and planning and will be cognisant of national requirements. This includes reflecting the health inequalities requirements as set out in the Core20Plus5

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>

1. **NOTE** and **COMMENT** on the current position in terms of the operational planning round
2. **NOTE** that the leads place position will be shared to inform the WY NHS ICB system submission

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. Link to 2023/24 priorities and operational planning guidance
2. 31 NHS Planning Objectives

Acronyms and Abbreviations explained

WY – West Yorkshire NHS ICB

ED – Emergency Departments

KLOE – Key Line of Enquiry

MSK - Musculoskeletal

LYPFT – Leeds and York Partnership NHS Foundation Trust

FIT - faecal immunochemical test typically for bowel cancer

NICE – National Institute for Health and Care Excellence

CVD – cardiovascular disease

CORE20PLUS5 - NHS approach to support the reduction of health inequalities, with defined target population cohorts and 5 focus clinical areas

LHCP – Leeds Health and Care Partnership

What are the implications for?

Residents and Communities	Activity plans to be agreed for 2023/24 to support access to health care services
Quality and Safety	No direct implications
Equality, Diversity and Inclusion	No direct implications
Finances and Use of Resources	Activity plans to be agreed for 2023/24 to support access to health care services
Regulation and Legal Requirements	No direct implications
Conflicts of Interest	No direct implications
Data Protection	No direct implications
Transformation and Innovation	No direct implications
Environmental and Climate Change	No direct implications
Future Decisions and Policy Making	No direct implications
Citizen and Stakeholder Engagement	No direct implications

1. Background and Context

1.1 This report provides the Leeds Committee with an update on progress made in responding to the NHS operational planning round for 23/24 and to highlight any emerging issues identified to date. It does not provide detail on the financial or workforce returns even through it is acknowledged that the three are intrinsically linked.

1.2 The Leeds place submitted our draft return to the West Yorkshire ICB in mid-February. A verbal update on initial feedback provided from West Yorkshire and NHS England can be provided at the Leeds Committee on the 14th March. At the time of submitting this report no feedback has been received.

Context and Background information

1.3 The 23/24 priorities and operational planning guidance states that the overall objective for the NHS this year is to achieve three clear tasks:

- Recovery of core services and productivity
- Make progress in delivering the key ambitions of the NHS Long Term Plan
- Continue transforming the NHS for the future

1.4 Within the planning guidance, 31 National NHS objectives are described that cut across the following areas:

- Urgent and emergency care
- Community health services
- Primary Care
- Elective care
- Cancer
- Diagnostics
- Maternity
- Use of resources
- Workforce
- Mental health
- People with a learning disability and autistic people
- Prevention and health inequalities

1.5 Although the 23/24 planning guidance has a focus on 31 objectives, it should be noted that the full activity planning requirement remains much more significant in line with previous years. The operational planning template requests 88 trajectories, and a number of these break down into sub-trajectories. Many of these are requested from both a provider and an ICB perspective. It is also important to note that

not all these trajectories map to 31 objectives. There are a number of the 31 objectives for which no trajectories have been requested – they will however feature in local plans.

1.6 The final NHS objective on the list under 'prevention and health inequalities' is '*continue to address health inequalities and deliver on the Core20PLUS5 approach'*. This objective refers to the CORE20PLUS5 frameworks for children and adults (a separate framework for each). These frameworks focus on reducing health inequalities for the most deprived 20 per cent of the population (core 20 – although in West Yorkshire the focus is on the 10% given that is already a significantly high proportion of the population – 26% in Leeds), reducing inequalities for particular population groups identified locally (plus) and accelerating improvements in five clinical areas (5). There are five specific measures in both the adults and the children's frameworks. These measures will be built into our local dashboards and monitored from an inequalities perspective.

1.7 To support the coordination and completion of this work, partners from NHS organisations have been meeting regular as part of our Citywide Planning Group.

1.8 A significant change this year is that locally all objectives and trajectories have been linked to a Population and Care Delivery Board (or other established governance groups where appropriate). Given tight timescales for completion of the draft return, boards have had minimal influence to date although Pathway Integrators have been working with some colleagues on the boards to collate information. It is anticipated that conversations with boards on the areas they are overseeing will take place in March 2023 to influence the final return. Boards will be asked to oversee achievement of the trajectories allocated to them. Current performance will be set out in their individual dashboards, so they have the information to do this.

Current Position

1.9 At the time of writing this report an initial draft activity planning submission has been made to WY with all applicable areas completed based upon the available guidance. Complementary additional guidance in the form of the UEC Recovery Plan has been published, however we are still anticipating the publication of the Primary Care Recovery plan that will inform this planning cycle and local plans.

1.10 Any points flagged within this paper are in relation to the 31 objectives as described above. This report also does not contain the detail of the additional 88 trajectories therefore, whilst this report can provide a level of assurance against the 31 objectives, it does not seek to detail the 88+ trajectories.

Current known points to note in relation to the 31 National NHS Objectives

1.11 A summary of those objectives that have been identified as requiring further work in order to be fully achieved can be found below:

- *Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals.* A significant number of areas detailed do not currently accept direct referrals. To make changes across all areas significant financial and pathway redesign resource would be required. The intention is to focus on ophthalmology over the next year and to create greater consistency in the Musculoskeletal (MSK) offers.
- *Achieve a 5% year on year increase in the number of adults and older adults supported by community mental health services.* There is a significant amount of activity in this area through the community transformation programme. Recruitment of the workforce required is a significant risk to achieving this objective. In addition to this much of the activity to support the delivery of this ambition is delivered through teams outside of LYPFT – for example third sector organisations. At present these contacts will not be counted towards this measurement as they do not flow through to the Mental Health data set.
- *Reduce adult general and acute (G&A) bed occupancy to 92% or below.* The system will be aiming for a reduction that enables improved ED performance. It is anticipated at present that this will be around 98%.
- *Make it easier for people to contact a GP practice, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within two weeks and those who contact their practice urgently are assessed the same or next day according to clinical need.* Current performance in terms of people receiving an appointment within 2 weeks is 80%. There are plans to continue to increase this although it is very likely additional investment will be required. This may come through the Primary Care Recovery Plan, which is expected at the end of February, but staffing will remain a challenge.
- *Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028*. Performance against

this measure is unknown as staging data is not consistently recorded. This is an on-going challenge for the system and impacts on our ability to understand health inequalities in terms of Cancer diagnosis.

1.12 Other areas of challenge for the system include:

- Elective recovery funding has been made available to deliver 107% of 2019 / 20 levels of weighted value activity. The West Yorkshire target is 108%. This target is currently seen as being unrealistic, however this is intrinsically linked to developing plans to support capacity across the system.
- As a system we have an effective advice and guidance process although we are unable to measure all the pre and post referral advice and guidance and consequently the diversion rate is substantially understated. This approach has been shared to WY and a way of better estimating this performance is currently being considered.
- There is a new trajectory required in relation to Cancer *'Percentage of Lower GI Suspected Cancer referrals with an accompanying FIT result'*. In Leeds we have a long standing and well embedded concurrent pathway. There is a concern that the nationally preferred approach could have a negative impact on health inequalities and may pose a risk unless adequate safety netting processes could be put in place. Therefore, we are proposing to keep the pathway that is already in place.

1.13 Overall feedback from the city-wide planners this year is that this year's planning process has been a significantly more challenging exercise because of the level of uncertainty in terms of financial allocations. Due to this uncertainty, there may yet be a requirement to amend planning submissions ahead of the final submissions in March.

2. Next Steps

2.1 As a health and care partnership, the current collaborative approach to completing the planning return will continue until the final submission is made.

2.2 Any feedback from West Yorkshire or NHS England on the draft submission will be accommodated within the final submission.

2.3 As the final planning submission date has been mandated by NHS England as the 30 March places have been requested to be submit their final return to West Yorkshire by 23rd March. It is requested that the final submission is approved by the Leeds Place Lead, Tim Ryley.

2.4 Each ICB has been asked to deliver a Joint Forward Plan (JFP). As a minimum this should describe how the ICB, and its partner trusts intend to arrange and / or provide NHS services to meet the population's physical and mental health needs. A high-level outline of the plan needs to be produced by the end of March 2023 with the final version (following consultation) by the end of June 2023. It needs to be aligned with 2023/24 NHS Operational Planning Guidance. The West Yorkshire ICB plan will be made up of plans from each of the five places and an overarching section describing the West Yorkshire contribution. There is no intention by the West Yorkshire ICB to develop a standard approach for 'places' to complete this. The intention in Leeds is to combine development of the JFP with the refresh of the Healthy Leeds Plan, ensuring a single plan setting out the short, medium and long term priorities for the system. There will be a focus on producing an initial draft of this over the coming month.

3. Recommendations

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

a) **NOTE** and **COMMENT** on the current position in terms of the operational planning round

b) **NOTE** that the leads place position will be shared to inform the WY NHS ICB system submission

4. Appendices

NHS England » 2023/24 priorities and operational planning guidance

NHS Planning Objectives

Appendix 2

Recovery of core services:

Urgent and emergency care	Improve A&E waiting times so that no less than 76% of patients are seen within 4 hours by March 2024 with further improvement in 2024/25
	Improve category 2 ambulance response times to an average of 30 minutes across 2023/24, with further improvement towards pre-pandemic levels in 2024/25
	Reduce adult general and acute (G&A) bed occupancy to 92% or below
Community health services	Consistently meet or exceed the 70% 2-hour urgent community response (UCR) standard
	Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals
Primary care	Make it easier for people to contact a GP practice, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within two weeks and those who contact their practice urgently are assessed the same or next day according to clinical need
	Continue on the trajectory to deliver 50 million more appointments in general practice by the end of March 2024
	Continue to recruit 26,000 Additional Roles Reimbursement Scheme (ARRS) roles by the end of March 2024
	Recover dental activity, improving units of dental activity (UDAs) towards pre-pandemic levels
Elective care	Eliminate waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer or in specific specialties)
	Deliver the system- specific activity target (agreed through the operational planning process)
Cancer	Continue to reduce the number of patients waiting over 62 days
	Meet the cancer faster diagnosis standard by March 2024 so that 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days
	Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028
Diagnostics	Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%

	Deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostic waiting time ambition
Maternity	Make progress towards the national safety ambition to reduce stillbirth, neonatal mortality, maternal mortality and serious intrapartum brain injury
	Increase fill rates against funded establishment for maternity staff
Use of resources	Deliver a balanced net system financial position for 2023/24
Workforce	Improve retention and staff attendance through a systematic focus on all elements of the NHS People Promise

Delivering the key NHS Long Term Plan ambitions and transforming the NHS

Mental health	Improve access to mental health support for children and young people in line with the national ambition for 345,000 additional individuals aged 0-25 accessing NHS funded services (compared to 2019)
	Increase the number of adults and older adults accessing IAPT treatment
	Achieve a 5% year on year increase in the number of adults and older adults supported by community mental health services
	Work towards eliminating inappropriate adult acute out of area placements
	Recover the dementia diagnosis rate to 66.7%
	Improve access to perinatal mental health services
People with a learning disability and autistic people	Ensure 75% of people aged over 14 on GP learning disability registers receive an annual health check and health action plan by March 2024
	Reduce reliance on inpatient care, while improving the quality of inpatient care, so that by March 2024 no more than 30 adults with a learning disability and/or who are autistic per million adults and no more than 12–15 under 18s with a learning disability and/or who are autistic per million under 18s are cared for in an inpatient unit
Prevention and health inequalities	Increase percentage of patients with hypertension treated to NICE guidance to 77% by March 2024
	Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20 percent on lipid lowering therapies to 60%
	Continue to address health inequalities and deliver on the Core20PLUS5 approach

Leeds Health & Care Partnership

NHS West Yorkshire Integrated Care Board

Meeting name:	Leeds Committee of the West Yorkshire Integrated Care Board
Agenda item no.	LC 76/22
Meeting date:	14 March 2023
Report title:	Leeds Health and Wellbeing Strategy Refresh - a strategy to 2030
Report presented by:	Tony Cooke, Chief Officer, Leeds Health Partnerships Wasim Feroze, Strategy and Partnership Development Manager, Leeds Health Partnerships
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Purpose and Action			
Assurance ☒	Decision ☒ (approve/recommend/ support/ratify)	Action ☒ (review/consider/comment/ discuss/escalate	Information ☒

Previous considerations:

The Leeds Health Partnerships Team has continued to engage with and update key partners and relevant forums, committees and Boards to inform the development of the refresh HWS. A series of events including two Leeds Health and Wellbeing Board (HWB) workshops (in October 2022 and January 2023). Further engagement with stakeholders has also included the Leeds Scrutiny Board (Adults, Health and Active Lifestyles), Healthwatch Leeds Board, Forum Central Health and Care Leaders Network, and the Children and Young People Partnership.

Executive summary and points for discussion:

Since 2012 it has been a statutory requirement to have a Health and Wellbeing Strategy. The current Leeds Health Wellbeing Strategy (HWS) covers the period of 2016-21 providing a framework for improving health and for making Leeds the best city for health and wellbeing. This paper provides an update on the refreshed strategy, the challenges for the city and the priorities that have emerged from conversations with the Leeds Health and Wellbeing Board and key stakeholders.

The HWS refresh also provides an opportunity to both outline the principles by which the Leeds health and care system operates as well as showing how we build on the strong partnerships in the city, aligning closely to key strategic ambitions and plans including the Best City Ambition Healthy Leeds Plan and the West Yorkshire Partnership Strategy.

This report further includes the current working draft of the Leeds HWS refresh for comments.

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) **Note** the updates on the refresh of the Leeds Health and Wellbeing Strategy b) **Note** the work that has been undertaken across the Partnership as part of the refresh of the Leeds Health and Wellbeing Strategy c) To provide further comments on the attached working draft of the refresh Leeds Health and Wellbeing Strategy.
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. Developing working draft of the refresh of the Leeds Health and Wellbeing Strategy.
Acronyms and Abbreviations explained
1. HWB – Health and Wellbeing Board 2. HWS – Health and Wellbeing Strategy 3. VCSE - Voluntary, Community and Social Enterprise 4. WY ICB – West Yorkshire Integrated Care Board

What are the implications for?

Residents and Communities	The strategy refresh takes a 'person-centred, life-course' approach where wellbeing starts with people at the heart of the refreshed strategy. The refresh priorities in this paper reiterate the current HWS vision of Leeds being a healthy and caring city for all ages, where people who are the poorest improve their health the fastest. Tackling health inequalities and the impacts of poverty will be central to the development of the HWS refresh aligned to existing key strategies, plans and ambitions.
Quality and Safety	The Leeds Health and Wellbeing Board is clear in its leadership role in the city and the system, with clear oversight of issues for the health and care system. The overarching commitment to drive improved quality across the health and care system remains a key feature of the Boards' and Strategy refresh proposed priorities.

Equality, Diversity and Inclusion	This paper highlights that the HWS refresh is aligned to priorities of our Leeds Health and Wellbeing Strategy 2016-2021 and our vision of Leeds being a healthy and caring city for all ages, where people who are the poorest improve their health the fastest. This will continue to be a key feature of the strategic priorities as set out in the current Health and Wellbeing Strategy to tackle inequalities.
Finances and Use of Resources	A continued feature of the HWS refresh will be reaffirming the aim of spending the Leeds £ wisely under the strategic leadership of the HWB- sharing or integrating resources, focusing on outcomes and seeking value for money as part of a continued long term commitment to financial sustainability.
Regulation and Legal Requirements	There are no specific legal implications of this report.
Conflicts of Interest	There are no specific conflicts of interest related to this report
Data Protection	There are no specific data protection matters related to this report.
Transformation and Innovation	This paper highlights the challenges we face across the city in tackling health inequalities and the impacts of poverty, which have been further exacerbated by the Covid-19 pandemic. Whilst these challenges exist, health and care partners remain committed in their relentless focus in improving the health of the poorest the fastest. This is reflected in reaffirming the vision of the current HWS in the refresh. As the health and care system has recently gone through further transformation, the strength of the partnerships remain vital to making a real difference to the health outcomes of people across Leeds. The HWS refresh will articulate clearly the priorities and the actions to deliver on this commitment and ambition.
Environmental and Climate Change	A key feature of the strategic priorities as set out in the current Health and Wellbeing Strategy is to tackle inequalities, aligning more closely to the city's Net Zero priorities – an approach which will be reflected in the HWS refresh. Moreover, the strategy refresh will highlight the importance of tackling health inequalities influenced and directly impacted by the environment.
Future Decisions and Policy Making	Future decisions related to the HWS refresh development is outline in this report with a high level timeline of the two phase approach described in section 4 of this report.

Citizen and Stakeholder Engagement	The Leeds Health and Wellbeing Board has made it a city-wide expectation to ensure the voices of citizens are reflected in the design and delivery of strategies and services. This paper highlights the wealth of sources which will inform the development of the HWS refresh including key engagement via the Big Leeds Chat and stakeholder groups which will continue over the coming months.

1. Context for Leeds

1.1 It is particularly important that the refresh of the Leeds Health and Wellbeing Strategy has a strong focus on tackling inequality and improving both the quality and peoples experience of health and care. This is because a number of long-term challenges have been exacerbated post-Covid.

1.2 This also means being clear about the extent of challenges such as waiting times for primary and secondary care, access to NHS dentistry, healthy life expectancy, workforce and recruitment concerns and the impact of challenging financial settlements on all services. The strategy should emphasize how this has impacted on real people and their lives through clear person-based narratives.

1.3 This narrative also needs to be aspirational further supported through innovation and change, but must also have a balance and be realistic of the levers available and what the optimum service level can be given resource constraints and what is achievable.

1.4 The financial pressure on households has also intensified with the impact of the cost-of-living crisis, seeing rising inflation and prices of food, fuel and energy, all of which disproportionately impact low-income households. In many cases these households were already struggling with poverty and low wages. Linked to this is the impact of winter on people's health with potential impacts of winter illnesses including flu and Covid. The impact of financial hardship and fuel poverty further presents risks to people's health – both physical and mental. The refreshed HWS must consider the impact of the cost-of-living crisis and how this will affect people's health, building on the breadth of work underway across the city from a range of partners.

1.5 The HWS refresh also provides an opportunity to both outline the principles by which the Leeds health and care system operates as well as showing how we build on the strong partnerships in the city. Aligning closely to key strategic ambitions and plans including the Best City Ambition and two other key city pillars in Inclusive Growth and Zero Carbon, as well as the West Yorkshire Partnership Strategy and Healthy Leeds Plan, the strategy will reset our continued relentless focus on improving the health of the poorest the fastest. It will be by a renewed commitment from a cross section of partners in health and care and beyond to tackle health inequalities and the impacts of poverty.

2. The West Yorkshire Partnership Strategy and Healthy Leeds Plan

2.1 Improving health and wellbeing outcomes for people and communities across the city will also be supported and delivered together with a range of connecting

strategies, plans and commitments. Therefore, it is key that the Leeds HWS refresh also aligns to established and developing strategies such as the Healthy Leeds Plan and West Yorkshire Partnership Strategy. Whilst these plans are distinct in focus, they will all contribute to tackling health inequalities in Leeds following a life course approach, including giving people the best start in life, living well and ageing well.

2.2 In line with our ethos of subsidiarity, the West Yorkshire Partnership Strategy has been built from neighbourhoods and places to ensure that work is locally led. The place strategies including the Leeds Health and Wellbeing Strategy forms the foundation of the overall Integrated Care Strategy and the refreshed approach will continue to be key in influencing at the regional level. All partners will work together so that people can thrive in a trauma informed, healthy, equitable, safe and sustainable society. This plan is overseen and owned by the NHS West Yorkshire Integrated Care Board closely aligned to the Leeds Health and Wellbeing Strategy.

2.3 Local places including the Leeds Health and Care Partnership are delivering the Health and Wellbeing Strategy together, overseen by the Health and Wellbeing Board and the Leeds Committee of the NHS West Yorkshire Integrated Care Board.

2.4 The approach to the refreshes of both the place and West Yorkshire strategies has been inclusive. There has been the opportunity for all members of the Partnership and the wider system to be involved through a networked approach to engagement. Teams developing these strategies continue to work closely and updates of the development of the refreshes and working drafts of the HWS refresh and West Yorkshire Partnership Strategy have been presented together at the Leeds Health and Wellbeing Board. The HWB connection with the Leeds Committee of the West Yorkshire Integrated Care Board is further strengthened by the link representation of members on both committees including the Independent Chair of the Leeds Committee of the WY ICB and the ICB Accountable Officer (Leeds Place).

2.5 The Healthy Leeds Plan sets out how the Leeds Health and Care Partnership will work together to improve outcomes for everyone in our city. This Plan will be delivered by bringing together key partners in Population Boards focused on a range of priorities such as supporting access to key cancer services. The overarching system goals will directly support the Health and Wellbeing Strategy priorities such as 'the best care in the right place at the right time' and key outcomes such as 'people living longer and having happier healthy lives'.

2.6 The relationship of these strategies will remain key as we move from development to delivery and in the next phase of the development of a five-year Joint Forward Plan building on existing local strategies and plans.

3. Background

3.1 Since 2012 it has been a statutory requirement to have a Health and Wellbeing Strategy. The Health and Care Act 2012 added new sections into the 2007 Act highlighting that a *"Joint Health and Wellbeing Strategy"* is a strategy for meeting the needs identified in Joint Strategic Needs Assessment. In setting priorities for partners to address locally determined needs, making best use of local assets and tackling wider determinants of health, health and wellbeing strategies outline key priority areas for improving people's health and reducing health inequalities.

3.2 The current Leeds Health Wellbeing Strategy (HWS) covers the period of 2016-21 providing a framework for improving health and for making Leeds the best city for health and wellbeing. The current strategy highlights that wellbeing starts with people and everything is connected. As we grow up and as we grow old, the people around us, the places we live in, the work we do, the way we move and the type of support we receive, will keep us healthier for longer. Focusing on twelve priorities, the HWS articulates the aspiration of how Leeds will be a healthy and caring city for all ages, where people who are the poorest improve their health the fastest. This vision aims to support people to build resilience, live happier, healthier lives, do the best for one another and to have access to the best care possible.

