Leeds Health & Care Partnership

NHS West Yorkshire Integrated Care Board

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

Wednesday 5th July 2023, 13:15 – 16:30
(Private pre-meet for members 13:00, public meeting 13:15)
St George's Centre, 60 Great George Street, LS1 3DL

AGENDA

No.	Item	Lead	Page	Time
LC 01/23	**Welcome, Introductions**	**Rebecca Charlwood** Independent Chair	-	13:15
LC 02/23	**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 03/23	**Minutes of the Previous Meeting** - To approve the minutes of the meeting held 14th March 2023	**Rebecca Charlwood** Independent Chair	7	
LC 04/23	**Matters Arising** - To consider any outstanding matter arising from the minutes that is not covered elsewhere on the agenda	**Rebecca Charlwood** Independent Chair	-	
LC 05/23	**Action Tracker** - To receive the action tracker for review	**Rebecca Charlwood** Independent Chair	18	
LC 06/23	**People's Voice** - To share a lived experience of health and care services	**Hannah Davies** Healthwatch Leeds	-	13:20
LC 07/23	**Questions from Members of the Public** - To receive questions from members of the public in relation to items on the agenda	**Rebecca Charlwood** Independent Chair	-	13:35
LC 08/23	**Place Lead Update** - To receive a report from the Place Lead	**Tim Ryley** Place Lead	21	13:45
LC 09/23	**Population and Care Delivery Board Update** - To receive a highlight update from the Maternity Population Board	**Julie Duodu** GP Clinical Lead for Maternity **Nikki Stanton** Senior Pathway Integration Manager	-	14:00
ROUTINE REPORTS				
LC 10/23	**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	28	14:10
LC 11/23	**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	31	

No.	Item	Lead	Page	Time
LC 12/23	**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	33	
LC 13/23	**Risk Management Report** - To receive and consider the risk management information provided	**Tim Ryley** Place Lead	35	14:25
FINANCE				
LC 14/23	**Finance Update at Month 2 (May) 2023-24** - To receive the financial position update	**Visseh Pejhan-Sykes** Place Finance Lead	70	14:40
BREAK 14:55 – 15:05				
ITEMS FOR DECISION/ASSURANCE/STRATEGIC UPDATES				
LC 15/23	**Refresh of the Healthy Leeds Plan (Joint Forward Plan)** - To consider and provide feedback on the current draft of the refreshed plan	**Jenny Cooke** Director of Population Health Planning	82	15:05
LC 16/23	**Local Care Partnerships (LCP) Update** - To receive an update on the Local Care Partnerships Development Programme	**Thea Stein** Chief Executive of Leeds Community Healthcare NHS Trust **Kim Adams** Programme Director Local Care Partnerships Development Programme	177	15:35
FORWARD PLANNING				
LC 17/23	**Items for the Attention of the ICB Board** - To identify items to which the ICB Board needs to be alerted, which it needs to be assured, which it needs to action and positive items to note	**Rebecca Charlwood** Independent Chair	-	16:05
LC 18/23	**Forward Work Plan** - To consider the forward work plan	**Rebecca Charlwood** Independent Chair	192	
LC 19/23	**Any Other Business** - To discuss any other business raised and not on the agenda	**Rebecca Charlwood** Independent Chair	-	
LC 20/23	**Date and Time of Next Meeting** The next meeting of the Leeds Committee of the WY ICB will be held at 1.15 pm (1:00 pm private pre-meeting for Committee Members) on Wednesday 4th October 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 21/23	**Confidential Minutes of the Previous Meeting** - To approve the minutes of the confidential meeting held on 14th March	**Rebecca Charlwood** Independent Chair	N/A	16:20