3.3 Progress has been measured against the 21 indicators and updates provided to the Health and Wellbeing Board throughout this period including as part of yearly reviews.

3.4 The HWS in Leeds has widely been recognised as an example of good practice (including by the Kings Fund and Health Foundation) and was one of the first to integrate economic development priorities into the health system. The same approach has been applied by other areas across England. The levels of leadership and strong buy-in and ownership of the strategy has also been noted by key bodies such as the Care Quality Commission (CQC).

3.5 Though Leeds had made some good progress on improving the health and wellbeing of the people of Leeds progress made against some of the indicators has been impacted by the growing health inequalities exacerbated by the pandemic.

3.6 Responding to the individual and system impact of the cost-of-living crisis means that a refreshed focus on tackling health inequalities is even more important now than it has been in the past.

3.7 Work was initiated in early 2020 to review and refresh the Strategy but this was put on hold due to the Covid-19 pandemic. At the HWB development session in February 2020, the Board considered proposals and agreed an approach for extending the HWS to 2023. Work was undertaken including starting the process in drafting a refreshed strategy with further engagement with the HWB in a session in June 2020. This report provides an update on the refreshed HWS as we progress the development of city's strategic framework to address health inequalities.

3.8 **Further key developments since 2016**

3.9 There have been a number of further key developments since the previous HWS was agreed. The following is not an exhaustive list but highlights some of the key changes which will inform the HWS refresh and the city's health and care partnership in tackling health inequalities:

- **Living with Covid – the impact of the pandemic:** The impact of the Covid-19 pandemic has been felt by all communities in Leeds, but for some the impact has been greater. During 2020, clear trends and evidence emerged nationally showing that Covid-19 mortality and morbidity impacted more severely on certain groups in our population with disproportionate impacts dependent upon age, gender, pre-existing conditions, ethnicity and deprivation. The pandemic has also intensified and exacerbated existing mental health inequalities and groups who were already at risk of poor mental health are more likely to have struggled during the pandemic. Long Covid and other potential long term impacts of the pandemic on health inequalities will be a key focus of health and care partners in Leeds over coming years.

- **Health and care integration– building on the strengths of health and care partnerships:** The response to the pandemic highlighted the strength of partnerships in Leeds. This partnership is made up of organisations including Leeds City Council, NHS, the Integrated Care Board, Voluntary, Community and Social Enterprise (VCSE) and Healthwatch Leeds and it has grown from the strength to strength. The Leaving No one Behind Health inequalities Covid Vaccination programme is one of many examples where partners have worked tirelessly to ensure that every part of the city has had access to the vaccine. Moreover, the work to improve health and care delivery for local people has not stopped and the Local Care Partnerships (LCPs) across the city further developing innovative partnership working at community level to support local health needs, for example by integrating employment support

into pilot GP practices. As the health and care system navigates these challenges, it has also gone through further transformation with the Health and Care Act 2022 establishing Integrated Care Boards (ICBs) and Integrated Care Partnerships (ICPs) across England in July 2022. Along with all partners, the ICBs and ICPs are central to the new architecture for health and care integration and maintain a responsibility for bringing together key health and care partners to jointly assess population health needs and agreeing a health and wellbeing strategy.

- **Best City Ambition:** With the increasing focus on population health needs and the determinants of good health and wellbeing, it is vital that the HWS refresh firmly connects to key strategic ambitions at a local level which influence directly or indirectly people's health needs and outcomes. The Best City Ambition (BCA) sets out an overall vision for the future of Leeds, shared amongst partners and communities in the city. At its heart is the mission to tackle poverty and inequality and improve quality of life for everyone who calls Leeds home. The Ambition champions a Team Leeds approach and describes how stakeholders in the city have committed to work together. The goals and priorities it includes are structured around the three pillars of Health and Wellbeing, Inclusive Growth and Zero Carbon – all key strategic ambitions going through a process of refresh too. The Ambition was produced in response to the findings of the 2021 Leeds Joint Strategic Assessment and, through the approaches, policy goals and breakthrough priorities it establishes, seeks to drive improvement over the next decade.

- **Enabling local strategies, plans and ambition:** As mentioned earlier in this report, alongside the BCA there are the Three Pillar strategies (Inclusive Growth, Net Zero and Health and Wellbeing), wider key health and care connecting plans such as the West Yorkshire Partnership Strategy, Healthy Leeds Plan and Children and Young People Plan (currently also undergoing a refresh) and a cross section of strategic ambitions (some under development) for example the Better Lives Strategy, Mental Health strategy, Food Strategy, Culture Strategy, Digital, Physical Activity Ambition, Age Friendly, with organisational priorities across the system. It is vital all are working in alignment with the HWS refresh given their key influence in tackling health inequalities. Moreover, connecting the strategy to key vision and work already underway across partners e.g. Anchor networks; the 'Building the Leeds Way' and The Leeds Innovation Arc will be important too. Rooted in the priorities of the HWS will be a firm commitment to fairness and a key part of achieving this will be our focus in becoming a Marmot City by taking action to reduce health inequalities and looking at this with a social determinants of health lens. Work is underway to agree a plan to reduce inequalities with an initial focus on Best Start in Life and Health and Housing.

- **Interface with national strategies, approaches and relationships:** It is important that the local HWS refresh also balances the national approaches

and strategies whilst also focusing on local priorities. These include NHS priorities linked to tackling health inequalities outline in legislation and in key plans such as the NHS Long Term Plan and Core20PLUS5.Leeds has also launched the Health and Social Care Hub bringing together the Department of Health and Social Care (DHSC) and various local partners to improve health outcomes across the region. Utilising key partnership working at all levels to improve health outcomes locally will be key to driving improvements in people's health.

3.10 Significantly new to the Strategy refresh approach will be the degree of development the HWB has undertaken in relation to hearing and including the voice of health inequalities in its work. Since the current Strategy, and in part as a response to the pandemic, the HWB has established significant and multiple mechanisms for hearing, planning and responding to those communities most likely to experience inequalities.

3.11The Tackling Health Inequalities Group is a subgroup of the Board is and advisory and challenge body for the Board's and partners actions and impact on inequalities. The Board's Allyship programme has paired HWB members with key third sector organisations in the city supporting direct insight into particular geographies and communities. The Board is also an active participant in a Kings Fund supported programme to bring insight from the most under served communities to the forefront of health and care decision making (Healthy communities together).

3.12The Big Leeds Chat detailed further in this report has also taken an approach towards specific events with communities within Leeds or representative groups/organisations. The HWB has further supported the development of the Communities of Interest Network – a network of organisations which support specific communities, often underserved, to collaborate and support better health and care planning and delivery, Finally, the Board has influenced and supported the core governance of the West Yorkshire Integrated Care Board and the Leeds local team and partnership governance towards embedding tackling health inequalities as a core purpose. The mechanisms are key to the refresh, the refinement of its actions and reaffirms the Strategy's continuing ambition to reduce inequalities.

3.13The Health and Wellbeing Board considered the broad principles and approach to the HWS refresh on the 27 September 2022, and it was highlighted that this is not complete rewrite of the current Health and Wellbeing Strategy in Leeds but builds on the strengths of the current Strategy, informed by a strong evidence base of intelligence/analysis from a variety of sources and engagement exercises to understand the health inequality challenges in the city as well as the lived experiences and health and care priorities of people and communities. The

following includes examples of sources which will inform the development of the HWS refreshed priorities and outcomes:

3.14 **Joint Strategic Assessment (JSA) 2021 Findings**

3.15 The JSA is a reliable source of data about key demographic, socio-economic and health trends in Leeds. Key findings from the JSA include:

- Stalling of improvements in life expectancy for people living in low income areas and growth in concerns about mental health across all communities. The gap in life expectancy between some of our most and least affluent areas is illustrated by a difference in life expectancy of 13 years for women and 11 years for men. In terms of wider comparisons, Leeds lags regional and national averages for female life expectancy with a recent Lancet report highlighting that one area of Leeds (Leeds Dock, Hunslet and Stourton) has the lowest female life expectancy in England).

- The city's population has continued to become more diverse, in terms of age, countries of origin and ethnicity. These changing demographics highlight a growing number of older people, and the profile of young people becoming more diverse and focused in communities most likely to experience poverty.

- Covid-19 has had a profound impact on children and young people with increasing mental health challenges. The importance of closing the educational attainment gap for the children and young people most likely to be experiencing poverty and disadvantage will be a priority for partners over coming years.

- Achieving net zero carbon ambitions by 2030 will be challenging and efforts should focus on four fundamental issues for health: minimising air pollution, improving energy efficiency to reduce fuel poverty, promoting healthy and sustainable diets, and prioritising active travel and public transport.

- As we focus on longer term recovery and growth - a focus on skills and life-long learning will be a central element, for young people and those people who will need to renew their skills.

- The population is growing and becoming more diverse, and as each year passes demographic trends are reflected in our oldest generations. Older people from diverse ethnicities, cultures and communities of interest who have a particular identity or experience can also face specific challenges as their established networks and support diminish over time. We also know that many older people are more likely to have multiple long-term conditions with socio-economic inequalities being a key influencing factor.

3.16 **Big Leeds Chat 2021- priorities from people and communities**

3.17 The Health and Wellbeing Board (HWB) has made a firm commitment to being

led by the people of Leeds, acknowledging that people should be at the centre of health and care decision making. Under the leadership of the HWB, the People's Voices Partnership (PVP) was established to bring together listening teams across the Leeds health and care partnership, so they could better collaborate on improving the engagement 'experience' of local people, work together to improve insight, to champion the voices of local people in decision making, and to ensure that the voices of those living with inequalities are better heard.

3.18 The Big Leeds Chat is a key element of this engagement and is a series of innovative, citywide conversations with senior leaders from across the health and care system together with the public to listen to people's experiences around health and wellbeing and find out what matters most to them. The Big Leeds Chat in 2021 involved 43 'conversations' (in-person discussion forums open to all people) taking place with both geographical communities, communities of interest and young people organisations. These took place at a number of venues between September and November, 2021. Ten key themes emerged from these conversations and formed the basis for 10 Big Leeds Chat Statements (where the HWB agreed on 28 April 2022 to support governance arrangements to progress each Statement):

1. Make Leeds a city where children and young people's lives are filled with positive things to do.
2. Make Leeds a city where there are plentiful activities in every local area to support everyone's wellbeing.
3. Make Leeds a city where people can use with services face-to-face when they need to.
4. Make Leeds a city where people feel confident they will get help from their GP without barriers getting in the way.
5. Make Leeds a city where each individual community has the local facilities, services and amenities they need.
6. Make Leeds a city where fears about crime and antisocial behaviour are no barrier to enjoying everything the community has to offer.
7. Make Leeds a city where services acknowledge the impact of the pandemic on people's mental health and where a varied range of service- and community-based mental health support is available.
8. Make Leeds a city with affordable activities that enable everyone to stay healthy.
9. Make Leeds a city where green spaces are kept tidy and welcoming, because services understand the vital role they play in keeping people well.
10. Make Leeds a city where everyone can get around easily on public transport, no matter their location or mobility needs.

3.19 **Leeds Best City Ambition– Health and Wellbeing**

3.20 As outlined earlier, Health and Wellbeing represents one of the three pillars contained in the Best City Ambition. The Ambition describes a vision that 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." A series of priorities underpin this vision, capturing issues including equal access to services, safe and welcoming communities, children having a great start in life, building connected communities which enable people to be physically active, and the imperative to improve poor quality housing to support good health and wellbeing.

3.21 The Ambition also launched five breakthrough priorities – targeted areas of work where cross-city teams will collaborate to tackle a specific and well-define challenge or opportunity. Many of the breakthroughs have a clear link to health and wellbeing, and indeed some have secured support from the Health and Wellbeing Board. The priorities are:

- Better homes for health and wellbeing
- Promoting mental health in the community
- Inclusive green jobs
- Learning outcomes for social mobility
- Responding to the cost-of-living crisis

3.22 Consultation and engagement to support development of the Best City Ambition was delivered through a mixture of face to face and online discussions, workshops and surveys. This included discussions at all ten of Leeds's community committees, in addition to engagement with equality hubs, community forums, city partners, the third sector, local community organisations and small groups of citizens directly. Some of the key headlines related to Health and Wellbeing highlighted the importance of:

- Ensuring better and more equal access to essential services in health and education and promoting care closer to home
- Ensuring children in all areas of the city have access to best start in life
- Access to green spaces, providing a place to be active and safe for play
- Improved mental health, wellbeing, and reduced loneliness
- Tackling poverty, particularly recognising the lifelong impacts of child poverty and its role in deepening inequalities

3.23 **National research and analysis**

3.24 Alongside key local and regional data and intelligence sources, there is also a rich set of analyses which continue to inform our understanding of the impact of health inequalities and links to determinants of health. Data from sources such as the Office for Health Improvement and Disparities (OHID) regional

dashboards linked to areas for example like Housing and Health and Employment and Health will complement local analysis.

3.25 Additionally, the team responsible for developing the strategy will work closely with local universities and national think-tanks like the Kings Fund, Wellcome Trust and Health Foundation to ensure the strategy is informed by the latest local, national and international best practice.

3.26 **Approach to the Leeds Health and Wellbeing Strategy refresh -What will look familiar?**

3.27 The Leeds Health and Wellbeing Strategy 2016 – 2021 is embedded across the health and care partnership by all partners and is widely seen as one of the most effective nationally providing a strong strategic direction of health and care priorities. Owned by the city and overseen by an effective Leeds Health and Wellbeing Board, it has been recognised by organisations like the Local Government Association as innovative and delivery focused.

3.28 Informed by the engagement with HWB members and key stakeholders, a key approach to the HWS refresh will be maintaining elements of what works effectively with the current strategy and updating parts which will further strengthen our focus in tackling health inequalities.

3.29 Key elements of the current strategy approach which will remain in relation to how the Health and Wellbeing Board utilises the strategy:

- Working with local people and communities, ‘anchor organisations’ and broader partners and networks that have a significant influence on the health and wellbeing of communities (people and geographical).
- A continued focus of the united partnership as a central ‘place board’, responsible for aligning and driving the work of partners behind shared ambitions.
- Taking an asset-based, population health approach to tackle the wider determinants of health.
- Making further progress on health and care integration and prevention
- A continued commitment to long term financial sustainability - sharing or integrating resources, focusing on outcomes and seeking value for money.

3.30 Several strong features of the current strategy remain relevant today and key to our ambitions and priorities. These broadly include the following:

- Wellbeing starts with people: this will remain a key focus to ensure that the refreshed strategy retains the effective approach of people at the heart of everything we do to improve health outcomes. The strength in our communities is a key asset and supporting a health and care system powered by our diverse communities will be vital.

- The strategy is always informed and rooted in evidence such as the JSA and people's voices.
- Continues to follow a whole life course framework that will seek to achieve improved outcomes ensuring the best start in life and ageing well.
- A relentless focus on addressing health inequalities and improving the health of the poorest the fastest and being the best city for health and wellbeing supported by five clear outcomes.
- Everything is connected principle backed by inclusive partnership and a unifying narrative context focused on shared priorities to achieve our agreed vision.
- Setting the long term, strategic direction for a wide range of partners who directly and indirectly influence health outcomes.
- Measuring progress continuously and consistently.
- Continue to be outward facing and sharing good practice: unifying strategy that is recognisable and shared locally, nationally and internationally.

3.31 **Strengthening our ambition and priorities– a strategy to 2030**

3.32 Informed by engagement with the HWB and the refreshed work exercise which took place in 2020, several key principles will inform the approach to update the HWS refresh priorities: Updating the language of the strategy to reflect the current context; alignment with key strategies and plans; further clarity about the inter-relationships between the priorities whilst also being clearer what each pertain to; creating opportunity to emphasise key areas of work more explicitly which were previously 'hidden' within other priorities; ensuring that the breadth of partners can 'see themselves' in the priorities and how they can contribute and going further in directly including evidence and statistics against priorities to clearly measure where we are making progress.

3.33 With these principles in mind, the HWS refresh will cover the period from 2023 to 2030 – firmly aligning with the key connected strategies such as the Best City Ambition and the other two strategic pillars in the city which are also currently undergoing reviews.

3.34 It is vital also that the refresh HWS also connects and is aligned to key delivery plans and strategies which all contribute to improving the health and wellbeing of people and communities who live, work and visit Leeds. In recognition of this it is proposed that the HWS refresh also has a strong narrative reflecting the determinants of health and health and care integration whilst retaining priorities which respond to the findings of the JSA and engagement with the public. It is proposed that within each of the refreshed priorities clear actions are developed which can be driven forward via existing partnerships groups.

3.35 **Recent developments and headline feedback from engagement**

3.36 The Leeds Health Partnerships Team has continued to engage with and update key partners and relevant forums, committees and Boards to inform the development of the refresh HWS.

3.37 A series of events including two Leeds Health and Wellbeing Board (HWB) workshops (in October 2022 and January 2023) have taken place and the development of aligned strategies (such as Inclusive Growth, Climate and the Marmot City Commitment) has also informed the refresh HWS strategy drafting. Conversations with key partners will be continuing over coming months until a final draft HWS is presented to Health and Wellbeing Board later in 2023.

3.38 Feedback from colleagues in children's services, public health, third sector, social care and economic development has helped refine the language and achieve clearer focus on each of the twelve priorities. Further comments, particularly from people themselves in the Big Leeds Chat, from elected members, the third sector and Healthwatch Leeds has emphasised the importance of reflecting real peoples experience of accessing services and the post-pandemic challenges.

3.39 Recent engagement has also highlighted the importance of the HWS refresh having an even stronger focus on tackling inequality and the wider determinants that drive demand for healthcare whilst at the same time focusing on improving the quality of provision via the Healthy Leeds Plan and Population Boards. This also includes working to drive improvements in peoples experience of health provision and being clear about the extent of the challenges the system faces.

Issues highlighted include:

- Challenges accessing GP appointments in some areas particularly for older people who are digitally excluded
- Increasing waiting times and targets missed for elective care pathways including cancer
- Challenges meeting demand for mental health services despite effective service provision once services are accessed e.g. children's services and neurodiversity
- Access to NHS dentistry for both children and adults
- Increasing numbers of people presenting with long term conditions and disabilities and the subsequent impact on healthy life expectancy
- Inequalities evident in accessing some services and subsequent treatment/prescribing patterns showing disadvantages for some groups, for example access to vaccinations for black and minority groups and to

hormone replacement therapy for women living in more deprived areas of the city
- Workforce issues such as recruitment, sickness and workplace stress post-pandemic
- Concern about the ongoing and increasing impact of challenging financial settlements on all services.
- There is a strongly expressed view that the strategy should emphasize how these factors have impacted on real people and their lives through clear person-based narratives that build on user-focused conversations at the Health and Wellbeing Board

3.40 The below points include some of the additional key headlines from recent engagement which will be further incorporated into the development of the refreshed HWS including the up to date thinking on the 12 draft proposed refreshed priorities:

- Clarity about the role of all partners in the delivery of the strategy recognising the important role of the whole ecosystem of health and care in delivering work which improves people's health and wellbeing outcomes.
- Articulating clearly how the strategy relates to tackling health inequalities in neighbourhoods and communities across Leeds recognising different parts of the city will have different needs.
- Ensuring an effective balance of data and lived experiences to track progress of strategy delivery, including utilising further key citizen engagement opportunities like the Big Leeds Chat to measure progress.
- Importance of citizen involvement in conversations about their health and care and access to services including communities of interest groups.
- Strong support for maintaining the direction of the current strategy with refinements to reflect the current context post-Covid including new NHS governance, demographic changes and the cost of living crisis
- The need to articulate a clear narrative to underpin priority areas that explains the changes the health and care system and its partners need to make over coming years whilst ensuring that a 'golden thread' of prevention, integration and reducing inequality runs through the strategy
- Ensure this narrative is rooted in a #TeamLeeds approach that places a focus on how people feel about, and engage with, the health and care system. This should also be asset based and community focused
- Keep twelve priorities but don't group into sub-headings as this adds complexity
- Clarify key indicators but work closely with partners to ensure these are meaningful and can clearly be used to explain progress and improved outcomes by 2030
- Use clear delivery plans for priority areas that don't currently have existing plans in particular the re-prioritised work on housing, employment, inequality and research

- Ensure the Health and Wellbeing Board has a balance between ‘deep dives’ into key priorities and understanding progress across the system as a whole
- The strategy shouldn’t impose new plans where those already exist but should align to existing plans for example the Healthy Leeds Plan and Mental Health Strategy
- Consider the addition of transport and culture as key areas influencing health.

3.41 **Developing approach to the working draft of Leeds Health and Wellbeing Strategy refresh**

3.42 The current working draft is attached at Appendix 1 of this report. This draft will be further developed over the coming months, further strengthened by continued engagement with stakeholders and groups.

3.43 In response to recent feedback, to further enhance our approach to the refresh of the HWS, we will:

- Describe a clear narrative of both the health inequality challenges and how we want the city to look like by 2030 under each priority
- Have citizen involvement and communities of interest at the heart of our approach including thinking more innovatively about how we further embed the voices of communities in how we measure progress
- Action plans for key areas with existing approaches – not creating any duplication of established plans and priorities
- A stronger alignment to existing key strategies including at the city and regional level.

3.44 The HWS refresh will be a strategy to 2030 to provide flexibility to changing national priorities and enable longer term planning. The framework of the strategy will have focused priorities with equality, diversity and inclusion at the heart supported by clearer outcomes.

3.45 Engagement with the Health and Wellbeing Board and partners has also supported the development of the 12 proposed priorities in the working draft attached to this report. These priorities are:

1) A Child Friendly and Age Friendly City where people have the best start and age well
2) Strong, engaged and well-connected communities
3) Improving housing for better health
4) Safe and sustainable places that protect and promote health and wellbeing
5) A city where everybody can be more active, more often
6) A strong economy with good local jobs for all

7) Maximise benefits of world leading research, innovation and health and care technology
8) Promoting prevention and improving health outcomes through an integrated health and care system
9) An inclusive, valued and well-trained workforce
10) Support for carers and enable people to maintain independent lives
11) The best care in the right place at the right time
12) A mentally healthy city for everyone

3.46 **Partnership principles**

3.47 The effective health and care partnerships in Leeds is one of our key strengths and the response to the Covid-19 is a recent example of what can be achieved collectively when faced with unprecedented challenges. As we enter a new part of the journey of health and care integration, the Team Leeds approach continues to be vital as we support one another to make Leeds the best it can be and the best city for health and wellbeing.

3.48 In sharing ideas and learning, working in genuine partnership and being ambitious about our collective impact the values which underpin our partnership will be clearly articulated in the HWS refresh as we navigate the challenges in the short, medium and long term.

3.49 **Indicators and measuring progress**

3.50 The current strategy has 21 indicators to measure progress against and linked to this work has been undertaken to identify outcomes, metrics and indicators for the key strategies and plans such as Healthy Leeds Plan.

3.51 Further work will be progressed to simplify and consolidate the number of different metrics and indicators within the refreshed Leeds HWS Strategy and ensure there is alignment with strategies such as the Best City Ambition performance framework (under development), Healthy Leeds Plan and connect to wider connecting strategies such as the West Yorkshire Partnership Strategy.

3.52 The final Strategy indicators should be at the population level and align to the outcomes described in the Strategy whilst also supported with gathering lived experiences to help with understanding the wider impact of our partnership work.

3.53 It is important that the progress continues to be reported to the Health and Wellbeing Board. The Board continually reviews, and challenges actions taken forward reflecting on the progress annually, commissioning a review directed by the Health and Wellbeing Board. It will continue to be guided by

the Leeds Health and Wellbeing Strategy and summarises the actions and updates from those who have brought items to the Board and an overview of progress around the priorities and indicators of the Leeds Health and Wellbeing Strategy.

3.54 In understanding lived experiences, we will explore opportunities in connecting to wider performance frameworks such as the Social Progress Index (SPI). Designed by the Social Progress Imperative, a global non-profit organisation based in Washington DC, the SPI first launched in 2014 and is now used across the world, including by the United Nations, as a comprehensive measure of real quality of life.

3.55 **Visual identity**

3.56 During the Strategy refresh work, the Health and Wellbeing Board considered using an enhanced visual identity which built on the approach utilised in the current strategy and recent developments in the communications of the Leeds Health and Care Partnership.

3.57 A refreshed approach to the look and feel of the strategic documents will be more representative of people who live and work in Leeds to better represent the diversity of the communities of Leeds. It is proposed that approach is used throughout the new Strategy.

3.58 The communications plan behind the HWS refresh is also in development. Through our communications we want to tell the story of the health and care in Leeds and the Leeds Health and Wellbeing Strategy in a clear, consistent and concise way, using content that is memorable and shareworthy. As a result of our communications, we want:

- Stakeholders who will enable the delivery of the Strategy to be enthused to act and buy-into the aims and priorities. This includes extending the call-to-act beyond the health and care system, public sector organisations, and the third sector
- All people who live and work in Leeds to see the benefits of the Strategy for them, and for all of Leeds
- To enhance Leeds' reputation, locally, nationally and internationally, as a city that is proactive in tackling health and wellbeing, through collaborative working, led by a strong Health and Wellbeing Board.

4. Timeline and Next Steps

4.1 As we make progress in the development of the HWS refresh, we are building on the review work which has already taken place before the pandemic and more recent cross partnership engagement. Moreover, as the two other pillars (Inclusive Growth and Zero Carbon) are also being reviewed the timeline below seeks to ensure as close alignment as possible in producing the HWS refresh.

4.2 There will be two phases in the development of the HWS refresh:

Phase 1: high level timeline to July 2023:

- **September 2022- December 2022:** Further development in refining strategy via HWB engagement and wider stakeholder engagement.
- **January 2023-May 2023**: Further committee engagement including Health and Wellbeing Board; Executive Board and Health and Care partnership organisational bodies engagement for endorsement and comments.
- **June 2023-July 2023:** Final design of the refreshed HWS document and associated products; Engagement across health and care partnership workforces promoting HWS refresh and formal public launch of HWS refresh

Phase 2: from July 2023:

- The second phase will be to work with the Leeds Health and Wellbeing Board and partners to agree clear plans under each of the priorities. This second phase should include capturing existing work underway which are contributing to the delivery of the HWS.

5. Recommendations

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

a) **Note** the updates on the refresh of the Leeds Health and Wellbeing Strategy

b) **Note** the work that has been undertaken across the Partnership as part of the refresh of the Leeds Health and Wellbeing Strategy

c) To provide further comments on the attached working draft of the refresh Leeds Health and Wellbeing Strategy.

6. Appendices

Appendix 1: Developing working draft of the refresh of the Leeds Health and Wellbeing Strategy.

The Leeds Health and Wellbeing Strategy 2023-2030

'Leeds will be a healthy and caring city for all ages, where people who are the poorest improve their health the fastest'

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Foreword

Hello and Welcome to the Leeds Health and Wellbeing Strategy.

Our last strategy was developed in 2016 and there is so much to be proud of in our achievements since then. This has been driven by a united partnership of the council, NHS, public sector, a thriving Voluntary, Community and Social Enterprise (VCSE) network, businesses, education, academia, and organisations championing the voices of our communities, such as Healthwatch Leeds.

The most significant event since our last strategy was developed is undoubtedly the pandemic. The city's response showed how we all came together to take care of each other, supported by our resilient communities. We saw 62,000 people in health and care work together with hundreds of volunteers, to make sure people had food, medicines and wellbeing checks. We also delivered an extraordinary vaccine roll out programme embedded in our local communities with over 1.8 million doses given in Leeds.

None of this would have been possible without the strong foundation of our partnership working supported by a 'Team Leeds' ethos and approach.

Many lives were tragically lost during the pandemic and each person will never be forgotten. We now need to navigate a world which has seen health inequalities grow because of the pandemic and continuing to get worse. This is because of new challenges such as the cost-of-living crisis which will be experienced differently by different communities and across generations. The impacts of poverty are particularly felt in our most socially and economically challenged parts of the city. This highlights the importance of focusing improvements on health outcomes across the whole life course from preconception, birth and childhood, through the transition to adulthood and older age.

Breaking the cycle of poverty and poor health is more important than it has ever been. This strategy sets out the blueprint of how we plan to make a difference and improve health and wellbeing outcomes of people in Leeds, whilst learning from the experience of the past few years.

Leeds is a forward looking, great northern city and the innovation, creativity, and commitment of partners to work together to improve health and wellbeing outcomes of our people has never wavered. We recently reaffirmed our ambition to tackle poverty and inequality with our Best City Ambition. Our determination to deliver positive outcomes for people has led us to commit to becoming a Marmot City. We have a solid foundation to drive this forward with a strong economy, exceptional schools, colleges and universities, a vibrant and diverse population and growing sectors such as digital health, data and medical technology. All are key to creating a healthier, greener and inclusive place for people to live, work and visit.

It is the people of Leeds, our greatest asset, that are at the heart of driving the ambition we set in 2016 to be the best city for health and wellbeing. We know that people want to see care that is communicated well, coordinated and compassionate. We will work together to deliver this, reaffirming our vision to be a health and caring city for all ages where people who are the poorest improve their health the fastest. This will remain key to our new Health and Wellbeing Strategy to the year 2030, which sets our long-term plan to respond to the great health and care challenges we face as a city.

This strategy is launched at a time of transformation in our health and care integration journey. The creation of the Integrated Care Boards and Integrated Care Partnerships as part of wider health and care system in Leeds provides a significant opportunity to further progress our priorities

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so that they are positively felt by all communities in the city. We will look to partnerships at all levels, neighbourhood, local, regional and national to deliver our vision.

The success of this strategy will continue to be determined by how people feel and the real difference we are making in improving their health and wellbeing outcomes. It is important to acknowledge that currently people are frustrated by long waits for some services including ambulance services and accident and emergency. Accessing NHS dentistry remains hard across Leeds and some GP practices are overstretched despite working valiantly to serve their communities. Social care remains chronically underfunded and workforce challenges exist in all sectors.

As a Health and Wellbeing Board, we believe we can deliver stronger services that are integrated and effective, but we acknowledge the extent of the challenge. We remain committed to our shared vision and this is a moment where we cannot afford to fail. We won't be able to do this alone and we must all play an active part, but we believe by working together, with compassion and care as one Team Leeds, we can deliver positive changes for all our communities.

Councillor Fiona Venner
Chair of the Leeds Health and Wellbeing Board

What is the Leeds Health and Wellbeing Board?

Wellbeing starts with people; our connections with family, friends and colleagues; the behaviour, care and compassion we show one another; the environment we create to live together. We all have a part to play in Leeds being a healthy city with high quality services.

The Health and Wellbeing Board (HWB) helps to achieve our ambition of Leeds being a healthy and caring city for all ages, where people who are the poorest, improve their health the fastest. The Board exists to improve the health and wellbeing of people in Leeds and to join up health and care services.

The Leeds Health and Wellbeing Board is made up of a group of senior representatives from organisations across Leeds, including Leeds City Council, the NHS, the Integrated Care Board, the voluntary and community sector and Healthwatch, which ensures the views of the public are fully represented and acted on. There is also a cross-party political representation, with meetings chaired by the Executive Member for Adult and Children's Social Care and Health Partnerships.

The Board meets regularly throughout the year, including via formal public meetings and development workshops. We get an understanding of the health and wellbeing needs and assets in Leeds by completing a Leeds Joint Strategic Assessment (JSA), which gathers information together about people and communities in our city. The latest JSA was produced in 2021.

Listening to people is central to the work of both the Health and Wellbeing Board and partners across the city, with findings feeding into strategic planning and service delivery. The Board works collectively, with the strengths and assets of Leeds people, to oversee, influence and shape action to ensure Leeds is a healthy city with high quality services.

By 2030 people’s health and wellbeing outcomes will be…

Section to clearly describe the clear outcomes we want to see in Leeds for people and communities over their life course. This will be illustrated with for example statistics which state the current position of a particular identified health and care challenge and what improvements we need to see by 2030 to enable people to have the best start, live well, work well and age well.

The challenges and opportunities

The diverse cultures, strong economy, vibrant partnership working, and the excellent services are just some of the many strengths which make Leeds a great place to live, learn, work and visit. However, not everyone is benefitting from what the city has to offer and there are unacceptable health inequality gaps.

Stalling improvements in life expectancy for people living in low-income parts of the city demonstrates the significant health and care challenge we face. The gap in life expectancy between some of our most and least affluent areas is 13 years for women and 11 years for men. This gap is even wider between some communities such as the Gypsies and Travellers communities in Leeds, with the average life expectancy around 50 years of age compared to the city’s population of around 78 years. More widely, the Leeds Dock, Hunslet and Stourton area of the city has the lowest female life expectancy in England and over 170,000 people in the city live in areas ranked amongst the most deprived 10% nationally.

The city is also responding to the long-term developing impacts of the Covid-19 pandemic which are being felt by all communities in Leeds. The evidence however shows the risk of death and specific illnesses and conditions affect some groups disproportionately depending on their age, gender, pre-existing conditions, ethnicity and deprivation. The pandemic also worsened existing mental health inequalities amongst children and young people, who were already at high risk of poor mental health.

Moreover, nationally we are seeing an emerging picture of how the pandemic has likely contributed to worsening inequalities. This includes the link between economic inactivity due to ill health and how the cost-of-living crisis further risks increasing this inequality gap.

These great challenges will be a key focus in this long-term strategy, and we will consistently review progress to ensure we remain flexible to the changing context over the coming years.

Building thriving communities & Improving health and wellbeing

Building thriving communities where people live happier and healthier lives requires that all the right ingredients are in place. These are often referred to as the determinants of good health and wellbeing. This strategy recognises that if we are to tackle health inequalities, we must recognise

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the influence of people's socio-economic conditions on their health outcomes. This means the best start to life, good education; inclusive, stable and well-paid jobs; quality homes that are affordable and safe are some of the key ingredients to improving people's health and wellbeing. Alongside this environmental sustainability and equity in decision-making across the whole system is also vital.

The growing and changing demographics in the city highlights the profile of young people becoming more diverse and focused in communities most likely to experience poverty. In 2021 almost 24% of children (under 16) were estimated to live in poverty in Leeds, compared to 19% nationally. A growing ageing population means we must continue to focus on how we further support older people, many of whom live alone, to maintain connections with other people and to access support that meets their needs.

To be the best city for health and wellbeing everyone must work together to do the best for one another and provide the best care possible when needed.

Hearing the voices of people living with inequalities

The Leeds Health and Wellbeing Board has made a firm commitment to being led by the people of Leeds, who are at the centre of health and care decision making. Under the leadership of the Board, the People's Voices Partnership (PVP) was established to bring together listening teams across the Leeds Health and Care Partnership to ensure that the voices of those living with inequalities are better heard.

The Big Leeds Chat is a key element of this engagement and is a series of innovative, citywide conversations between senior leaders from across the health and care system and the public. These conversations are focussed on listening to people's experiences around health and wellbeing and finding out what matters most to them. The Big Leeds Chat in 2021 involved 43 'conversations' taking place with local communities, communities of interest and young people's organisations. Ten key themes emerged from these conversations and formed the basis for 10 Big Leeds Chat Statements, which have informed the priorities in the Leeds Health and Wellbeing Strategy and will be progressed through the work of the Leeds Health and Wellbeing Board:

1. Make Leeds a city where children and young people's lives are filled with positive things to do.
2. Make Leeds a city where there are plentiful activities in every local area to support everyone's wellbeing.
3. Make Leeds a city where people can use services face-to-face when they need to.
4. Make Leeds a city where people feel confident they will get help from their GP without barriers getting in the way.
5. Make Leeds a city where each individual community has the local facilities, services and amenities they need.
6. Make Leeds a city where fears about crime and antisocial behaviour are no barrier to enjoying everything the community has to offer.
7. Make Leeds a city where services acknowledge the impact of the pandemic on people's mental health and where a varied range of service- and community-based mental health support is available.
8. Make Leeds a city with affordable activities that enable everyone to stay healthy.
9. Make Leeds a city where green spaces are kept tidy and welcoming, because services understand the vital role they play in keeping people well.
10. Make Leeds a city where everyone can get around easily on public transport, no matter their location or mobility needs

The Tackling Health Inequalities Group is a subgroup of the Board and will continue to act as an advisory and challenge body for the Board's and partners' actions and impact on inequalities.

Our Communities of Interest Network brings the voices of people from 24 different communities experiencing the greatest health inequalities closer to decision-making, including representing their views to the Board.

The How Does It Feel for Me project is allowing users of health and care services to share their experiences as they move through different parts of the system. The Co-Production Network further brings together health and care partners, working together to strengthen our approaches to co-production, which enables us to involve people at all stages of change. People's voices are also at the heart of our service transformation programmes, for example the ongoing work to transform community mental health services.

To get a direct insight into the needs of marginalised communities, the Leeds Health and Wellbeing Board has developed The Allyship programme which connects Board members with key third sector organisations in the city.

This will all remain a key component in ensuring the priorities of all communities guide the work of the Health and Wellbeing Board and the delivery of this strategy.

Improving access to quality health and care services

Good health is about physical, mental, and social wellbeing. As more people continue to experience multiple long-term conditions, health and care services need to adapt to these changes. People in Leeds have told us they want to feel confident they will get the help needed from services without barriers getting in the way. We will continue to focus on this as one integrated health and care system which will improve people's health. We will also be focussed on reducing health inequalities across the entire population to build and maintain the best long-term health possible for everyone.

Having access to quality health and care services remains a key priority in this strategy. It is vital that we have timely and person-centred care and whilst the cost of providing high quality care continues to rise, we must continue to work hard to deliver this for the people of Leeds. This will ensure people's health and wellbeing can be better, fairer and sustainable.

Our system will continue to promote wellbeing and prevent ill health recognising people have different needs, and what good health looks like varies between people. By looking at our population in this way we can better understand what people need, to address the challenges they face. It will also support the Health and Care Partnership to provide high-quality services, which are easier to access and navigate, effectively meeting people's needs.

We will further develop our localities and neighbourhood-based community building approach such as Asset Based Community Development and Local Care Partnerships. This is where people and organisations work together as equal partners actively involved in the design and delivery of health and care supported by their communities.

One integrated system focused on improving health and wellbeing outcomes

Improving health services needs to happen alongside maintaining financial sustainability. This remains a major challenge. Rising cost pressures and sustained and increasing demand of health and care services means making the best use of the collective resources across organisations. This will continue to help us to develop the city's health and care system which has seen its own recent transformation supported by a strengthened governance structure including at the city level

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with the establishment of The Leeds Committee of the West Yorkshire Integrated Care Board (ICB). The ICB will make decisions about the best way to allocate resources across the city to have the biggest impact on improving health outcomes and people's experiences and reducing inequalities.

Our health and care workforce is also facing increasing pressures. It is vital that we continue to work together to make Leeds the best place to train and work at any age and to support our colleagues to flourish in safe and inclusive workplaces. We have a highly motivated, creative and caring workforce in our city, working hard to deliver high quality care for people in Leeds. It will remain important that we continue to build a strong workforce and support people. Many of whom live as well as work in the city and play a key role in helping to reduce inequalities and delivering care for the future.

Connecting strategies to better tackle health inequalities

This Health and Wellbeing Strategy is about how we put in place the best conditions in Leeds for people to live fulfilling lives in a healthy city with high quality services. Everyone in Leeds has a stake in creating a city which does the very best for its people. This strategy is our blueprint for how we will achieve that. It is led by the partners on the Leeds Health and Wellbeing Board and it belongs to everyone.

Improving health and wellbeing outcomes for people and communities across the city will also be supported and delivered together with a range of connecting strategies, plans and commitments. Each of these will help us to deliver our ambition to be the best city for health and wellbeing. We have taken a life course approach to tackling health inequalities. This means we will consider the biggest issues at each stage of a person's life from early years to older age. It will take a concerted effort across all levels - local, regional and national. An approach which recognises that a diverse range of factors including social, economic and environmental circumstance, influence a person's physical and mental health and wellbeing outcomes.

The following strategy and plans will be key in helping to deliver improved health and wellbeing outcomes for the people and communities in Leeds and we will ensure there is a clear and strong alignment across all to ensure the most effective delivery of the city's health and wellbeing strategic priorities:

Best City Ambition: The Best City Ambition is our overall vision for the future of Leeds to 2030. At its heart is our mission to tackle poverty and inequality and improve quality of life for everyone who calls Leeds home. The Best City Ambition aims to help partner organisations and local communities in every part of Leeds to understand and support the valuable contribution everyone can offer – no matter how big or small – to making Leeds the best city in the UK. As part of the Best City Ambition five breakthrough projects have been established specifically on promoting mental health in the community; better homes for health and wellbeing; inclusive green jobs; learning outcomes for social mobility and responding to the cost-of-living crisis. These will be driven by a diverse group of people and organisations drawn from all parts of Leeds. This group will agree a clear end goal to deliver progress on these key areas of focus.

Leeds Inclusive Growth Strategy: The Leeds Inclusive Growth Strategy sets out how we aim to make the city a healthier, greener and inclusive economy that works for everyone. The strategy details how we will harness partnerships across the city to improve the health of the poorest the fastest linking to people and communities with place and productivity. The Leeds Anchor Network will play a key role as part of our place-based approach to inclusive growth and community wealth

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building. Together with organisations using their economic power and human capital in partnership with communities to mutually benefit the long-term wellbeing of both.

Net Zero ambition: Leeds has committed to be carbon neutral by 2030. Tackling climate change will mean that we focus on reducing pollution and promoting cycling, walking and the use of public transport whilst also promoting a less wasteful, low carbon economy. The Leeds Health and Care Commitment will be one of many key components of addressing poor health outcomes. This Commitment is a set of principles and actions to work towards being a resilient, sustainable health and care system that mitigates the impact of climate change.

Healthy Leeds Plan: The Healthy Leeds Plan sets out how the Leeds Health and Care Partnership will work together to improve outcomes for everyone in our city. It details the areas where we know we can make a difference to people's health in Leeds and outlines how we will know we have been successful. This Plan will be delivered by bringing together key partners in Population Boards focused on a range of priorities such as supporting access to key cancer services and people who have a learning disability or who are neurodivergent.

West Yorkshire Partnership Strategy: The West Yorkshire Partnership Five-Year strategy is the vision for the future of health, care and wellbeing in the region, where all partners are working together so people can thrive in a trauma informed, healthy, equitable, safe and sustainable society. This plan is overseen and owned by the NHS West Yorkshire Integrated Care Board. Closely aligned to the Leeds Health and Wellbeing Strategy, and developed with the Leeds Health and Wellbeing Board, the delivery of the West Yorkshire Partnership strategy ambitions is set out in a Joint Forward Plan.

Leeds Marmot City Commitment: Building on the city's long history of working to address health inequalities, Leeds has committed to become a Marmot City. This involves working in partnership with the Institute of Health Equity to take a strategic, whole-system approach to improving health equity. Working collaboratively with partners and communities, we will work together to achieve a fairer Leeds for everyone. There will be an initial focus on the Best Start and Housing priorities of this work with progress being overseen by the Leeds Health and Wellbeing Board.

Our partnership principles

We will continue to work in ways that support our Team Leeds approach. The following key principles developed by the Leeds Health and Care Partnership, will underpin how we work together to deliver on our ambition and vision set in this strategy:

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.

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

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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 £.

What is the Leeds Health and Care Partnership?

We know that people's lives are better when those who deliver health and care work together.