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

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
	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
			Nursing and Midwifery Council contracted as Lay Panel Member for Investigation Committee	Financial Interests	Direct	01/08/2021	Ongoing
			Wellspring Multi-Academy Trust Voluntary Trustee / Director	Non-Financial Professional Interests	Direct	01/09/2015	Ongoing
			Wellspring Multi-Academy Trust Chair	Non-Financial Professional Interests	Direct	02/11/2022	Ongoing
			Family member employed by PCN in Rotherham, south Yorkshire	Indirect Interests	Indirect	01/01/2019	Ongoing
			Family member employed by Bradford Teaching Hospitals NHS FT	Indirect Interests	Indirect	01/01/2020	Ongoing
Dr	George Winder	Chair of Leeds GP Confederation.	GP Partner Oakwood Lane Medical Practice	Financial Interests	Direct	01/01/2013	Ongoing
			Clinical Director, Seacroft PCN	Financial Interests	Direct	01/07/2019	Ongoing
			Chair of Leeds GP Confederation	Financial Interests	Direct	01/01/2023	Ongoing
	James Goodyear	Director of Strategy, LTHT	Nil Declaration				
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
			Director Jemjo Healthcare Ltd	Financial Interests	Direct	01/05/2022	Ongoing
			Spouse business - Airtight International Ltd, Nails 17 Ltd	Indirect Interests	Indirect	10/05/2012	Ongoing
			Director Governor, Leeds Jewish Free School	Non-Financial Personal Interests	Direct	16/01/2014	Ongoing
			Chair of Governor's Brodetsky Primary School	Non-Financial Personal Interests	Direct	01/09/2012	Ongoing
			Director, trustee Brodetsky Foundation Trust	Non-Financial Personal Interests	Direct	17/06/2014	Ongoing
			Founding Fellow of the Faculty of Clinical Informatics	Non-Financial Professional Interests	Direct	01/05/2018	Ongoing
			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
			Leeds Acupuncture Clinic - father's and brother's business	Indirect Interests	Indirect	10/05/2012	Ongoing
			Clinical Lead - Yorkshire & Humber Local Health & Care record Exemplar, inc membership of NHSE Clinical Advisory Group	Financial Interests	Direct	01/11/2018	Ongoing

	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
Dr	John Beal	Chair, Healthwatch Leeds	Board member (currently Chair) of Healthwatch Leeds	Non-Financial Professional Interests	Direct	01/01/2013	Ongoing
			Member of Yorkshire Branch Council and West Yorkshire Committee of British Dental Association	Non-Financial Professional Interests	Direct	01/01/1990	Ongoing
			Vice Chair of British Fluoridation Society	Non-Financial Professional Interests	Direct	01/01/1983	Ongoing
			Family Member is a clinician in Leeds Community Health NHS Trust	Indirect Interests	Indirect	01/01/2008	Ongoing
Professor	Phil Wood	Chief Executive - LTHT	Chair of Northeast and Yorkshire Genomic Medicine Service Partnership Board	Non-Financial Professional Interests	Direct	01/02/2023	Ongoing
Professor	Phil Wood	Chief Executive - LTHT	Honorary Professor in Healthcare Leadership, University of Leeds	Non-Financial Professional Interests	Direct	01/02/2023	Ongoing
	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
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
			Sector representative for MHLDA on the ICB Board	Financial Interests	Direct	01/07/2022	Ongoing
			Trustee on the board of the workforce development trust	Indirect Interests	Indirect	01/07/2022	Ongoing
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
			Honorary contract with LTHT NHS Trust	Non-Financial Professional Interests	Direct	01/01/2021	Ongoing
			GP Partner, Oakwood Lane Medical Practice	Financial Interests	Direct	01/01/2014	Ongoing
			Husband – Director, Craggs Shoe Repairs – has some contracts with fire and ambulance services	Indirect Interests	Indirect	01/01/2003	Ongoing
			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
			Director, Craggs Wetherby Limited – this is a shoe repair shop in Wetherby	Financial Interests	Direct	01/11/2018	Ongoing
	Shanaz Gul	Third Sector Representative	Director of Hamara, seeks to do business re Health and Social Care	Financial Interests	Direct	01/01/2019	Ongoing
			Voluntary Rep for Forum Central and Third Sector Leeds Leadership group	Non-Financial Professional Interests	Direct	01/11/2021	Ongoing
	Thea Stein	Chief Executive – Leeds Community Healthcare NHS Trust	Trustee of Nuffield Trust	Financial Interests	Direct	06/12/2019	Ongoing
			CQC Executive Reviewer	Non-Financial Professional Interests	Direct	01/01/2018	Ongoing

	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
			Related to Officer working in the CCG's Digital Communications Officer – Niece by marriage	Indirect Interests	Indirect	11/12/2017	Ongoing
	Yasmin Khan	Independent member of the Leeds Committee of the WY ICB	Nil Declaration				