The Leeds Health and Care Partnership (LHCP) includes health and care organisations from across Leeds: Leeds City Council, NHS partners, Voluntary, Community and Social Enterprise organisations, Healthwatch Leeds, Local Care Partnerships, Leeds GP Confederation and the Leeds Office of the NHS West Yorkshire Integrated Care Board.

We are also part of the wider West Yorkshire Health and Care Partnership which is an 'Integrated Care System' working to improve the health and wellbeing of people across West Yorkshire.

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Building on what we have achieved

- *To include case studies of key achievements of the current HWS –* ***illustrative examples included below to provide an idea of what could be included in this section.***
- *Organisations on the HWB will be asked to provide case study examples*

Case study example: Lincoln Green employment and skills project

Through our Health and Wellbeing Strategy and our Inclusive Growth Strategy, we are committed to developing a strong local economy that everyone can benefit from. The city's biggest employers are collaborating on projects via the Anchors Institution Network which support this commitment, including supporting people from poorer communities into employment.

Lincoln Green is one of the poorest communities in Leeds and was among the 1% most deprived wards nationally. The majority of households are on a very low income (74% on less than £15k), and its residents also experience some of the greatest health inequalities in Leeds. As such, Lincoln Green has been identified as a priority neighbourhood.

As a committed member of the Anchor Institution Network, Leeds Teaching Hospital Trust (LTHT), collaborated with Leeds City Council (LCC) and local charity Learning Partnerships, to deliver a bespoke recruitment process and employment programme, supporting the residents of Lincoln Green to be better equipped to successfully gain employment at LTHT.

In total, 130 people attended an employability programme, which helped improve IT skills, confidence building, application and interview skills, among others. 59 of those were successful in achieving an offer of permanent employment with LTHT

Due to the success of this programme, other Anchor Institution Network members are developing similar projects, supporting more people from poorer communities into good quality employment.

Case study example: Utilising the benefits of technology and innovation

Leeds is a hub of digital transformation. We are home to 160 med-tech and health informatics companies and home to 22% of all digital health jobs in England. This means we are perfectly placed to benefit from the power of health and care innovation and technology.

The Leeds Academic Health Partnership has been collaborating with West Yorkshire and Harrogate Cancer Alliance, local NHS trusts, and with Leeds based company PinPoint Data Science Ltd. to develop a new blood test which will support GPs to better triage patients who are showing symptoms of cancer.

This new blood test was developed using a form of Artificial Intelligence known as 'machine learning' to analyse a broad range of signals in the blood and combines with general, anonymised patient information to produce a single number: the chance that a patient has cancer.

It has been designed as a decision support tool, providing GPs with more information and enabling them to more effectively triage patients when they first present with symptoms. This revolutionary test is currently being evaluated across West Yorkshire, and if approved for full implementation, promises to deliver shorter referral waiting times, reduced patient anxiety and improved early cancer detection.

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Summary on a Page

Leeds Health and Wellbeing Strategy 2023-2030

Our ambition:
Leeds will be the best city for health and wellbeing

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

5 Outcomes

1. People will live longer and have happier, healthier lives
2. People will live full, active and independent lives
3. People's quality of life will improve with access to quality services
4. People will be actively involved in their health and care, supported by their communities
5. People will live in healthy, safe and sustainable places

Indicators TBA

We live our **Partnership Principles**

- We start with people
- We deliver
- We are Team Leeds

12 Priorities

A Child Friendly and Age Friendly City where people have the best start and age well

Why is this important?

Communities in Leeds have continued to grow, with greater diversity and a growing younger and ageing population. This developing picture is more evident in communities which face the greatest inequalities. Moreover, the legacy of Covid-19 and its impact means our commitment to be a caring city for everyone is vital. This will mean we can support people to thrive in their early years and later life.

There are now around 9,500 babies born in Leeds every year. Ensuring the best start in life provides important foundations for good health and wellbeing throughout life, enabling successful and enriching futures for our children and young people. This is also why one of the city's breakthrough projects, and the initial focus of our Marmot City commitment, is on early years.

We know the Covid-19 pandemic has further amplified the challenges facing young people. This is why targeted actions which make the most of every child's potential remains an important goal for the city as we continue to re-set and transform services. This will further affect the health of families too, recognising that our priorities can help to tackle challenges such as the disproportionate impact on women from Black ethnic backgrounds who are four times more likely to die during childbirth.

Today around 25% of people living in Leeds are 60 and above. The over 80s population is the demographic rising the fastest. The number of people in Leeds living beyond 80 is expected to rise by approximately 50% in the next 20 years. We want to be the Best City to Grow Old In. This is what underpins our Age Friendly Leeds ambition, creating a place where people age well. Where older people are valued, feel respected and appreciated and seen as the assets they are as employees, community connectors, volunteers, carers, investors and consumers.

Older people face health and care inequalities. For example, they are more likely to have multiple long-term health conditions which disproportionately affect older people living in our poorest communities. Inequalities in older age are cumulative and have a significant impact on a person's health, wellbeing and independence.

By 2030 we will…

See improved outcomes in the earliest period in a child's life, from before conception to age two. We will see parents and babies supported to create the conditions where stress is reduced, and positive bonds and attachments can form. We will work together to offer parents-to-be and new parents targeted pathways informed by women and families to improve communications, support and care before, during and after pregnancy. Care will be delivered in an integrated way such as 'Building the Leeds Way' which is a long-term vision to transform healthcare facilities across Leeds Teaching Hospitals for patients and staff.

It is also vital that we remain committed to our goal to halve stillbirths and neonatal deaths. We will deliver a strength-based localised offer where community maternity services will understand more about the locality they work in and the partners and people they work with. We will build on the outstanding social work and support journey in the city, ensuring consistent quality across all our work with vulnerable children and young people. We must remain committed to the 'Think Family, Work Family' approach, delivering solutions which are coordinated around the relationships, needs and assets in families and the wider community. This is alongside improving the mental health of

children and young people and parents and carers. We will do this by, taking a 'whole family' approach to mental health.

Making Leeds a Child-Friendly City for our children and young people must also be guided by a truly inclusive approach. Working as a partnership across health and care services, joining up practices which also deliver positive outcomes for children and young people with special educational needs and disabilities and additional needs.

Children and young people need to have a safe, healthy, and balanced diet to improve health and wellbeing outcomes. Leeds has taken a whole system strength focused approach to tackling child obesity to transform the way people's health and social care needs are supported. We must continue to focus on reducing child obesity building on the learning of pre-pandemic years. These priorities highlight the importance of wider factors such as the environment and learning influencing our health and wellbeing.

The reality of climate change also means there will be more frequent and intense weather extremes. The impact of fuel poverty also requires a continued focus on addressing the health challenges which may be affected by these circumstances such as reducing excess winter deaths. Furthermore, addressing the clear link between frailty and deprivation must remain a focus whilst delivering on the objective to ensure that people will die well and have a good death. This will need to be supported by person centred, holistic and accessible palliative and end-of-life care with personalised support for carers, families and friends.

Across all ages we must challenge the impacts of poverty, recognising the scale and effects of poverty on all communities, young and old. Working together we can mitigate these impacts on health and wellbeing outcomes and to support every child's journey into secure adulthood. This too, will ensure that the relationship between older and younger generations is defined by mutual support and compassion.

A clear action plan to deliver this priority will be developed with the Health and Wellbeing Board and relevant partners.

Strong, engaged and well-connected communities

Why is this important?

Connecting to our richly diverse communities across the city is vital if we are to address their health and care needs and improve health and wellbeing outcomes. The city's response to the pandemic highlighted what can be achieved when different organisations work together through communities to achieve shared goals. Harnessing the strength of these partnerships will remain crucial as we continue to tackle health inequalities in the coming years. This includes supporting diverse communities such as vulnerable groups, people in poverty, migrants, refugees and asylum seekers, the homeless and people with disabilities.

Pride in our communities and places are vital assets in a sustainable future for the city and its local centres. We know that whilst the Covid-19 pandemic demanded the use of digital platforms and tools for people to remain connected; this equally led to a hunger for more communities to connect with their friends, neighbours and fellow Leeds residents in person. Tackling loneliness and supporting people to keep well is vital with access to activities that are affordable, easy to get to and are balanced between in-person and digital. Access is also linked to stronger connections and making Leeds a city where people can connect with services when they need to remain important.

Work on this priority will be guided by the three Cs: Communication, Compassion and Coordination

By 2030 we will…

Have improved residents' access to digital equipment and the internet through superfast broadband.

To support strong, engaged and well-connected communities, we will build on the important work and approaches which have successfully led to transforming services and support for communities across Leeds. We will further develop the strength-based model of social work driving key work such as Street Support programme. Our well-established neighbourhood networks and the Asset Based Community Development (ABCD) approach will be vital too. Moreover, supporting digital inclusion remains important, building on the development of innovative ways to use digital to better connect people, including those living with dementia in Leeds.

Develop services that support people to access the right support when they need it, and to thrive using their individual and community assets. This will remain key in helping to reduce health inequalities in Leeds whilst also considering the impacts of the wider social determinants on people within localities.

Have reduced social isolation and loneliness, particularly where it is affecting vulnerable groups and people with high levels of need. We will commit to developing communities where no one is lonely, with diverse opportunities for people to live healthy, active and happy lives.

Support key enablers which connect our communities with a sustainable, affordable, inclusive and healthy transport network, and placemaking which encourages people to be physically active. They are crucial in enabling people to get around the city easily and safely and making it easier for people to access essential services such as health and groceries. Making it easy and safe for people to walk and cycle to services, core amenities, and facilities is not just good for health but essential for sustainable and local neighbourhoods too.

The focus of the Health and Wellbeing Board and partners will be to see progress informed by what people are telling us matters to them. This includes making Leeds a city where everyone can get around easily on public transport, no matter their location or mobility needs.

A clear action plan to deliver this priority will be developed with the Health and Wellbeing Board and relevant partners.

Improving housing for better health

Why is this important?

Housing plays a critical role as a wider determinant of health. Meeting the city's housing needs and providing high quality, safe, affordable homes in inclusive communities is a key priority. This will also mean we can support places where residents have close access to services and amenities. Improving housing for health is a key commitment in our plan to be a Marmot City and is a breakthrough project in our Best City Ambition. This demonstrates our strong city commitment to improve outcomes on this priority area which all partners will be key to helping deliver.

Proactive and preventative housing solutions support people to live independently and minimise preventable health and social care interventions, which need to be a key feature to improve people's health and wellbeing**.** The opportunities provided by innovative digital and technology

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solutions will be increasingly significant too, not only in supporting people to be healthy and independent in their home but also in creating healthier living environments.

By 2030 we will…

Have made clear progress in ensuring that adaptations, minimising hospital admissions and streamlining hospital discharges are linked to housing needs. We will also ensure that key referral pathways for those affected by homelessness and mental health support are collaborative.

Have developed a whole system approach to supporting independence of children and young people, and adults as part of an integrated system to achieving cost-effective solutions and positive outcomes for people. Supporting diverse housing options tailored to individual needs will be a key element of this such as extra care housing. Supporting people to live in housing that can accommodate future support and care needs in an environment that promotes social inclusion and active independence will be important too.

Have made significant progress in addressing the impact of fuel poverty by improving health and wellbeing through increasing affordable warmth without increasing carbon emissions. Crisis intervention for vulnerable people in cold homes will also need to be a key part of tackling poverty and health inequalities.

A clear action plan to deliver this priority will be developed with the Health and Wellbeing Board and relevant partners.

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Safe and sustainable places that protect and promote health and wellbeing

Why is this important?

Health protection and promotion has always played a key part in tackling health inequalities. The response to the Covid-19 pandemic highlighted the vital role of our health protection system which responded rapidly and innovatively to an unprecedented and constantly shifting context. This also placed intense demands and disruption on key services, settings and workplaces across the city. As we continue to live with Covid, it is crucial that health protection and promotion continues to prioritise and work with communities most vulnerable to the impact of Covid-19.

By 2030 we will…

Have a Leeds health protection system which encourages people and systems to adopt safer behaviours and to build community resilience to any future pandemic. This will be by following public health advice, in common with longstanding ways of managing other infectious respiratory illnesses such as influenza or the common cold. The health protection system will also focus on wider prevention priorities such as the impact of poor air quality reducing the incidence of tuberculosis and excess winter deaths.

Enabling every community in the city to have safe, connected and sustainable spaces to access green spaces can improve mental and physical health across all ages. We must continue to provide a wide range of opportunities for people to access quality services. People being physically active in our green spaces is vital so that everyone can enjoy being active, no matter what their abilities or interests. This can also help to reduce the incidence and severity of conditions such as obesity, heart disease, diabetes, anxiety and depression in people of all ages and backgrounds.

We want Leeds to be a welcoming city, accessible to all where children and young people have safe spaces to play and have fun; and where older people feel safe too.

Achieving this priority means expanding the network of Safe Places across the city, where a person with a learning disability can go and ask for help if they are lost, frightened or in difficulty.

People with disabilities have a right to live in the community, to move around within it and to be able to access all the places available. To enable this, we must create places where people have safe and accessible facilities available which meets their needs.

We must remain committed to support victims and survivors including those who have experienced domestic violence and abuse, to have housing options where they can live safely and be supported. This will mean improving responses and increase support to victims and survivors with complex needs (especially mental health needs) in safe accommodation.

A clear action plan to deliver this priority will be developed with the Health and Wellbeing Board and relevant partners.

A city where everybody can be more active, more often

Why is this important?

Embedding physical activity into everyday life provides a unique opportunity to contribute to improving the health and happiness of people, families and communities and can help to tackle deepening inequalities. We can reduce obesity, become more socially connected and recover better from health problems whilst also contributing to a healthier place, a greener city and a stronger local economy.

Physical activity levels in the city have been significantly affected by the Covid-19 pandemic. This has particularly affected specific groups disproportionally, including women, young people, disabled people, those with a long-term health conditions and ethnic minorities. 1 in 4 of all adults in Leeds are inactive, 1 in 3 older people are inactive, and only half of children have had the recommended one hour of physical activity a day. Inequalities have widened and lifestyle habits have changed – leading to less active and more sedentary hours.

By 2030 we will…

Have made significant progress in supporting the delivery of city's Physical Activity Ambition, focusing our efforts to address this challenging emerging pattern of physical inactivity and driving a radical cultural shift to increase physical activity over the long term.

It is important that people in Leeds feel they can be more active. A key element of this will be creating an environment where physical activity is the easiest choice to be active every day, working with people to understand the drivers affecting their physical activity levels.

It also means exploring and delivering innovative solutions to active travel with a whole system approach to health improvement and tackling health inequalities. Strong infrastructure, creative planning and behaviour change can help create active travel as an accessible, safer, healthier, more environmentally friendly option than driving. This crucially has the potential to address health disparities and deliver positive health and well-being outcomes for people in Leeds, including in the communities which face the most social and economic challenges.

A clear action plan to deliver this priority will be developed with the Health and Wellbeing Board and relevant partners.

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A strong economy with good local jobs for all

Why is this important?

Leeds has seen a significant increase in the number of people in the city who live in areas that are ranked in the most deprived 10% nationally. More than 70,000 adults are facing in-work poverty. Economic inactivity nationally is also on the rise significantly affecting people over 50 and highlighting the need to improve employment outcomes for all, including refugee and asylum seekers, people with mental health, learning disabilities and physical health problems.

A good job is really important for good health and wellbeing of working age people. Focusing on improving people's health and wellbeing is key to delivering an economy that works for everyone and where the benefits of economic growth are distributed fairly across the city, creating opportunities for all. This will include raising the bar on inclusive recruitment, better jobs, and healthy workplaces. It will mean encouraging people who have been economically inactive back into the workplace; maximising employment and skills opportunities; developing clear talent pipelines and supporting good quality careers education.

Leeds economy has many strengths including our digital health, medical technology, and health data sectors, supported by a wealth of talent and a huge concentration of innovative organisations, which means we are well placed to develop as a location of choice for health and social care businesses. Our key health and care institutions will also be vital to driving inclusive growth in the city. The Innovation Arc vision is a key example of this - a series of innovation neighbourhoods, formed around the city's natural anchors of our main universities, the proposed adult and children's hospitals, and major private sector partners.

By 2030 we will…

Have built on our thriving partnerships in the city, utilising the strong network of organisations such as our Leeds Anchor Institutions Network, where partners share a commitment to using their place-based economic, human and intellectual power to better the long-term welfare of their local communities. Specifically supporting the joined-up work with a targeted approach to economic and health interventions in the most socially and economically challenged communities will be vital.

We must also do all we can to continue to promote the health and wellbeing of the workforce and reduce social inequalities through how people are employed. We will build on successful projects, such as the Lincoln Green project which linked employment opportunities to people living in their local areas, the One Workforce programme, and the Leeds Health and Care Talent pipeline. All will be key to delivering an economy that is accessible for all.

A clear action plan to deliver this priority will be developed with the Health and Wellbeing Board and relevant partners.

Maximise benefits of world leading research, innovation and health and care technology

Why is this important?

Leeds has an ambition to deliver growing cross-city research capacity and making Leeds a test bed for innovation and new technologies, including in health and care and the delivery of a just transition to net zero. New technology can give people more control of their health and care and enable more coordinated working between organisations. Advances in research, innovation and technology also enable us to better understand the causes of ill-health, strengthen diagnosis of medical conditions, and develop more effective treatments. This will further contribute to tackling

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health inequalities by enabling us to focus innovation on improving the health of the poorest the fastest

By 2030 we will…

Have made further progress in delivering our place-based and person-centred approach. This will be focused on integrating healthcare and wider services in every community across the city supported by key organisations across sectors. The NHS, council, VCSE organisations and key partnerships such as the Leeds Academic Health Partnership will all be vital to achieve the best outcomes for local people.

So that we can ensure the best start in life, we will utilise modern data technologies and techniques to understand what determines a person's health, life chances from birth through to old age and improve service delivery. To support people to live and age well, we will work to deliver health and wellness services tailored for individuals and ensuring that people's information follows them through their journey regardless of the organisation they are interacting with. To have a city which works well, we must deliver 21st Century connectivity and infrastructure that provides the backbone for world-class service delivery. We will achieve this by building on existing collaborative work and improving information flow between organisations. This will create a thriving digital community, modern infrastructure and skilled workforce which will attract new and established businesses to Leeds.

We must also support and empower people to effectively manage their own conditions in ways which suit them. This means continuing to support digital inclusion and enabling people to be more confident to access their information and contribute to their records.

A clear action plan to deliver this priority will be developed with the Health and Wellbeing Board and relevant partners.

Promoting prevention and improving health outcomes through an integrated health and care system

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Why is this important?

In Leeds, we have focused on early intervention and have developed and sustained prevention approaches over time, which has helped to deliver improved outcomes and excellent services for people across the city. This can also support in improving healthy life expectancy and narrowing the health inequality gap.

Investing and scaling up prevention and using asset-based approaches to build community capacity, must continue to be at the centre of our approach to tackling poverty and health inequalities. This approach focuses on what people can do, not what they can't.

Our health and care needs are changing: our lifestyles are increasing our risk of preventable disease and are affecting our wellbeing. Whilst people living longer is a positive development it also brings with it specific health and care challenges, with more multiple long-term conditions like asthma, diabetes, and heart disease, and with avoidable and unfair differences in health between different groups of people increasing.

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By 2030 we will…

Have further developed our whole city approach driven by all partners to promote wellbeing and preventing ill health. The refreshed Healthy Leeds Plan will be a key component in helping to deliver this.

There are some specific areas where we can make a really big difference to prevent ill-health and deliver actions to reduce the causes, leading to improvements in health lifestyles. We need to maintain a continued focus on healthy diets, stopping smoking and harmful drinking.

Building on the strong foundation of key work such as the outstanding Forward Leeds drug and alcohol treatment service in Leeds will help to drive progress on this priority. There will be further opportunities in the additional funding to the city's Drug and Alcohol partnership to support adults and young people who are struggling with drugs and alcohol issues, through dedicated prevention, early intervention, and tailored programmes.

Supporting investment in evidence-based prevention services where we know this will improve health outcomes is essential, particularly in the most socially and economically challenged parts of the city. So too is investment in areas that deliver greater prevention across disease pathways and targeted prevention programmes. These help to promote healthy ageing, supporting people known to be at high risk of developing long term physical and mental health conditions.

The way we work together as one integrated health and care system in Leeds will also be key to delivering improved health and wellbeing outcomes for everyone across the city. The recent development of our integrated care partnership in Leeds provides a great opportunity to build on the strengths of existing Team Leeds approach and partnership principles to tackle health inequalities.

How we look at people's health is also guiding how we reduce health inequalities across the entire population, over the whole life course, and also recognising the influence of the determinants of health. This approach understands people have different needs, and what good health looks like varies between people. We will look at the population of Leeds as a few defined groups of people who have similar health and care needs. By looking at our population in this way, we can better understand what people need to address the challenges they face. We can also tailor better care and support for individuals and their carers, design more joined-up and sustainable health and care services and make better use of public resources to the benefit of people and communities.

This approach will be key to helping deliver key ambitions like delivering the best in cancer care for the people of Leeds. 1 in 2 people will develop some form of cancer during their lifetime. In Leeds 4,100 people are diagnosed with cancer each year. As an integrated system we will work with all communities to ensure that everyone affected by cancer has access to the same high-quality care with more cancers being diagnosed earlier.

In key areas where we want to see better health outcomes like cancer, learning disability and neurodiversity, maternity and end-of-life care, the city's Population Boards will play a key role. These Boards will ensure key partners are involved in designing new ways of working which will improve health and wellbeing and ensure decisions are coordinated to improve every aspect of health and care. Population Boards will include doctors, public health experts, charities, the local council, and health system leaders who are responsible for improving the population segment's health and wellbeing.

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A clear action plan to deliver this priority will be developed with the Health and Wellbeing Board and relevant partners.

An inclusive, valued and well-trained workforce

Why is this important?

We have a highly motivated, creative and caring workforce in our city, working hard to deliver high quality care for people in Leeds. Our health and care workforce were at the frontline of our city-wide response to the Covid-19 pandemic. As we move into the next phase of integrated health and care and rebuild from the pandemic, they will remain key to help deliver change and support the best possible health and wellbeing for the people of Leeds.

We have 62,000 people who work in health and care in Leeds and we want to further progress in making Leeds the best place to train and work in at any age. The Leeds Health and Care Academy, in partnership with our local schools, colleges and universities will play a central role in developing focused interventions that promote social mobility across the life course and widen opportunities for working in health and care.

By 2030 we will…

Be progressing our work to deliver for everyone in Leeds by working with communities. We will be providing opportunities for skills, jobs and wealth creation. We will be engaging and recruiting those in our communities facing the most social and economic challenges and inspiring the next generation of the health and care workforce.

The One Workforce approach in Leeds health and care is a key element of ensuring no part of our health and care workforce is left behind and is based on common purpose and deep partnership working. Joint planning and connecting care closer to home in a stable way for the wider workforce will be key to driving this approach. So too will be addressing gaps in services through attracting, training and recruitment, and removing barriers to enable new models of service delivery. We must also remain committed to learning together to ensure our workforce is delivering 21st century care, helping to ensure we will achieve our workforce ambitions in Leeds.

This must further focus on how the type of job roles and ways of working shift in focus to prevent ill-health, narrow inequalities in the workforce and improve health and wellbeing. City-wide workforce analysis and planning will also be key to better enable us to deliver our shared workforce priorities responding effectively to the needs of the future in a changing health and care system. Better data sharing and building capability across our city must be part of this approach.

Valuing our health and care workforce also means supporting their health and wellbeing. From GPs, nurses, cleaners, receptionists, social workers, care home and home care staff, third sector workers – all must be supported to ensure we have a healthy and well-trained workforce. These workers are part of the city’s health and care system and who are the first to come into contact with people accessing services. It is vital these groups are supported to work in a healthy and safe working environment and to maintain their own physical and mental health and wellbeing.

We want to see a truly inclusive workforce free from discrimination, that reflect the communities that we serve, and to benefit from the perspectives and skills that our richly diverse population brings to the workplace.

We further need to ensure that our future leaders reflect this diversity and build on pioneering work already underway in the city such as delivering the Workforce Race Equality Standard across children’s and adult social care.

A clear action plan to deliver this priority will be developed with the Health and Wellbeing Board and relevant partners.

Support for carers and enable people to maintain independent lives

Why is this important?

In Leeds, we know that people are ageing with multiple long-term health conditions. There is also an increase in the likelihood of having more than one long-term condition in the most socially and economically challenged parts of the city.

Cases of diabetes, respiratory disease, dementia and cardiovascular disease will continue to increase as the population of Leeds grows and ages.

Carers, including unpaid carers, continue to play a vital role in supporting people across the city. It is estimated that Leeds has 75,000 carers which is around 1 in 10 people. Carers come from all walks of life, all cultures and can be of any age. Being a young carer can affect school attendance, educational achievement and future life chances. Carers are more likely to have a long-term physical or mental health conditions and we know that unpaid carers have been particularly affected by the Covid-19 pandemic with increased time spent caring and fewer opportunities to take breaks.

By 2030 we will…

Be delivering an approach which continues to focus on the way care is provided to enable people to better manage their own health conditions. We must focus on supporting people to maintain independence and wellbeing within local communities for as long as possible. Supporting people through a crisis can also have a transformational impact, really helping them to flourish.

Care must be person-centred, coordinated around all of an individual's needs through networks of care rather than single organisations treating single conditions. To have more active involvement in health and care we all need to make the most appropriate use of services. This means having better and more coordinated and inclusive information, which will make it easier for people to access the services they need, when they need them by.

We will also need to improve the way we identify carers including unpaid carers and must recognise, value and support carers, putting them at the heart of everything we do.

This means that in order to reduce the health inequalities that carers experience due to their caring role, we must support shared aims and values. This is supported by taking a strong partnership approach to ensure that carers in Leeds stay mentally and physically healthy for longer.

A clear action plan to deliver this priority will be developed with the Health and Wellbeing Board and relevant partners.

The best care in the right place at the right time

Why is this important?

The integration of care in the community is crucial. The transformative potential of organisations working together at a neighbourhood level to meet local needs has been emphasised further with the Covid-19 pandemic.

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Outcomes for people can vary depending on where, when and how they are supported. We know that getting the right help and support at the right time can help people to manage their daily lives as independently as possible. Delivering the right type of care can address people spending more time in hospital than they need.

By 2030…

We will be further delivering population–based, integrated models of care with services which meet local needs. These services will be supported by multidisciplinary teams which help to achieve more independent and safe outcomes and help more people stay at home, whilst improving the experience for people, carers, and staff.

Better, integrated and co-ordinated partnerships and approaches supported with co-operation; communication and coordination can also help in getting people back home after a hospital stay. Rooted in neighbourhoods and communities, with coordination between primary, community, mental health and social care. They will need to ensure care is high quality, accessible, timely and person-centred. Providing care in the most appropriate setting will ensure our health and social care system can cope with surges in demand with effective urgent and emergency care provision.

Building on models like Local Care Partnerships (LCPs) will be vital. LCPs include a range of people working together, regardless of the employing organisation, to deliver joined-up collaborative care that meets the identified population's needs. Each partnership includes statutory organisations, third sector (community groups) and elected members, alongside local people, to develop services that support people to access the right support when they need it and thrive using their individual and community asset.

Population health management must also be key to driving proactive, data-driven approaches. This will help inform the way we provide health and care support for local people, whilst also, tackling some of the biggest health priorities. Through targeted interventions to prevent ill-health we can improve the care and support for people with ongoing health conditions.

A clear action plan to deliver this priority will be developed with the Health and Wellbeing Board and relevant partners.

A mentally healthy city for everyone

Why is this important?

Our vision for Leeds is to be a mentally healthy city for everyone. The impact of the Covid-19 has exacerbated the mental health challenges in the city. People living in poorer parts of Leeds are more than twice as likely to experience anxiety and depression but are least likely to complete treatment for these types of conditions. Rates of both suicide and self-harm admission (being cared for in hospital) are also higher in poorer areas of the city. The highest rates of suicide are found in middle aged men, and girls and young women have the highest rates of being admitted into hospital because of self-harm. We also know that ethnic minority communities in the city are more likely to be admitted into a mental health setting in crisis.

Good housing and employment, opportunities to learn, financial inclusion and debt are all key determinants of emotional wellbeing and good mental health. Improving mental health is everyone's business. It will take the collective determination of all strategic partners, businesses and communities to help achieve the city's vision.

By 2030 we will…

See significant progress in progressing positive outcomes in people's mental health across all ages including through the work of the city's breakthrough project on promoting mental health in the community and building on the Leeds Mental Health Framework. This will also in part be delivered through the Leeds Mental Health Strategy and focus on improving services alongside other key strategies and action plans like The Leeds Future in Mind Strategy. This co-ordinates work to promote emotional wellbeing, and to prevent and treat mental health problems in children and young people.

Targeted mental health promotion and prevention within communities most at risk of poor mental health, suicide and self-harm will be at the centre of our focus over the coming years. We will also work together with partners to reduce over-representation of people from ethnic minority communities admitted in crisis.

Education, training and employment will also be more accessible to people with mental health problems.

Improving transition support and developing new mental health services for 14- to 25-year-olds will also be vital alongside all services recognising the impact that trauma or psychological and social adversity has on mental health.

Timely access to mental health crisis services and support and ensuring that people receive a compassionate response will further help to deliver this priority.

Support older people to access information and appropriate treatment that meets their needs and to improve the physical health of people with serious mental illness.

Working together we can help to realise a city where people of all ages and communities live longer and lead fulfilling, healthy lives.

A clear action plan is in place to deliver this priority through the Mental Health Strategy Delivery Group and will be linked into the Health and Wellbeing Board and relevant partners.

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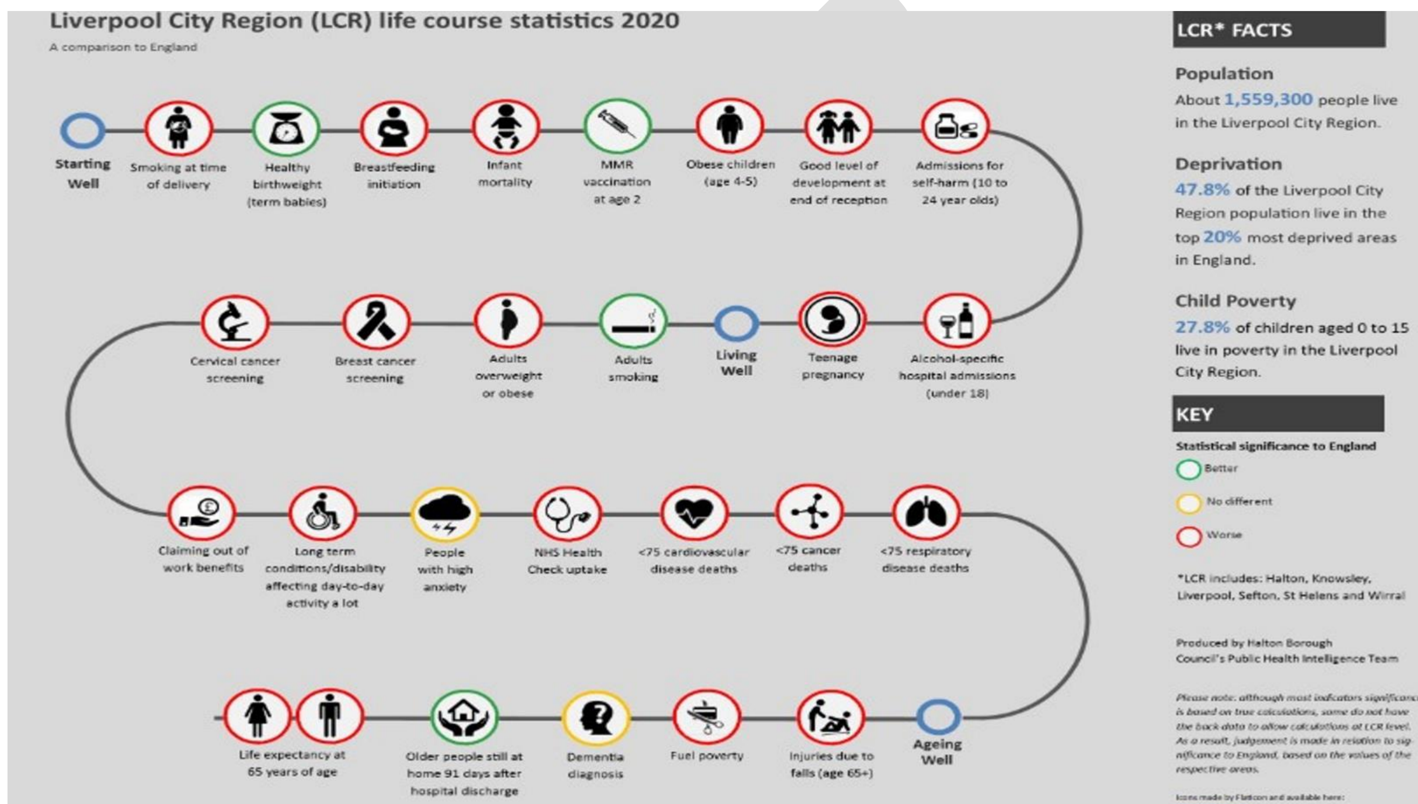
How will we know we are making a difference?

Measuring progress of our 12 priorities

- *Single page describing indicators presented as part of life-course approach in strategy*
- *Presented similarly to Liverpool City Region infographic example below*



Health and Wellbeing is everyone's business

Leeds Health and Wellbeing Board:

- Provide leadership and direction to help and influence every partner and stakeholder in Leeds to achieve the 5 outcomes for all people and communities in the city.
- Further embed the Board's city-wide expectation to ensure the voices of everyone in Leeds are reflected in the design and delivery of strategies and services.
- Provide a public forum for decision making and engagement across health and wellbeing.
- Continually ask what we are all doing to reduce health inequalities, create a sustainable system and improve wellbeing.

People

- Take ownership and responsibility for promoting personal health and wellbeing.
- Be proactive and confident in accessing services which are available.
- Get involved in influencing and making change in Leeds.

Local communities:

- Support vulnerable members of the community to be healthy and have strong social connections.
- Take ownership and responsibility for promoting community health and wellbeing.
- Make best use of community assets and leadership to create local solutions.

Other Boards and Groups

- Work closely and jointly with partnership boards and groups to support the priorities of the Leeds Health and Wellbeing Strategy.
- Create clear action plans and strategies which help achieve specific priorities and outcomes of the Leeds Health and Wellbeing Strategy.
- Promote partnerships wherever possible, working as one organisation for Leeds.

Health and Care organisations

- Provide and commission services which support the priorities of the Leeds Health and Wellbeing Strategy.
- Make plans with people, understanding their needs and designing joined-up services around the needs of local populations.
- Provide the best quality services possible, making most effective use of 'the Leeds Pound' - our collective resource in the city.

How to get involved

The Health and Wellbeing Strategy will be a live document which will be shaped by what partners, people and communities are telling us. This will ensure that we can respond to any new or emerging developments which will influence achieving our ambition and vision.

There are loads of ways that you can get involved with the work of the Health and Wellbeing Board. Listening to the community and hearing about the experiences of people's health and

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wellbeing is vital to the Board. Detailed below are some of the ways you can get involved with the Board.

- Asking questions to the Health and Wellbeing Board
- Social media
- Public Engagement e.g. via Big Leeds Chat/How does it Feel for Me?

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Leeds Health & Care Partnership

NHS West Yorkshire Integrated Care Board

Meeting name:	Leeds Committee of the West Yorkshire Integrated Care Board
Agenda item no.	LC 77/22
Meeting date:	14 March 2023
Report title:	Urgent Decision: Practice Proposal - The merger of Fountain Medical Centre and Morley Health Centre
Report presented by:	Sam Ramsey, Head of Corporate Governance and Risk
Report approved by:	Sam Ramsey, Head of Corporate Governance and Risk
Report prepared by:	Harriet Speight, Corporate Governance Manager

Purpose and Action

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

Previous considerations:

N/A

Executive summary and points for discussion:

Due to timescales, a decision was taken on 8th February 2023 by the Chair and Place Lead, in line with the urgent decisions section of the terms of reference, on behalf of the Leeds Committee of the West Yorkshire Integrated Care Board (WY ICB) to approve the merger of Fountain Medical Centre and Morley Health Centre (Dr Saddiq) ahead of the closure of the site within Morley Health Centre in April 2023.

Leeds Committee members were consulted on the proposal via email in advance of the decision and were provided with the report and recommendation to approve the proposal by the Primary Care Board (Appendix 1).

Members are asked to note that all Committees of the WY ICB must report urgent decision to the West Yorkshire Audit Committee. This will be reported within the Integrated Governance Report to the next WY Audit Committee meeting.

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

☐ Improve healthcare outcomes for residents in their system

☒ Tackle inequalities in access, experience and outcomes

☐ Enhance productivity and value for money

☐ Support broader social and economic development

Recommendation(s)

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

1.	**RATIFY** the decision taken on 8 February 2023 to approve the merger of Fountain Medical Centre and Morley Health Centre (Dr Saddiq) ahead of the closure of the site within Morley Health Centre in April 2023.
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.	Practice Proposal: The merger of Fountain Medical Centre and Morley Health Centre (including closure of GP site within Morley Health Centre)
2.	Urgent Decision Notice (Signed) 8 February 2023
Acronyms and Abbreviations explained	
N/A	

What are the implications for?

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

Meeting name:	Leeds Committee of the West Yorkshire Integrated Care Board
Agenda item no:	UA1
Meeting date:	Urgent Action – 2 February 2023
Report title:	Practice Proposal: The merger of Fountain Medical Centre and Morley Health Centre (including closure of GP site within Morley Health 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:	Lisa Kundi, Senior Manager Primary Care Integration

Purpose and Action

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

Previous considerations:

In October 2022 Primary Care Board provided approval for Fountain Medical Centre and Morley Health Centre (Dr Saddiq) to commence a period of engagement with a view to merging the practices on 1 April 2023 and subsequently closing the site within Morley Health Centre.

A period of engagement was undertaken between October and December and the outcome of the engagement and subsequent business was presented to the Primary Care Board on 5 January 2023.

At the meeting on 5 January 2023, Primary Care Board reviewed the business, engagement feedback and provided approval for Fountain Medical Centre and Morley Health Centre (Dr Saddiq) to merge the two practices ahead of the closure of the site within Morley Health Centre in April 2023.

Executive summary and points for discussion:

In October 2022 Primary Care Board provided approval for Fountain Medical Centre and Morley Health Centre to commence a period of engagement with a view to merging the practices on 1 April 2023 and subsequently closing the site at Morley Health Centre thereafter.

The proposal would provide greater resilience, particularly for Dr Saddiq as a single-handed GP and see the whole population having access to a wider service offer in a purpose built estate.

The engagement commenced on the 18 October 2022 for 6 weeks and was supported by the Leeds Primary Care and Communications and Engagement Team at the ICB.

This paper sets out the formal application from the practices, outcomes of the patient engagement and the recommendation from Primary Care Board on 5 January 2023. The Primary Care Board reviewed the proposal and supported the application to merge the two practices.

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 ICB is asked to:</u> 1. Note the feedback from patients and local stakeholders around the impact of the proposed changes at Fountain Medical Centre and Morley Health Centre; and 2. Approve the proposal for Fountain Medical Centre and Morley Health Centre to merge the two practices ahead of the closure of the GP site within Morley Health Centre thereafter subject to notice period 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. Business Case 2. Engagement Report
Acronyms and Abbreviations explained
1. PMS – Personal Medical Services (Contract for General Practice Service) 2. GMS - General Medical Services (Contract for General Practice Service) 3. GP – General Practitioner 4. ICB – Integrated Care Board 5. 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 resilience and range of services on offer for patients currently registered at Morley Health Centre through increased workforce and improved facilities. There remains a cluster of practices within this geographical area that patients could also choose to register with.
Quality and Safety	As above

Equality, Diversity and Inclusion	None identified
Finances and Use of Resources	There are some implications for estates which are covered in this paper in reference to the site within Morley Health Centre which would become vacant if the proposal is approved. NB. This only relates to the GP practice element of Morley Health Centre.
Regulation and Legal Requirements	The proposal has been managed in accordance with the Primary Medical Care Policy and Guidance Manual (PGM) (v4)
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 to be addressed

1. SUMMARY OF PROPOSAL

1.1 This paper outlines an application from the partners of Fountain Medical Centre (B86067) and Morley Health Centre (B86001) to merge the two practices together under a single PMS contract on 1 April 2023. The application includes the intention to close the site within Morley Health Centre shortly after according to the notice period agreed with the landlord.

1.2 This paper summarises the considerations for commissioners and the outcome of the engagement exercise recently undertaken.

1.3 The merger proposal is to support the ongoing resilience of Dr Saddiq who is a single-handed GP. The practices work well together as part of the PCN and given their proximity; the proposal is a natural progression in their close working relationship that will support the sustainability of both practices. Dr Saddiq will continue to work as part of the newly merged practice.

1.4 The merged practice will be based on one site at Fountain Medical Centre, a greater choice of services will be available for patients currently registered with Morley Health Centre. It will also support the day-to-day operations of the practice removing the complexity of working from multiple sites. The site at Morley Health Centre is in a larger LCH owned estate, whereas the accommodation at Fountain offers modern purpose-built facilities with minimal reconfiguration required to operate as a larger merged practice.

1.5 Fountain Medical Centre holds a PMS contract, whereas Morley Health Centre is currently GMS. The new merged practice would require Fountain Medical Centre's contract to be varied to include the services currently provided by Morley Health Centre. The contract with Dr Saddiq would then be terminated.

1.6 The practices anticipate that the merger and subsequent closure of the site at Morley Health Centre will offer a better, more comprehensive service to patients and importantly increase the resilience and longer-term viability of both practices.

2. PRACTICE INFORMATION

2.1 Fountain Medical Centre and Morley Health Centre are located in the centre of Morley on Cooperation Street 0.2 miles apart. Fountain Medical Centre has a list of 15,070 patients and Morley Health Centre a list of 2475.

2.2 Fountain Medical Centre is located in a large modern purpose-built facility which hosts a number of other services including a pharmacy. Morley Health Centre is within a community health centre which hosts a number of other services.

2.3 Whilst this proposal includes the closure of the GP Practice at Morley Health Centre, all employed staff including Dr Saddiq would TUPE to Fountain Medical Centre. There would be no reduction in the clinical or administrative capacity and by merging, the practices feel there are opportunities to release

efficiencies, achieve economies of scale and improve the quality of care available for patients.

2.4 The merged practice boundary would cover all areas that are currently covered by both practices.

2.5 Fountain Medical Centre have the internal space to accommodate this merger and plan some internal works to accommodate more staff within existing office space. There are future aspirations for further expansion into the loft space however, this is not essential to the merger.

2.6 The practices recognise that whilst the facilities and range of staff available will offer an improved experience for patients, there will be some that wish to retain the relationship and service offer that they received at from Dr Saddiq at Morley Health Centre as a small practice. The practices plan to mitigate this by offering patients the option to see Dr Saddiq as part of the transition. The involvement exercise will also offer the opportunity to hear any other concerns for patients.

3. PATIENT AND STAKEHOLDER ENGAGEMENT

3.1 The engagement process started on 18 October for a period of 6 weeks.

3.2 The practices led on the engagement and a variety of activities and methods were used to seek the views of registered patients at both practices.

3.3 Both practices held an initial meeting with both their respective PPGs to seek their views on how they should communicate the proposals and ensured this feedback was reflected in the involvement process.