Deputies in attendance

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

Draft Minutes

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

Tuesday 14 March 2023, 1.15pm – 4.30pm

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

Members	Initials	Role	Present	Apologies
Rebecca Charlwood	**RC**	Independent Chair, Leeds Committee of the WY ICB	✓	
Tim Ryley	**TR**	Place Leeds, ICB in Leeds	✓	
Visseh Pejhan-Sykes	**VPS**	Place Finance Lead, ICB in Leeds		✓
Cheryl Hobson	**CH**	Independent Member – Finance and Governance	✓	
Yasmin Khan	**YK**	Independent Member – Health Inequalities		✓
Thea Stein	**TS**	Chief Executive, Leeds Community Healthcare NHS Trust (LCH)	✓	
Dr Sara Munro	**SM**	Chief Executive, Leeds & York Partnership Foundation NHS Trust (LYPFT)	✓	
Professor Phil Wood	**PW**	Chief Executive, Leeds Teaching Hospital NHS Trust (LTHT)	✓	
Dr George Winder	**GW**	Chair, Leeds GP Confederation		✓
Dr Ruth Burnett (Deputising for GW)	**RB**	Executive Medical Director, Leeds GP Confederation	✓	
Caroline Baria	**CB**	Director of Adults & Health, Leeds City Council (LCC)	✓	
Victoria Eaton	**VE**	Director of Public Health, LCC	✓	
Shanaz Gul	**SG**	Third Sector Representative	✓	
Dr John Beal	**JB**	Chair, Healthwatch Leeds	✓	
Dr Sarah Forbes	**SF**	Medical Director, ICB in Leeds		✓
Dr Keith Miller (Deputising for SF)	**KM**	Associate Medical Director, ICB in Leeds	✓	
Jo Harding	**JH**	Director of Nursing and Quality, ICB in Leeds	✓	
Additional Attendees				
Sam Ramsey	**SR**	Head of Corporate Governance & Risk, ICB in Leeds	✓	
Harriet Speight	**HS**	Corporate Governance Manager, ICB in Leeds	✓	

Members	Initials	Role	Present	Apologies
Jenny Cooke (Item 83)	**JC**	Director of Population Health Planning, ICB in Leeds	✓	
Harriet Wright (Item 67)	**HW**	Community Project Worker, HealthWatch Leeds	✓	
Tony Cooke (Item 76)	**TC**	Chief Officer, Leeds Health Partnerships	✓	
Wasim Feroze (Item 76)	**WF**	Strategy Partnership Development Manager, Leeds Health Partnerships	✓	

Members of public/staff observing – 4

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62/22	**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.	
63/22	**Apologies and Declarations of Interest** Apologies had been received from Yasmin Khan, Dr George Winder and Dr Sarah Forbes. Dr Ruth Burnett was in attendance as deputy for Dr George Winder and Dr Keith Miller was in attendance as deputy for Dr Sarah Forbes. Members were asked to declare any interests presenting an actual or potential conflict of interest arising from matters under discussion.	
64/22	**Minutes of the Previous Meeting – 13 December 2022** The public minutes were approved as an accurate record. **<u>The Leeds Committee of the WY ICB:</u>** a) **Approved** the minutes of the previous meeting held on 13 December 2022.	
65/22	**Matters Arising** There were no matters raised on this occasion.	
66/22	**Action tracker** The committee noted the completed actions set out in the action tracker.	
67/22	**People's Voice** The Chair introduced Harriet Wright (HW) from Healthwatch Leeds, who provided a summary of recent work undertaken by HealthWatch between March and May 2022 to understand people's experiences of discharge care from hospitals and services	