3.4 The proposed changes were outlined on both practice websites with a link to an online survey.

3.5 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 2 planned public events.

3.7 The practices organised and held 2 public events, one face to face at a local venue and a second through Zoom.

3.8 The first event was well attended however, despite a reminder text message to patients inviting them to the second Zoom meeting, only 2 patients attended. The reminder did however generate a significant further number of responses to the online survey.

3.9 A total of 235 people actively engaged in the involvement exercise through either attending a meeting or submitting a survey. Most responses via the survey were from patients at Fountain Medical Centre however, as a proportion of the list size, approximately twice as many patients responded from Morley Health Centre compared to Fountain Medical Centre.

3.10 The engagement identified several key themes, including:

- Getting an appointment
- Getting through on the telephone
- Concerns about accessing online services
- Concerns about the merged practice's ability to provide services and personalised care to increased numbers of people
- Car parking and estates
- Continuity of care and seeing the same clinician

3.11 An FAQ document was created and updated with responses to patients queries and concerns throughout the process. This was updated in response to feedback via the survey and questions raised at the public events. A full breakdown of the responses and feedback can be found in the involvement report in Appendix B.

3.12 Although concerns and queries were raised throughout the involvement process, overall, the response to the proposal was understood by patients. The practices were able to provide assurance that staff would transfer to the merged practice and further increased to meet demand. The practice will also soon be testing 'queue busting' technology on their phonelines that will enable patients to remain in a call queue but instead receive a call back.

3.13 The Involvement Report details the process and outcomes and includes key themes including the practice response to some of the patient concerns raised. (see Appendix B)

4 FINANCIAL IMPLICATIONS AND RISK

4.1 The proposal is that the PMS contract for Fountain Medical Centre is varied to include the services currently provided by Morley Health Centre. As there are no longer any financial differentiations between a PMS and GMS contract, there will be no material financial implications.

4.2 There will be some cost implications for the ICB in moving of IT from Morley Health Centre and reconfiguration of IT points at Fountain Medical Centre.

4.3 There will be a cost saving to the ICB in terms of rent reimbursement for the rooms at Morley Health Centre. Fountain Medical Centre have confirmed that with some minor reconfiguration of existing space, they will be able to accommodate the addition staff moving over.

4.4 The current agreement in place between Dr Saddiq and LCH as the landlord at Morley Health Centre requires a 1-month notice period. LCH have indicated

that they would request a longer notice period however, this is for the relevant parties to discuss once a decision has been made and will have some cost implications for the ICB in terms of rent reimbursement and notice period agreed.

4.5 Fountain Medical centre currently host wound care clinics on behalf of Morley PCN. Due to this merger and their intention to become a training practice again, they have confirmed that they will no longer be able to accommodate this service. This is a highly valued service by practices, LCH and patients and we are working in partnership with LCH to move this service to some of the vacated rooms at Morley Health Centre.

5 COMMUNICATIONS AND INVOLVEMENT

5.1 Local councillors were contacted to make them aware of the proposal and the intention to engage with patients. The email was acknowledged with the offer of support but no further comments.

5.2 Practices within Morley PCN were contacted and made aware of the proposal. This was then discussed in further detail at the following Morley PCN meeting. The PCN acknowledged that they would need to update their PCN agreement should the merger go ahead but had no objections.

5.3 All pharmacies within the vicinity were contacted with one response received from Well Pharmacies who have several sites within Morley. The pharmacy had some concerns that there could be an impact to the closest site and offered support to Fountain to maximise their use of online prescription options. The pharmacy was keen to work with the merged practices to mitigate any potential negative impact.

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 8.11).

6.2 The closure of the site at Morley Health Centre will be enacted in line with NHS England's Policy and Guidance Manual (PGM) (Part B, section 8.15) 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 the site at Morley Centre.

6.5 The Primary Care Team will continue to work with partners to seek a solution for the wound care clinics within Morley PCN.

7. RECOMMENDATION

7.1 **The Leeds Committee of the ICB is asked to:**

a) Note the feedback from patients and local stakeholders around the impact of the proposed changes at Fountain Medical Centre and Morley Health Centre

b) Approve the proposal for Fountain Medical Centre and Morley Health Centre to merge the two practices ahead of the closure of the GP site at Morley Health Centre thereafter subject to notice period as recommended by the Primary Care Board.

REQUEST FOR URGENT ACTION

Urgent action is required from the Leeds Committee of the West Yorkshire Integrated Care Board (WY ICB) to approve the merger of Fountain Medical Centre and Morley Health Centre (Dr Saddiq) ahead of the closure of the site within Morley Health Centre in April 2023.

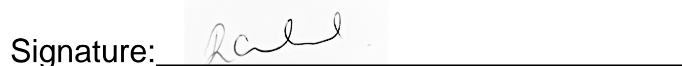
RESPONSIBLE DIRECTOR: Gaynor Connor, Director of Primary Care & Same Day Response

RESPONSIBLE MANAGER: Kirsty Turner, Associate Director of Primary Care

DATE: 08 February 2023

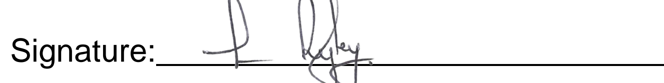
APPROVAL BY:

Leeds Committee of the WY ICB Chair

Signature: Date: 08/02/2023

Name: Rebecca Charlwood

Place Lead and Accountable Officer

Signature: Date: 08/02/2023

Name: Tim Ryley

To be ratified at the Leeds Committee of the West Yorkshire Integrated Care Board meeting on 14 March 2023

Leeds Health & Care Partnership

NHS West Yorkshire Integrated Care Board

Meeting name:	Leeds Committee of the West Yorkshire Integrated Care Board (ICB)
Agenda item no.	LC 78/22
Meeting date:	14 March 2023
Report title:	Sub-Committee Annual Reports and Terms of Reference
Report presented by:	Sam Ramsey, Head of Corporate Governance & Risk
Report approved by:	Rebecca Charlwood, Independent Chair, Leeds Committee of the ICB
Report prepared by:	Sam Ramsey, Head of Corporate Governance & Risk

Purpose and Action

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

Previous considerations:

Delivery Sub-Committee – 23 February 2023

Quality and People's Experience Sub-Committee – 7 March 2023

Finance and Best Value Sub-Committee – 02 March 2023

Executive summary and points for discussion:

The Sub-Committees of the Leeds Committee of the West Yorkshire Integrated Care Board are reviewed on an annual basis, in line with their terms of reference, to provide assurance that they are fulfilling their duties and remain effective.

The report presents a review of the three sub-committees (Delivery, Finance & Best Value and Quality & People's Experience) during the period 1 July 2022 to March 2023. Members are asked to receive the annual report (attached at Appendices 1 – 3) as assurance that the sub-committees have fulfilled their function.

Each of the sub-committees' terms of reference have been reviewed and are attached at appendices 4 - 6 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:

a) **RECEIVE** the annual reports

b) **CONSIDER** if there are any further actions to be taken to improve the effectiveness of the sub-committees

c) **APPROVE** the amends to the terms of reference.

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. Delivery Sub-Committee Annual Report 2022/23
2. Finance & Best Value Sub-Committee Annual Report 2022/23
3. Quality & People's Experience Sub-Committee Annual Report 2022/23
4. Delivery Sub-Committee amended Terms of Reference
5. Finance & Best Value Sub-Committee amended Terms of Reference
6. Quality & People's Experience Sub-Committee amended Terms of Reference

Acronyms and Abbreviations explained

1. ICB – Integrated Care Board

What are the implications for?

Residents and Communities	The annual reports identify the work undertaken through the sub-committees including people's voice and people's experience.
Quality and Safety	The report highlights the work of the Quality and People's Experience Sub-Committee through the annual report.
Equality, Diversity and Inclusion	The report highlights implications for equality, diversity, and inclusion throughout.
Finances and Use of Resources	The report highlights the work of the Finance Sub-Committee through the annual report.
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	The Committee are asked to review and approve the amended terms of reference.
Citizen and Stakeholder Engagement	The annual reports identify the work undertaken through the sub-committees including people's voice and people's experience.

1. Purpose of this report

1.1 The report presents a review of the three sub-committees (Delivery, Finance & Best Value and Quality & People's Experience) during the period 1 July 2022 to March 2023.

1.2 The annual reports, attached at Appendices 1 – 3 include a review of the sub-committees' activities and assurances provided since becoming established on 1 July 2022, and a summary of the self-assessment survey that was undertaken by members and attendees.

1.3 Each of the sub-committees' terms of reference have been reviewed and are attached at appendices 4 - 6 for approval.

2. Key Points

2.1 Each of the sub-committees held its inaugural meeting in September 2022 and has met three times during 2022/23. The sub-committee effectiveness survey has been undertaken in line with the terms of reference and to enable comparison in the future to identify areas that require further improvement as they become more established.

2.2 Feedback was received via the Delivery Sub-Committee that there was a lack of shared understanding of the purpose but recognised that it would become clearer in time.

2.3 The Finance & Best Value Sub-Committee feedback suggested that the membership should be broader and more representative of the whole Leeds system to allow for sufficient scrutiny with a need for greater shared responsibility.

2.4 Feedback via the Quality & People's Experience Sub-Committee recognised the ongoing development of reports and suggested the need to continue to broaden the focus on quality beyond the NHS to the wider sector.

2.5 It was recognised that the sub-committees are still in early stages of development, however each sub-committee found it helpful to consider the work undertaken to date and the assurances that they had provided. The review of the terms of reference provides the opportunity to consider widening the membership and redefining the areas of focus.

2.6 Minor amendments are proposed to the terms of reference, in relation to the membership and frequency of the sub-committees, and all amends are included as tracked changes. The Leeds Committee of the WY ICB is asked to approve these amendments.

3. Next Steps

3.1 The effectiveness of the Leeds Committee of the ICB will be reviewed and discussed at the development session in April 2023. A self-assessment survey is currently being developed through the West Yorkshire Governance Network and this will be designed to gauge the Committee's effectiveness by taking the views of those who attend, across several themes. The results will be used to inform the Committee's annual report and provide assurance to the WY ICB Board. It will also be used to assist the Committee in reviewing of terms of reference and inform future development of the Committee.

3.2 In addition to this, national plans are in place to support ICBs across the country with their first governance review during quarter one of 2023/24. This review will take place across West Yorkshire and include contributions and engagement from Place Committees.

3.3 Any agreed actions in relation to the sub-committee's effectiveness will be taken forward from April 2023.

4. Recommendations

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

a) **RECEIVE** the annual reports

b) **CONSIDER** if there are any further actions to be taken to improve the effectiveness of the sub-committees

c) **APPROVE** the amends to the terms of reference.

5. Appendices

Delivery Sub-Committee Annual Report 2022/23

Finance & Best Value Sub-Committee Annual Report 2022/23

Quality & People's Experience Sub-Committee Annual Report 2022/23

Delivery Sub-Committee amended Terms of Reference

Finance & Best Value Sub-Committee amended Terms of Reference

Quality & People's Experience Sub-Committee amended Terms of Reference

Delivery Sub-Committee Annual Report 2022/23

1. Background

The Delivery Sub-Committee provides assurance to the Leeds Committee of the West Yorkshire Integrated Care Board (WY ICB) in relation to progress we are making with our plans to improve outcomes, tackle health inequalities and improve the effectiveness and efficiency of services.

As set out on the terms of reference, the Delivery Sub-Committee focuses on seeking assurance on the following areas of the Leeds Health & Care Partnership (LHCP) business:

Operational Performance:

- NHS constitutional standards and other national planning priorities
- Local operational priorities set out in the LHCP operational plan

Improving Outcomes:

- Improvements in the health outcomes of the population as set out in Healthy Leeds: Our Plan for Health and Care in Leeds
- Reducing health inequalities
- Benchmarking against NHS Outcomes Framework
- Progress on Service Transformation (Healthy Leeds Plan)

West Yorkshire and NHS England

- Monitoring progress against the West Yorkshire 10 Priorities
- Coordination of the LHCP input to the NHS England Quarterly Assurance processes

Risk Management

- Reviewing risks assigned to the Sub-Committee by the Leeds Committee of the ICB and ensure that appropriate and effective mitigating actions are in place

Reasonable assurance is defined as the Sub-Committee being provided with evidence that performance is in line with agreed targets or trajectories, and where it is not, evidence of reasonable mitigation and an action plan to rectify any issues.

Where the Sub-Committee receives insufficient assurance, it will challenge, assess risks and escalate to the Leeds Committee of the WY ICB when necessary.

Membership

Membership of the Sub-Committee as currently outlined in the terms of reference is as follows:

- Chair - Independent Member – Health Inequalities and Delivery
- Independent Member – Finance and Probity
- Non-Executive representation from partner organisations
- Executive Members (Leeds Office of the WY ICB)
    - Director of Population Health Planning
    - Director of Pathway Integration
- Partner Members, representatives from the following:
    - Leeds Teaching Hospitals Trust
    - Leeds & York Partnership Foundation Trust
    - Leeds Community Healthcare Trust
    - Leeds City Council
    - Primary Care
    - Third Sector
    - Director of Public Health

The Leeds Place Lead is also invited to attend each meeting.

The Sub-Committee met three times during 2022/23, inclusive of the February 2023 meeting. An overview of the Sub-Committee's work and the assurances they were provided with is outlined below.

2. Review of Committee Activities & Assurances

- **Health Inequality Reporting Specification –** The Sub-Committee receives a bi-annual report including a RAG rated data specification, which has been developed to support the work of the Leeds Tackling Health Inequalities Group (THIG) and to provide assurance to the Delivery Sub-Committee. The specification is based around the national Core20Plus5 approach to addressing health inequalities and will support the Sub-Committee and THIG to understand performance against Core20Plus5 outcomes and identify areas where there is a particular need for further investigation / intervention.

- **Delivery Performance Report –** The Sub-Committee receives a report to each meeting that provides an overview of reported performance in Leeds against national and local measures and metrics. The report consists of a summary of performance areas of specific note, taken from a wider

performance dashboard.

- **Risk Management** - The Sub-Committee seeks assurance that delivery related risks are being managed appropriately, by acknowledging the factors that provide assurance, identifying any gaps, noting any mitigating factors and the adequacy of action plans to address under-performance. The Sub-Committee receives and reviews the risks rated as high amber (12) and risks that are scored at 15 or above.

- **Population and Care Delivery Board Reporting** – From February 2023, the Sub-Committee will receive reports from each of the following Population and Care Delivery Boards on a cycle throughout the year - Healthy, Children and Young People, Maternity, On the Day Response, Mental Health, Learning Disabilities and Neurodiversity, Frailty, End of Life, Long Term Conditions, Cancer, and Planned Care. Each report will include a section related to delivery and performance for the prior and upcoming six-month period.

- **Healthy Leeds Plan Strategic Indicator Remeasurement 2022 –** In September 2022, the Sub-Committee received and discussed current performance as reported within the Healthy Leeds Plan remeasurement 2022.

- **Deep Dive: Access to Primary Medical Services –** Following a request from the Leeds Committee of the WY ICB, the Sub-Committee conducted a 'deep dive' into access to primary care services. The Sub-Committee scrutinised a range of evidence and noted reasonable assurance to the Leeds Committee of the WY ICB 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.

3. Self-Assessment

The self-assessment questionnaire was sent to 12 members/attendees of the Sub-Committee; 5 responses were received. The combined responses are attached at Appendix 2.

The Delivery Sub-Committee held its inaugural meeting in September 2022, and therefore is still in early stages of development. The responses to the survey are reflective of this, with mixed responses to most statements and some comments noting that it is too early to judge at this stage.

In summary, the responses and comments referred to:

- Lack of shared understanding of the purpose of the Sub-Committee, however recognition that this will become clearer in time.

- Poor representation of the whole partnership in terms of attendance.
- Support for the venue used for meetings and the facilities available.
- Support for the agenda setting process, however suggestion for future agendas to be shaped more clearly by the current areas of high risk.

The review of the Sub-Committee's Terms of Reference will provide opportunity to consider widening the membership and redefining the areas of focus. Meetings will continue to be held in Merrion House for 2023/24, considering the feedback above, however members are asked to reflect on whether any meetings should be held remotely.

This initial survey will enable comparison in the future to identify areas that require further improvement as the Sub-Committee becomes more established and its membership evolves.

4. Terms of Reference

The Sub-Committee's Terms of Reference are attached at Appendix 3 for review. The Corporate Governance team have reviewed and included tracked changes within this with minor amendments, including adding the Place Lead to the core membership.

The Sub-Committee are also asked to consider the following statements within the terms of reference business and whether these should remain as areas to seek assurance on:

- **Systems Resilience and Emergency Planning** – assurance that Leeds has robust processes for dealing with emergencies including critical incidents, disease outbreaks and pandemics
- **Climate Change** – progress on delivery of net zero carbon targets across Leeds NHS Providers

Leeds Health & Care Partnership

NHS West Yorkshire Integrated Care Board

Appendix 2

Finance and Best Value Sub-Committee Annual Report 2022/23

1. Background

The Finance and Best Value Sub-Committee provides assurance to the Leeds Committee of the West Yorkshire Integrated Care Board (WY ICB) by seeking assurance and providing performance oversight of key financial and performance plans, indicators and/or targets, including good stewardship of resources, as specified in the Leeds Health and Care Partnership's strategic and operational plans, in order to ensure best value and clinical outcomes.

As set out on the terms of reference, the responsibilities of the Finance and Best Value Sub-Committee are as follows:

- Ensure financial management achieves value for money, efficiency and effectiveness in the use of resources, allowing the partnership to achieve best value and outcomes for its investments, with a continuing focus on cost reduction and achievement of efficiency targets.
- Identify and manage mechanisms put in place by the partnership to drive cost improvements.
- Review the partnership's medium-term financial planning and annual budgets and provide assurance to the Leeds Committee of the WY ICB on appropriateness of investment and efficiency priorities within the plans.
- Ensure appropriate information is available to manage financial issues, risks and opportunities across the place.
- Monitor and review population health management and resource allocation.
- Monitor and review the achievement of the financial plan, including good stewardship of resources and identify risks to achievement of these.
- Provide a forum to evaluate requirements and advise the Leeds Committee of the WY ICB on committing resources to respond to performance issues and potential investments.
- Work with place partners to identify and agree common approaches across the system such as financial reporting, estimates and judgements.
- Ensure that processes for financial management (including reporting) are robust and advise the Leeds Committee of the WY ICB appropriately on the content of the Finance Report.
- Review contractual arrangements and payment mechanisms, ensuring fitness for purpose, best value and clinical outcomes.

- Develop the understanding of 'place-based' financial decision-making to inform the development of the Leeds Health and Care partnership and the West Yorkshire Integrated Care System.

Reasonable assurance is defined as the Sub-Committee being provided with evidence that performance is in line with agreed targets or trajectories, and where it is not, evidence of reasonable mitigation and an action plan to rectify any issues.

Where the Sub-Committee receives insufficient assurance, it will challenge, assess risks and escalate to the Leeds Committee of the WY ICB when necessary.

Membership

Membership of the Sub-Committee as currently outlined in the terms of reference is as follows:

- Chair – Independent Member – Finance and Governance
- Independent Member – Health Inequalities and Delivery
- Further Non-Executive representation from partner organisations
- Executive Members (Leeds Office of the WY ICB)
  - ICB Place Lead
  - ICB Place Finance Lead
  - Medical Director

  The following Executive Members will be invited where required, dependent on the agenda item discussion:

  - Director of Population Health
  - Director of Pathway Integration
  - Director of Primary Care and Same Day Response
- Partner Members, representatives from the following *where relevant dependent on the agenda item discussion:*
  - Leeds Teaching Hospitals Trust
  - Leeds & York Partnership Foundation Trust
  - Leeds Community Healthcare Trust
  - Leeds City Council

The Sub-Committee met three times during 2022/23, inclusive of the March 2023 meeting. An overview of the Sub-Committee's work and the assurances they were provided with is outlined below.

2. Review of Committee Activities & Assurances

- **Finance Update** – At each meeting, the Sub-Committee receives a report that provides an update of the financial position for the Leeds Place of the WY ICB and in the context of the wider WY ICB financial position. The report provides details of current and future actions to ensure the city has a

sustainable financial position. 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.

- **Risk Management** – At each meeting, the Sub-Committee seeks assurance that finance related risks are being managed appropriately, by acknowledging the factors that provide assurance, identifying any gaps, noting any mitigating factors and the adequacy of action plans to address under-performance. The Sub-Committee receives and reviews the risks rated as high amber (12) and risks that are scored at 15 or above.

- **Population and Care Delivery Board Reporting** – From March 2023, the Sub-Committee will receive reports at each meeting from each of the following Population and Care Delivery Boards on a repeating cycle throughout the year - Healthy, Children and Young People, Maternity, On the Day Response, Mental Health, Learning Disabilities and Neurodiversity, Frailty, End of Life, Long Term Conditions, Cancer, and Planned Care. Each report will include a section related to finance and resources for the prior and upcoming six-month period.

- **Policies, Plans and Strategies –** In September 2022, the Sub-Committee considered and provided comment on the draft West Yorkshire Integrated Care System Finance Strategy 2022-2027. The Sub-Committee also received verbal updates on the timelines for the Medium-Term Financial Plan and the 2023/24 Financial Plan.

- **Business Cases and Propositions** – In September 2022, the Sub-Committee reviewed an early draft submission of the 22/23 business case for Community Diagnostics Centres (CDC) at three Leeds sites and supported the initial proposals; the finalised business case will be considered at the Sub-Committee meeting in June 2023. In December 2022, the Sub-Committee also considered a summary of six improved value propositions developed by the Population and Care Delivery Boards and provided comment and action to be taken in advance of consideration at the subsequent meeting of the Leeds Committee of the WY ICB.

3. Self-Assessment

The self-assessment questionnaire was sent to 12 members/attendees of the Sub-Committee; 7 responses were received. The combined responses are attached at Appendix 2.

The Finance and Best Value Sub-Committee held its inaugural meeting in September 2022, and therefore is still in early stages of development. The

responses to the survey are reflective of this, with mixed responses to most statements and some comments noting that it is too early to judge at this stage.

In summary, the responses and comments referred to:

- More clarity required regarding the purpose and remit of the Sub-Committee, with the need for greater shared responsibility and future reports to be provided from leaders across the Leeds system.
- The need for the membership to be broader and more representative of the whole Leeds system to allow for sufficient scrutiny.
- Support for meetings to be held at a single venue.

The review of the Sub-Committee's Terms of Reference will provide opportunity to consider widening the membership and redefining the areas of focus. Meetings will continue to be held in Merrion House for 2023/24, considering the feedback above, however members are asked to reflect on whether any meetings should be held remotely.

This initial survey will enable comparison in the future to identify areas that require further improvement as the Sub-Committee becomes more established and its membership evolves.

4. Terms of Reference

The Sub-Committee's Terms of Reference are attached at Appendix 3 for review. The Corporate Governance team have reviewed and included tracked changes within this with minor amendments including amending the frequency outlined.

Quality & People's Experience Subcommittee Annual Report 2022/23

1. Background

The Quality & People's Experience Subcommittee (QPEC) provides assurance to the Leeds Committee of the West Yorkshire Integrated Care Board (WY ICB) that quality outcomes are achieved for the population of Leeds, that services are safe and they provide a good experience for our populations.

As set out on the terms of reference, the QPEC focuses on:

- Bringing a Leeds-wide lens to quality assurance and improvement, bringing together system partners from health and social care and third sector to who will be mutually accountable
- Seeking assurance that quality standards are being met and, where these are not being delivered, understanding how services are applying improvement approaches to address them
- Providing a collaborative approach to improvement where quality challenges span different services and providers of care
- Overseeing and assuring itself of the quality of commissioned health and social care services in Leeds, via measurements of quality within the system, e.g. using metrics and outcome data to assess the situation, along with narrative and assurance from city partners, and feedback from people using the services
- Ensuring a Population Health approach to quality and seeking to understand how quality outcomes are measured for each population group, how value is delivered, and how the service user experience is being captured and improved
- Reviewing emerging and existing quality risks in the system and actions being taken to support improvement via a regular quality reporting mechanism to the sub-committee from the ICB in Leeds Quality team
- Receiving updates on patient safety from the Leeds place, the implementation of the new patient safety framework and the safety improvement plans that are part of the framework.

The QPEC Subcommittee reports directly into the Leeds Committee of the WY ICB via the Committee Escalation and Assurance Report – Alert, Advise, Assure report. It also feeds into the West Yorkshire System Quality Group and the West Yorkshire Quality Committee via the Director of Nursing and Quality (ICB in Leeds).

Risk Management

The QPEC subcommittee reviews risks assigned to them and ensures that appropriate and effective mitigating actions are in place.

Reasonable assurance is defined as the subcommittee being provided with evidence that quality improvement is in line with agreed targets or trajectories, and where it is not, evidence of reasonable mitigation and an action plan to rectify any issues.

Where the subcommittee receives insufficient assurance, it will challenge, assess risks and escalate to the Leeds Committee of the WY ICB when necessary.

Membership

Membership of the subcommittee as currently outlined in the terms of reference is as follows:

- Chair – Independent Chair
- Independent Member – Health Inequalities and Delivery
- Executive Members (ICB in Leeds)
  - Director of Nursing and Quality
  - Director of Population Health
  - Medical Director
- Director level representative with responsibility for quality assurance and improvement
  - Leeds Teaching Hospitals Trust
  - Leeds Community Healthcare Trust
  - Leeds & York Partnership Foundation Trust
  - Leeds City Council Adults Services
  - Leeds City Council Children and Young Peoples Services
- Director of Leeds Strategic Workforce & Health and Care Academy
- Independent Chair of Leeds Safeguarding Adults Board (LSAB)
- Independent Chair of Leeds Children and Young Peoples Partnership (LSCP)
- Chair of the Safer Leeds Partnership
- Public Health/ Public Health consultant
- Office of Data Analytics representative
- Third Sector representative
- Healthwatch Leeds
- Primary Care representative

Following a shadow meeting (development session) of the QPEC Subcommittee held in June 2022, the QPEC Subcommittee has met three times during 2022/23, inclusive of the March 2023 meeting. An overview of the subcommittee's work and the assurances they were provided with is outlined below.

2. Review of Committee Activities & Assurances

- **Quality Highlight Report** – The subcommittee receives a report that provides a healthcare system overview of key highlights of quality across the Leeds place, including providers' regulatory status. The principles on which items are reported to the QPEC include: national agenda significantly impacting on local systems work; quality performance consistently below standards at a place level; items on a topical issue that may be high profile and/or media sensitive; and current and unmitigated quality and safety risks for the Leeds system. The reporting format and presentation of content will continue to be developed using partner and subcommittee member feedback.

- **People's Experience** – the subcommittee seeks assurance that people are involved across the system and a quality approach is being applied. Members receive insight gathered from the People's Voices Partnership's *How Does It Feel For Me?* balanced scorecard and via Healthwatch Leeds. People's experience insight is also provided in the Quality Highlight report. From March 2023, members will receive a People's Experience report at each meeting to highlight the depth and breadth of experience across Leeds. Additional insight will be provided via the Population and Care Delivery Board reports.

- **Risk Management** - Members receive and review the red and high amber (12) risks aligned to the subcommittee. The subcommittee seeks assurance that quality related risks are being managed appropriately, by acknowledging the factors that provide assurance, identifying any gaps, noting any mitigating factors and the adequacy of action plans to address under-performance.

- **Population and Care Delivery Board Reporting** – From March 2023, the subcommittee will receive reports from the following Population and Care Delivery Boards on a cycle throughout the year: Healthy Adults, Children and Young People, Maternity, Same Day Response, Mental Health, Learning Disabilities and Neurodiversity, Frailty, End of Life, Long Term Conditions, Cancer and Planned Care. Each report will include a section related to quality and people's experience for the previous and upcoming six-month period.

- **Quality Architecture** – subcommittee members are updated on the quality and safety framework within which the subcommittee operates. Updates have been presented on the Patient Safety Incident Response Framework (PSIRF) and the new Care Quality Commission (CQC) strategy with its core ambitions of assessing local systems and tackling inequalities in health and care.

3. Self-Assessment

The self-assessment questionnaire was sent to 21 members/attendees of the Subcommittee; eight responses were received. The combined responses are attached at Appendix 2.

The QPEC Subcommittee held its inaugural meeting in September 2022, and therefore is still in early stages of development. The responses to the survey reflect this, with mixed responses to most statements and some comments noting that it is too early to judge at this stage.

In summary, the responses and comments referred to:

- a need to increase understanding of where the subcommittee and its work fit in the supporting quality architecture;
- a need to continue to broaden the focus on quality beyond the NHS to the wider sector;
- the ongoing development of papers, including the Quality Highlight report and the Population and Care Delivery Board reports;
- inconsistent attendance at meetings and the importance of nominating deputies; and
- support for face to face meetings, with parking as a consideration, but also some flexibility around remote meetings.

The review of the Subcommittee's Terms of Reference will provide opportunity to consider some of the above issues. Meetings will continue to be held in community venues for 2023/24; however members are asked to reflect on whether any meetings should be held remotely.

This initial survey will enable comparison in the future to identify areas that require further improvement as the subcommittee becomes more established and its membership evolves.

4. Terms of Reference

The Subcommittee's Terms of Reference are attached at Appendix 3 for review. The Corporate Governance team have reviewed and included tracked changes within this with minor amendments.

The subcommittee are asked to consider the following proposed statements for inclusion in the terms of reference:

- **Role of this subcommittee 2.8** - The subcommittee will also feed into the West Yorkshire System Quality Group and the West Yorkshire Quality Committee, with the Director of Nursing and Quality attending both West Yorkshire meetings.
- **Reporting 7.2 -** The subcommittee will also report into the West Yorkshire System Quality Group and the West Yorkshire Quality Committee.

Leeds Health & Care Partnership

NHS West Yorkshire Integrated Care Board

Terms of Reference

Leeds Committee
of the West Yorkshire Integrated Care Board

Delivery Sub-committee

Version: ~~Final 1.0~~

Date approved: ~~14 July 2022~~

Approved by: L~~eeds Committee of the West Yorkshire Integrated Care Board~~

~~**Review date:**~~ ~~13 December 2022~~ February 2023

Change history

Version number	Changes	Editor	Date
0.3	Updated in line with governance requirements	Sam Ramsey	08/02/2022
1.0	Final version approved by Leeds Committee of ICB	Various	14/07/2022
2.0	Review of Terms of Reference	Sam Ramsey	09/02/2023

1. Introduction

1.1 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.

1.2 These terms of reference are for the Delivery sub-committee of the Leeds Health and Care Committee of the WY ICB. The Committee has no executive powers, other than those specifically delegated in these terms of reference.

1.3 The ICB is part of the West Yorkshire Integrated Care System, which has identified a set of guiding principles that shape everything we do:

- We will be ambitious for the people we serve and the staff we employ.
- The West Yorkshire partnership belongs to its citizens and to commissioners and providers, councils and NHS. We will build constructive relationships with communities, groups and organisations to tackle the wide range of issues which have an impact on health inequalities and people's health and wellbeing.
- 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 apply subsidiarity principles in all that we do – with work taking place at the appropriate level and as near to local as possible.

1.4 The ICS has committed to behave consistently as leaders and colleagues in ways which model and promote our shared values:

- We are leaders of our organisation, our place and of West Yorkshire.
- We support each other and work collaboratively.
- We act with honesty and integrity, and trust each other to do the same.
- We challenge constructively when we need to.
- We assume good intentions; and
- We will implement our shared priorities and decisions, holding each other mutually accountable for delivery.

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

1.6 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.

1.7 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.

2. Role of this sub-committee

2.1 The Delivery sub-committee will support the Leeds Committee of the WY ICB in ~~the~~ providing assurance to the committee with respect to progress we are making with our plans to improve outcomes, tackle health inequalities and improve the effectiveness and efficiency of services.

2.2 In fulfilling its role the subcommittee will seek reasonable assurance relating to the performance and improvement in health outcomes being achieved by service transformation.

2.3 The sub-committee will also receive assurance on progress being made by Population and Care Boards to improve outcomes and reduce health inequalities.

2.4 Reasonable assurance is defined as the sub-committee being provided with evidence that performance is in line with agreed targets or trajectories, and where it is not, evidence of reasonable mitigation and an action plan to rectify any issues.

2.5 Where the sub-committee receives insufficient assurance, it will challenge, assess risks and escalate to the Leeds Committee of the ICB when necessary.

2.6 The sub-committee will oversee the continuous development of the scope, format, presentation and mechanisms of the system of performance reporting.

2.7 The sub-committee will have a focus on seeking assurance on the following areas of the Leeds Health & Care Partnership (LHCP) business:

2.8 Systems Resilience and Emergency Planning

- ~~Assurance that Leeds has robust processes for dealing with emergencies including critical incidents, disease outbreaks and pandemics~~
- Assurance that Leeds has a robust winter plan.

2.9 Operational Performance:

- NHS constitutional standards and other national planning priorities
- Local operational priorities set out in the LHCP operational plan.

2.10 Improving Outcomes:

- Improvements in the health outcomes of the population as set out in Healthy Leeds: Our Plan for Health and Care in Leeds
- Reducing health inequalities
- Benchmarking against NHS Outcomes Framework
- Progress on Service Transformation (Healthy Leeds Plan).

2.11 West Yorkshire and NHS England

- Monitoring progress against the West Yorkshire 10 Priorities
- Coordination of the LHCP input to the NHS England Quarterly Assurance processes.

~~**2.12 Climate Change**~~

- ~~Progress on delivery of net zero carbon targets across Leeds NHS Providers.~~

~~2.13~~2.12 Risk Management

- Reviewing risks assigned to the sub-committee by the Leeds Committee of the ICB and ensure that appropriate and effective mitigating actions are in place

2.13 Through its operation the Delivery sub-committee will:

- promote integration of health and social care
- promote innovation; and
- promote research, education and training.

3. Membership

3.1 This part of the terms of reference describes the membership of the sub-committee.

3.2 Core membership

The membership of the Committee will be as follows:

- Chair - Independent Member – Health Inequalities and Delivery
- Independent Member – Finance and Probity
- Non-Executive representation from partner organisations
- Executive Members (Leeds Office of the WY ICB)
  - Director of Population Health Planning
  - Director of Pathway Integration
  - Leeds Place Lead
- Partner Members, representatives from the following:
  - Leeds Teaching Hospitals Trust
  - Leeds & York Partnership Foundation Trust
  - Leeds Community Healthcare Trust
  - Leeds City Council
  - Primary Care
  - Third Sector
  - Director of Public Health

3.3 Required attendees

- Officers from across the Health and Care Partnership may be invited to attend where required.

3.4 Officers may request or be requested to attend the meeting when matters concerning their responsibilities are to be discussed or they are presenting a paper.

3.5 Any member of the Leeds Committee of the WY ICB can be in attendance subject to agreement with the Chair.

4. Arrangements for the conduct of business

4.1 Chairing meetings

4.2 The meetings will be run by the chair. In the event of the chair of the sub-committee being unable to attend all or part of the meeting, the remaining members of the sub-committee should appoint a chair for the meeting.

4.3 Quoracy

4.4 No business shall be transacted unless at least 50% of the membership is present. The quorum is 6 individuals. This must include representation from the following as a minimum:

- The Chair or his/her nominated Deputy Chair
- Executive member of the Leeds Office of the WY ICB
- At least two partner members.

4.5 For the sake of clarity:

a) No person can act in more than one capacity when determining the quorum.

b) An individual who has been disqualified from participating in a discussion on any matter and/or from voting on any motion by reason of a declaration of a conflict of interest, shall no longer count towards the quorum.

4.6 Members of the sub-committee may participate in meetings by telephone, video or by other electronic means where they are available and with the prior agreement of the chair. Participation by any of these means shall be deemed to constitute presence in person at the meeting.

4.7 Members are normally expected to attend at least 75% of meetings during the year.

4.8 With the permission of the person presiding over the meeting, the Executive Members and the Partner Members of the sub-committee may nominate a deputy to attend a meeting of the sub-committee that they are unable to attend. The deputy may speak and vote on their behalf.

4.9 Conflict resolution / arbitration

4.10 The sub-committee will be expected to reach a consensus when agreeing matters of business. This will mean that core members are expected to compromise and demonstrate the behaviours listed within the Terms of Reference.

4.11 If the group cannot reach a consensus on a specific matter, the group will consider inviting an independent facilitator to assist with resolving the specific

matter. Under exceptional circumstances any substantive difference of views among members will be reported to the Leeds Committee of the WY ICB.

4.12 Frequency of meetings

4.13 The sub-committee will meet at least four times in the ~~bi-monthly with six meetings scheduled each~~ calendar year. Development sessions may also be held throughout the year.

4.14 Declarations of interest

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

4.16 The nature of the role and scope of the Delivery sub-committee means that conflicts of interest will be inherent within the business. Conflicts of interest cannot be avoided but should be recognised and mitigated where possible.

4.17 If any member has an interest, financial or otherwise, in any matter and is present at the meeting at which the matter is under discussion, he/she will declare that interest as early as possible and act in accordance with the ICB's Conflicts of Interests Policy. Subject to any previously agreed arrangements for managing a conflict of interest, the chair of the meeting will determine how a conflict of interest should be managed. The chair of the meeting may require the individual to withdraw from the meeting or part of it. The individual must comply with these arrangements, and actions taken in mitigation will be recorded in the minutes of the meeting.

4.18 Members are expected to protect and maintain as confidential any privileged or sensitive information divulged during the work of the committee. Such items should not be disclosed until such time as it has been agreed that this information can be released.

4.19 Support to the Committee

4.20 Administrative support will be provided to the sub-committee by the Corporate Governance team within the Leeds Office of the WY ICB. This will include:

- Agreement of the agenda with the chair in consultation with the Executive Lead, taking minutes of the meetings, keeping an accurate record of attendance, management and recording of conflicts of interest, key points of the discussion, matters arising and issues to be carried forward.
- Maintaining an on-going list of actions, specifying members responsible, due dates and keeping track of these actions.

- Sending out agendas and supporting papers to members five working days before the meeting.
- An annual work plan to be updated and maintained on a monthly basis.

5. Remit and responsibilities of the committee

5.1 The West Yorkshire Integrated Care Board high level Scheme of Reservation and Delegation (SoRD) is attached at Appendix 1 and outlines those responsibilities that will be delegated to a committee or sub-committee.

6. Authority

6.1 The sub-committee will receive information and intelligence from NHS and social care providers across the city and seek assurance on improvement. Where any concerns are raised that require further investigation or assurance, the sub-committee is authorised to commission more detailed reports on specific areas for assurance and learning.

6.2 The sub-committee is authorised to investigate any activity within its terms of reference. It is authorised to seek any information it requires within its remit, from any employee of the ICB and they are directed to co-operate with any such request made by the sub-committee.

6.3 The sub-committee is authorised to commission any reports or surveys it deems necessary to help it fulfil its obligations.

6.4 The sub-committee is authorised to obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary. In doing, so, the Committee must follow procedures put in place by the ICB for obtaining legal or professional advice.

6.5 The sub-Committee is authorised to create working groups as are necessary to fulfil its responsibilities within its terms of reference.

7. Reporting

7.1 The sub-committee will report directly into the Leeds Committee of the WY ICB and will present a Chair's Summary to each meeting. The Chair shall draw to the attention of the Leeds Committee of the WY ICB any significant issues or risks relevant.

~~7.2 The sub-Committee will also report into the West Yorkshire System Quality group.~~

8. Conduct of the sub-committee

8.1 Members must demonstrably consider the equality and diversity implications of decisions they make and consider whether any new resource allocation achieves positive change around inclusion, equality and diversity.

8.2 Members of the sub-committee will abide by the 'Principles of Public Life' (The Nolan Principles) and the NHS Code of Conduct.

8.3 Information obtained during the business of the sub-committee must only be used for the purpose it is intended. Sensitivity should be applied when considering financial, activity and performance data associated with individual services and institutions.

8.4 Members are expected to protect and maintain as confidential any privileged or sensitive information divulged during the work of the sub-committee. Such items should not be disclosed until such time as it has been agreed that this information can be released.

9. Behaviours and practice all members will demonstrate

- Act across the Leeds health and care system in line with Nolan's Seven Principles of Public Life: Selflessness, Integrity, Objectivity, Accountability, Openness, Honesty, Leadership.
- Act in the best interests of the population of Leeds.
- Resolve differences between members and present a united front in the best interests of the people of Leeds.
- Openness and transparency in discussions.
- Hold each other to account.
- Offer constructive challenge to improve service delivery and ensure financial balance.
- Openness and transparency in decision making, being explicit when not agreeing/supporting a decision.
- Undertake the necessary discussions within their own organisations prior to the group meeting in order to make decisions within the meeting.

10. Equality

10.1 The group shall have due regard to equality in all its activities and shall take steps to demonstrate it has consulted with communities appropriately in its decisions.

11. Review of the sub-committee

11.1 The sub-committee will produce an annual work plan in consultation with the Leeds Committee of the WY ICB.

11.2 The sub-committee will undertake an annual self-assessment of its performance against the annual plan, membership and terms of reference. This self-assessment will form the basis of the annual report. Any resulting proposed changes to the terms of reference will be submitted for approval by the Leeds Committee of the WY ICB.

11.3 These terms of reference and membership will be reviewed initially after six months, and thereafter at least annually following their approval.

Leeds Health & Care Partnership

NHS

NHS West Yorkshire
Integrated Care Board

Appendix 5

Terms of Reference

Leeds Committee
of the West Yorkshire Integrated Care Board

Finance & Best Value Sub-committee

Version: ~~Final 1.0~~

Date approved: ~~14 July 2022~~

Approved by: ~~Leeds Committee of the West Yorkshire Integrated Care Board~~

Review date: ~~13 December 2022~~ February 2023

Change history

Version number	Changes	Editor	Date
0.2	Updated in line with governance requirements	Sam Ramsey	08/02/2022
0.3	Further amends following discussion with Chair	Sam Ramsey	10/06/2022
2.0	Review of terms of reference	Sam Ramsey	February 2023

1. Introduction

1.1 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.

1.2 These terms of reference are for the Finance and Best Value sub-committee of the Leeds Health and Care Committee of the WY ICB. The Committee has no executive powers, other than those specifically delegated in these terms of reference.

1.3 The ICB is part of the West Yorkshire Integrated Care System, which has identified a set of guiding principles that shape everything we do:

- We will be ambitious for the people we serve and the staff we employ.
- The West Yorkshire partnership belongs to its citizens and to commissioners and providers, councils and NHS. We will build constructive relationships with communities, groups and organisations to tackle the wide range of issues which have an impact on health inequalities and people's health and wellbeing.
- 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 apply subsidiarity principles in all that we do – with work taking place at the appropriate level and as near to local as possible.

1.4 The ICS has committed to behave consistently as leaders and colleagues in ways which model and promote our shared values:

- We are leaders of our organisation, our place and of West Yorkshire.
- We support each other and work collaboratively.
- We act with honesty and integrity, and trust each other to do the same.
- We challenge constructively when we need to.
- We assume good intentions; and
- We will implement our shared priorities and decisions, holding each other mutually accountable for delivery.

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

1.6 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.

1.7 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.

2. Role of this sub-committee

2.1 The Finance and Best Value sub-committee is accountable to the Leeds Committee of the WY ICB for providing assurance on its work.

2.2 The remit, responsibilities, membership and reporting arrangements of the sub-committee are set out in these terms of reference. The sub-committee has no executive powers, other than those specifically delegated in these terms of reference. The sub-committee is not a decision-making committee,

but is advisory and to provide assurance to the Leeds Committee of the WY ICB.

2.3 The role of the sub-committee is to advise and support the Leeds Committee of the WY ICB through performance oversight of key financial and performance plans, indicators and/or targets, including good stewardship of resources, as specified in the Leeds Health and Care Partnership's strategic and operational plans, in order to ensure best value and clinical outcomes.

2.4 The sub-committee is responsible for advising and supporting the Leeds Committee of the WY ICB in:

- scrutinising and tracking the delivery of key financial and service priorities, outcomes and targets as specified in the Leeds Health and Care Partnership's strategic and operational plans
- ensuring that the Leeds Committee of the WY ICB develops and adopts appropriate policies and procedures to support effective governance of financial matters.

2.5 Responsibilities

2.6 Ensure financial management achieves value for money, efficiency and effectiveness in the use of resources, allowing the partnership to achieve best value and outcomes for its investments, with a continuing focus on cost reduction and achievement of efficiency targets.

2.7 Identify and manage mechanisms put in place by the partnership to drive cost improvements.

2.8 Review the partnership's medium-term financial planning and annual budgets and provide assurance to the Leeds Committee of the WY ICB on appropriateness of investment and efficiency priorities within the plans.

2.9 To ensure appropriate information is available to manage financial issues, risks and opportunities across the place.

2.10 Monitor and review population health management and resource allocation.

2.11 Monitor and review the achievement of the financial plan, including good stewardship of resources and identify risks to achievement of these.

2.12 Provide a forum to evaluate requirements and advise the Leeds Committee of the WY ICB on committing resources to respond to performance issues and potential investments.

2.13 To work with place partners to identify and agree common approaches across the system such as financial reporting, estimates and judgements.

2.14 Ensure that processes for financial management (including reporting) are robust and advise the Leeds Committee of the WY ICB appropriately on the content of the Finance Report.

2.15 Review contractual arrangements and payment mechanisms, ensuring fitness for purpose, best value and clinical outcomes.

2.16 Develop the understanding of 'place-based' financial decision-making to inform the development of the Leeds Health and Care partnership and the West Yorkshire Integrated Care System.

~~2.16~~

2.17 Reviewing risks assigned to the sub-committee by the Leeds Committee of the ICB and ensure that appropriate and effective mitigating actions are in place

3. Membership

3.1 This part of the terms of reference describes the membership of the sub-committee.

3.2 Core membership

The membership of the Committee will be as follows:

- Chair – Independent Member – Finance and Governance
- Independent Member – ~~Health Inequalities and Delivery~~
- Further Non-Executive representation from partner organisations
- Executive Members (Leeds Office of the WY ICB)
    - ICB Place Lead
    - ICB Place Finance Lead
    - Medical Director

  The following Executive Members will be invited where required, dependent on the agenda item discussion:

    - Director of Population Health
    - Director of Pathway Integration
    - Director of Primary Care and Same Day Response
- Partner Members, representatives from the following *where relevant dependent on the agenda item discussion:*
    - Leeds Teaching Hospitals Trust
    - Leeds & York Partnership Foundation Trust
    - Leeds Community Healthcare Trust
    - Leeds City Council

3.3 Required attendees

- Officers from across the Health and Care Partnership may be invited to attend where required.

3.4 Officers may request or be requested to attend the meeting when matters concerning their responsibilities are to be discussed or they are presenting a paper.

3.5 Any member of the Leeds Committee of the WY ICB can be in attendance subject to agreement with the Chair.

4. Arrangements for the conduct of business

4.1 Chairing meetings

4.2 The meetings will be run by the chair. In the event of the chair of the sub-committee being unable to attend all or part of the meeting, the remaining members of the sub-committee should appoint a chair for the meeting.

4.3 Quoracy

4.4 No business shall be transacted unless at least 6 individuals are present. The quorum is 6 individuals. This must include representation from the following as a minimum:

- The Chair or his/her nominated Deputy Chair
- ICB Place Finance Lead or his/her nominated Deputy Chair
- Executive member of the Leeds Office of the WY ICB
- At least one partner member

4.5 For the sake of clarity:

a) No person can act in more than one capacity when determining the quorum.

b) An individual who has been disqualified from participating in a discussion on any matter and/or from voting on any motion by reason of a declaration of a conflict of interest, shall no longer count towards the quorum.

4.6 Members of the sub-committee may participate in meetings by telephone, video or by other electronic means where they are available and with the prior agreement of the Chair. Participation by any of these means shall be deemed to constitute presence in person at the meeting.

4.7 Members are normally expected to attend at least 75% of meetings during the year.

4.8 With the permission of the person presiding over the meeting, the Executive Members and the Partner Members of the sub-committee may nominate a deputy to attend a meeting of the sub-committee that they are unable to attend. The deputy may speak and vote on their behalf.

4.9 Conflict resolution / arbitration

4.10 The sub-committee will be expected to reach a consensus when agreeing matters of business. This will mean that core members are expected to compromise and demonstrate the behaviours listed within the Terms of Reference.

4.11 If the group cannot reach a consensus on a specific matter, the group will consider inviting an independent facilitator to assist with resolving the specific matter. Under exceptional circumstances any substantive difference of views among members will be reported to the Leeds Committee of the WY ICB.

4.12 Frequency of meetings

4.13 The sub-committee will meet at least four times in the ~~bi-monthly with six meetings scheduled each~~ calendar year. Development sessions may also be held throughout the year.

4.14 Declarations of interest

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

4.16 The nature of the role and scope of the Finance sub-committee means that conflicts of interest will be inherent within the business. Conflicts of interest cannot be avoided but should be recognised and mitigated where possible.

4.17 If any member has an interest, financial or otherwise, in any matter and is present at the meeting at which the matter is under discussion, he/she will declare that interest as early as possible and act in accordance with the ICB's Conflicts of Interests Policy. Subject to any previously agreed arrangements for managing a conflict of interest, the chair of the meeting will determine how a conflict of interest should be managed. The chair of the meeting may require the individual to withdraw from the meeting or part of it. The individual must comply with these arrangements, and actions taken in mitigation will be recorded in the minutes of the meeting.

4.18 Members are expected to protect and maintain as confidential any privileged or sensitive information divulged during the work of the committee. Such items should not be disclosed until such time as it has been agreed that this information can be released.

4.19 Support to the sub-committee

4.20 Administrative support will be provided to the sub-committee by the Corporate Governance team within the Leeds Office of the WY ICS. This will include:

- Agreement of the agenda with the Chair in consultation with the Executive Lead, taking minutes of the meetings, keeping an accurate record of attendance, management and recording of conflicts of interest, key points of the discussion, matters arising and issues to be carried forward.
- Maintaining an on-going list of actions, specifying members responsible, due dates and keeping track of these actions.
- Sending out agendas and supporting papers to members five working days before the meeting.
- An annual work plan to be updated and maintained on a monthly basis.

5. Remit and responsibilities of the committee

5.1 The West Yorkshire Integrated Care Board high level Scheme of Reservation and Delegation (SoRD) is attached at Appendix 1 and outlines those responsibilities that will be delegated to a committee or sub-committee.

6. Authority

6.1 The sub-committee will receive information and intelligence from NHS and social care providers across the city and seek assurance on improvement. Where any concerns are raised that require further investigation or assurance, the sub-committee is authorised to commission more detailed reports on specific areas for assurance and learning.

6.2 The sub-committee is authorised to investigate any activity within its terms of reference. It is authorised to seek any information it requires within its remit, from any employee of the ICB and they are directed to co-operate with any such request made by the sub-committee.

6.3 The sub-committee is authorised to commission any reports or surveys it deems necessary to help it fulfil its obligations.

6.4 The sub-committee is authorised to obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary. In doing, so, the Committee must follow procedures put in place by the ICB for obtaining legal or professional advice.

6.5 The sub-committee is authorised to create working groups as are necessary to fulfil its responsibilities within its terms of reference.

7. Reporting

7.1 The sub-committee will report directly into the Leeds Committee of the WY ICB and will present a Chairs Summary to each meeting. The Chair shall draw to the attention of the Leeds Committee of the WY ICB any significant issues or risks relevant.

7.2 The sub-committee will also be supported and advised by the Director of Finance Group.

8. Conduct of the committee

8.1 Members must demonstrably consider the equality and diversity implications of decisions they make and consider whether any new resource allocation achieves positive change around inclusion, equality and diversity.

8.2 Members of the sub-committee will abide by the 'Principles of Public Life' (The Nolan Principles) and the NHS Code of Conduct.

8.3 Information obtained during the business of the sub-committee must only be used for the purpose it is intended. Sensitivity should be applied when considering financial, activity and performance data associated with individual services and institutions.

8.4 Members are expected to protect and maintain as confidential any privileged or sensitive information divulged during the work of the sub-committee. Such items should not be disclosed until such time as it has been agreed that this information can be released.

9. Behaviours and practice all members will demonstrate

- Act across the Leeds health and care system in line with Nolan's Seven Principles of Public Life: Selflessness, Integrity, Objectivity, Accountability, Openness, Honesty, Leadership.
- Act in the best interests of the population of Leeds.
- Resolve differences between members and present a united front in the best interests of the people of Leeds.
- Openness and transparency in discussions.
- Hold each other to account.
- Offer constructive challenge to improve service delivery and ensure financial balance.
- Openness and transparency in decision making, being explicit of when not agreeing/supporting a decision.
- Undertake the necessary discussions within their own organisations prior to the group meeting in order to make decisions within the meeting.

10. Equality

10.1 The group shall have due regard to equality in all its activities and shall take steps to demonstrate it has consulted with communities appropriately in its decisions.

11. Review of the sub-committee

11.1 The sub-committee will produce an annual work plan in consultation with the Leeds Committee of the WY ICB.

11.2 The sub-committee will undertake an annual self-assessment of its performance against the annual plan, membership and terms of reference. This self-assessment will form the basis of the annual report. Any resulting proposed changes to the terms of reference will be submitted for approval by the Leeds Committee of the WY ICB.

11.3 These terms of reference and membership will be reviewed ~~initially after six months, and thereafter at least annually following their approval~~annually.

Leeds Health & Care Partnership

NHS
NHS West Yorkshire
Integrated Care Board

Appendix 6

Terms of Reference

Leeds Committee
of the West Yorkshire Integrated Care Board

Quality and People's Experience Subcommittee

Version: ~~Final 1.0~~
Date approved: ~~14 July 2022~~
Approved by: ~~Leeds Committee of the West Yorkshire Integrated Care Board~~
Review date: ~~13 December 2022~~ March 2023

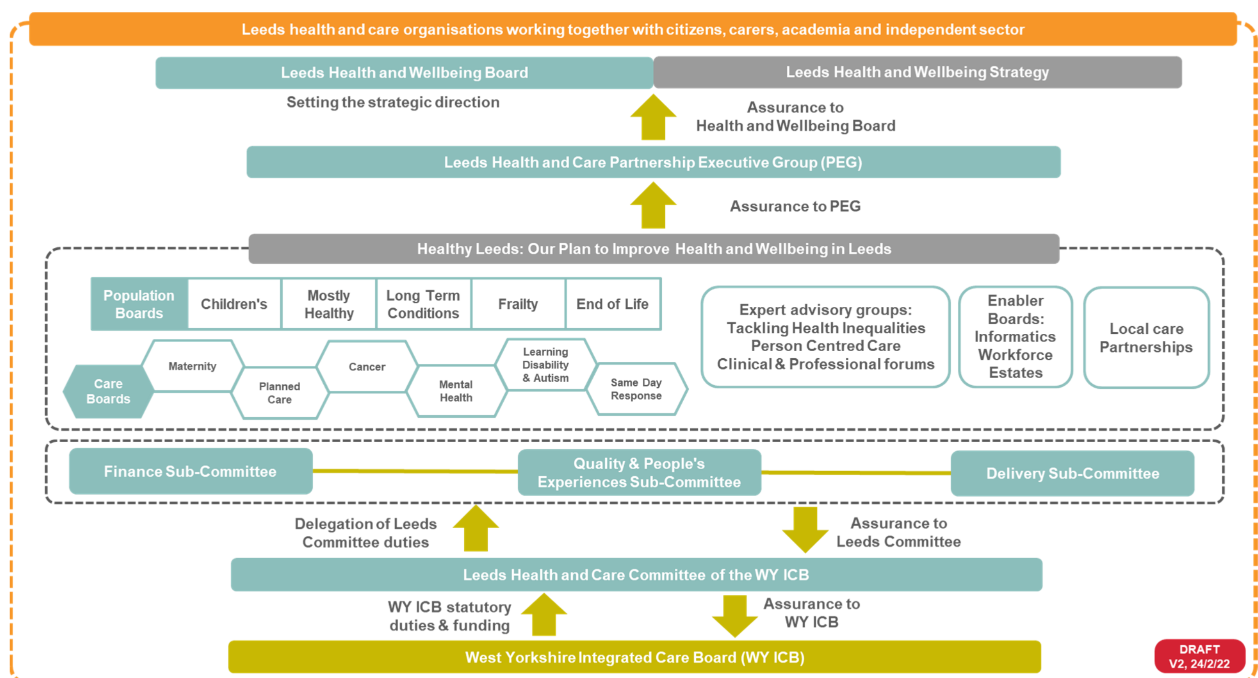
Change history

Version number	Changes	Editor	Date
0.3	Updated in line with governance requirements	Sam Ramsey	08/02/2022
0.6	Updated by Director of Nursing & Quality & Head of Governance	Sam Ramsey	31/05/2022

1. Introduction

1.1 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.

1.2 These terms of reference are for the Quality and People's subcommittee of the Leeds Health and Care Committee of the WY ICB. The subcommittee has no executive powers, other than those specifically delegated in these terms of reference.



1.3 The ICB is part of the West Yorkshire Integrated Care System, which has identified a set of guiding principles that shape everything we do:

- We will be ambitious for the people we serve and the staff we employ.
- The West Yorkshire partnership belongs to its citizens and to commissioners and providers, councils and NHS. We will build constructive relationships with communities, groups and organisations to tackle the wide range of issues which have an impact on health inequalities and people's health and wellbeing.
- 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 apply subsidiarity principles in all that we do – with work taking place at the appropriate level and as near to local as possible.

1.4 The ICB has committed to behave consistently as leaders and colleagues in ways which model and promote our shared values:

- We are leaders of our organisation, our place and of West Yorkshire.
- We support each other and work collaboratively.
- We act with honesty and integrity, and trust each other to do the same.
- We challenge constructively when we need to.
- We assume good intentions; and
- We will implement our shared priorities and decisions, holding each other mutually accountable for delivery.

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

1.6 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.

1.7 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.

2. Role of this subcommittee

2.1 The role of the Quality and People's Experience Subcommittee is to ensure that we have quality at the heart of the place-based partnership in Leeds. The main role of the subcommittee will be to seek assurance that quality outcomes are achieved for the population of Leeds, that services are safe, and they provide a good experience for our populations.

2.2 The subcommittee will bring a Leeds-wide lens to quality assurance and improvement, bringing together system partners from health and social care and third sector to who will be mutually accountable. A key role for the subcommittee will be assurance that quality standards are being met, but also where is not being delivered, we understand how services are applying improvement approaches to address them. The subcommittee will also seek assurance that where quality challenges span different services and providers of care, we have a collaborative approach to improvement.

2.3 It will be the responsibility of the subcommittee to oversee and assure itself of the quality of commissioned health and social care services in Leeds. The subcommittee will need to understand measurements of quality within the system, using metrics and outcome data to assess the situation, along with narrative and assurance from city partners, and feedback from people using the services.

2.4 One of the ways the Quality and People's Experience subcommittee will have a focus on quality is through the lens of Population Health and will seek to understand how quality outcomes are measured for each population group, how value is delivered, and how the service user experience is being captured and improved. Regular updates from the Population and Care Delivery Boards will feed into the Quality and People's Experience subcommittee throughout the year.

2.5 The Quality and People's Experience subcommittee will be required to understand any emerging quality risks in the system and actions being taken to support improvement. This will be through a regular quality reporting mechanism to the subcommittee from the Leeds Office of the ICB Quality team. The subcommittee will also receive the Leeds Office of the ICB risk register as part of its forward plan.

2.6 The subcommittee will receive updates on Patient Safety from the Leeds place, the implementation of the new patient safety framework, and the safety improvement plans that are part of the framework.

2.7 It is envisaged that there will be expert and advisory groups that support the work of the Quality and People's Experience subcommittee. These groups may already exist within the system. Examples of these groups may be Tackling Health inequalities, Person Centred Care, or 'How does it feel for me' around people's experience

2.8 The subcommittee will report directly into the Leeds Committee of the WY ICB. The subcommittee will also feed into the West Yorkshire System Quality Group and the West Yorkshire Quality Committee, with the Director of Nursing and Quality attending both West Yorkshire meetings.

2.9 Commitments

2.10 The subcommittee through some preparatory workshops have agreed a number of commitments to help guide its work. These are:

2.11 We will ensure that the fundamental standards of quality are delivered across the Leeds Health and Care system

2.12 We will continually improve the quality of the services we deliver, and apply Quality Improvement (QI) principles to system quality challenges

2.13 We will listen to people who receive care about their experience and commit to continuously improving this experience

2.14 We will engage our clinical leaders in quality improvement work that spans across organisational boundaries

2.15 We will agree our shared priorities for quality improvement, holding each other mutually accountable for delivery of those improvements

2.16 We will work on the triple aim of delivering high-quality care, improved outcomes and value for money in everything we do

2.17 We are leaders of our organisation but also in our place and we will support each other in partnership around a shared approach to quality

2.18 We act with honesty and integrity, and trust each other to do the same

2.19 We challenge constructively when we need to, but always demonstrating respectful behaviours

2.20 We assume good intentions and work collaboratively around this work.

3. Membership

3.1 This part of the terms of reference describes the membership of the subcommittee.

3.2 Core membership

The membership of the subcommittee will be as follows:

- Chair – Independent Chair
- Independent Member – Health Inequalities and Delivery
- Executive Members (Leeds Office of the WY ICB)
  - Director of Nursing and Quality
  - Director of Population Health
  - Medical Director
- Director level representative with responsibility for quality assurance and improvement
  - Leeds Teaching Hospitals Trust
  - Leeds Community Healthcare Trust
  - Leeds & York Partnership Foundation Trust
  - Leeds City Council Adults Services
  - Leeds City Council Children and Young Peoples Services
- Director of Leeds Strategic Workforce & Health and Care Academy
- Independent Chair of Leeds Safeguarding Adults Board (LSAB)
- Independent Chair of Leeds Children and Young Peoples Partnership (LSCP)
- Chair of the Safer Leeds Partnership
- Public Health/ Public Health consultant
- Office of Data Analytics representative
- Third Sector representative
- Healthwatch Leeds
- Primary Care representative

3.3 Required attendees

- Deputy Director of Quality and Nursing (Leeds Office of the ICB)
- Head of Quality (Leeds Office of the ICB)
- Head of Quality Improvement and Patient Safety (Leeds Office of the ICB)
- Head of Safeguarding/Designated professional for Safeguarding (Leeds Office of the ICB)

3.4 Officers may request or be requested to attend the meeting when matters concerning their responsibilities are to be discussed or they are presenting a paper.

3.5 Any member of the Leeds Committee of the WY ICB can be in attendance subject to agreement with the chair.

4. Arrangements for the conduct of business

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4.2 The meetings will be run by the chair. In the event of the chair of the subcommittee being unable to attend all or part of the meeting, the remaining members of the subcommittee should appoint a chair for the meeting.

4.3 Quoracy

4.4 No business shall be transacted unless at least 50% of the membership is present. The quorum is 9 individuals. This must include representation from the following as a minimum:

- The Chair or his/her nominated Deputy Chair
- Executive member of the Leeds Office of the WY ICB~~S~~
- At least three other members from the core membership.

4.5 For the sake of clarity:

a) No person can act in more than one capacity when determining the quorum.

b) An individual who has been disqualified from participating in a discussion on any matter and/or from voting on any motion by reason of a declaration of a conflict of interest, shall no longer count towards the quorum.

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4.13 The subcommittee will meet bi-monthly with six meetings scheduled each calendar year. Development sessions may also be held throughout the year.

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

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7.2 The subcommittee will also report into the West Yorkshire System Quality Group and the West Yorkshire Quality Committee.

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Leeds Health & Care Partnership

NHS West Yorkshire
Integrated Care Board

LC 80/22

LEEDS COMMITTEE OF THE WEST YORKSHIRE INTEGRATED CARE BOARD
WORK PROGRAMME 2023-24

ITEM	Jul 23	Oct 23	Dec 23	Mar 24	Lead
STANDING ITEMS					
Welcome & Introductions	X	X	X	X	Chair
Apologies & Declarations of Interest	X	X	X	X	Chair
Minutes of previous meeting	X	X	X	X	Chair
Matters Arising	X	X	X	X	Chair
Action Tracker	X	X	X	X	Chair
Questions from Members of the Public	X	X	X	X	Chair
Summary & Reflections	X	X	X	X	Chair
People's Voice	X	X	X	X	-
Place Lead Update	X	X	X	X	TR
Forward Work Plan	X	X	X	X	Chair
Items for the Attention of the ICB	X	X	X	X	Chair
GOVERNANCE ITEMS					
Sub-Committee Assurance Reports	X	X	X	X	Relevant Chairs
Committee Effectiveness	X				Chair
Risk Management Report	X	X	X	X	TR
Terms of Reference Review	X				SR
FINANCIAL PLANNING					
Financial Position Update	X	X	X	X	VPS
Operational Planning				X	VPS
ITEMS FOR DECISION					
Business Case: Community Diagnostics Centre	X				JBS/RA
Leeds Joint Working Agreement (JWA): Anticoagulation working with Daiichi-Sankyo	X				LM
Local Care Partnership (LCP) Update	X				TS
GP procurement for Shadwell and Shakespeare Practices		X			KT