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	in Leeds. Members also watched a short video of interviews with patients and their families around their experiences. HW highlighted that 38% of patients were dissatisfied with discharge care, showing the clear need for improvement, however also noted that the research found some examples of good practice around coordination and after care to be built upon throughout the system. HW advised that the recommendations to improve discharge care were centred around involving people and their family members in conversations at all stages, and appropriate follow up following discharge. The Chair thanked HealthWatch Leeds for all their work to ensure that the voices of the people of Leeds are heard. Tim Ryley (TR) advised that the HealthWatch report and recommendations were shared at the Leeds System Assurance Board (SRAB), and several actions had taken place since to improve the discharge process, including an increase in the number of discharge coordinators at LTHT and a broader piece of work around system flow, with patient and family involvement at the centre of the process. John Beal (JB) added that the third sector also play a significant role in providing support to patients throughout the discharge process, in hospital and in the community. Thea Stein (TS) reflected that the most crucial element to improving discharge care is communication, and the Chair noted that the 'three C's'– communication, coordination, and compassion – continues to be a consistently strong theme shown through patient stories and support for embedding this approach into work streams across the partnership.	
68/22	**Questions from Members of the Public** There were no questions received from members of the public on this occasion.	
69/22	**Place Lead Update** TR provided an overview of the report, highlighting significant challenges relating to access to mental health, neuro-diversity diagnosis, waiting times for the emergency department, and system flow pressures. TR advised that despite challenges, there had been good progress in several areas, which is testament to hard work of colleagues across the system. TS advised that one in eight children in Leeds at some point during their school life will seek a diagnosis for neurodiversity, as opposed to any one time as implied within the report. TS highlighted the importance of the distinction as a high number of those seeking diagnosis do not convert into a diagnosis. Members discussed the multi-factorial challenges surrounding waiting times for neuro-diversity diagnosis in Leeds, including increased demand as a result of cultural shift and increased awareness, as well as national disinvestment in early intervention.	

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	Shanaz Gul (SG) also advised of recent research that had shown Black and Minority Ethnic (BAME) parents experience particular challenges in seeking diagnosis and support, noting the prevalence of fear around labelling symptoms as misbehaviour and the cultural sensitivities surrounding this. The committee was advised that work is ongoing at WY level to further understand and address the challenges around neuro-diversity diagnosis and noted its support for this critical work. In response to a query around system flow challenges, TR advised there had been some improvement however was not completely sustainable at this stage. Partners also reported pressures around recruitment and industrial action that continue to challenge system flow. Phil Wood (PW) reiterated the importance of ensuring that the system does not accept consequences of challenging circumstances that have become more common – such as long waits without beds. **<u>The Leeds Committee of the WY ICB:</u>** a) **Considered** and **noted** the contents of the report	
70/22	**Quality and People's Experience Sub-Committee Update** The Chair provided a brief overview of the assurance report included in the agenda pack and highlighted the following key points: - The sub-committee received the updated risk register and the risks relating to risk of harm and mental health were discussed at length. Members emphasised the importance of prioritising the increasing risk of harm, particularly relating to access to mental health services. The subcommittee agreed to escalate to the Leeds Committee of the WY ICB to raise the profile of the risk, and to consider what can be done collectively as a system to further mitigate the risk and increase the priority and focus of reducing risk of harm, utilising other parts of the system, such as the Mental Health Transformation Programme. - 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 and discussed the findings. The '3 Cs' - communication, compassion, and co-ordination were seen as integral to apply when working across the health and care system. - It was suggested that a deep dive be brought back to a future meeting relating to patient experiences, with further discussion required to determine the most appropriate way of ensuring all partners and services are involved. - The sub-committee received the first round of Population and Care Delivery Board reports and welcomed the comprehensive and assuring content. The Chair thanked the Boards for their work.	

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	In reference to the suggestion for a deep dive into patient experiences, TR supported the approach to a system wide approach and advised that the Care Quality Commission (CQC) had set out plans to undertake system level reviews to understand people's experiences, recognising that people do not experience a single NHS trust, rather they experience a service which may be delivered across several organisations, including the third sector. Jo Harding (JH) added that, along with whole system sign-up, deep dives conducted in this way would also require a degree of independence given the number of partners involved. **<u>The Leeds Committee of the WY ICB:</u>** a) **Received** the update.	
71/22	**Delivery Sub-Committee Update** The Chair of the Sub-Committee, Yasmin Khan (YK), was not in attendance. Cheryl Hobson (CH) provided a brief overview of the assurance report included in the agenda pack on behalf of YK, as follows: - 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 (Item 75 refers). The sub-committee was supportive of the work undertaken to date and referred to the Leeds Committee for consideration. - 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, similarly to QPEC, recognised the '3 Cs' as essential building blocks for good person-centred care. - There was some discussion around the sustainability of the 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. - The sub-committee received the first round of Population and Care Delivery Board reports and welcomed the comprehensive and assuring content. **<u>The Leeds Committee of the WY ICB:</u>** a) **Received** the update.	
72/22	**Finance and Best Value Sub-Committee Update**	

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	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 key points: - The sub-committee received the finance update, and were advised that 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 WY system. - The sub-committee received a presentation detailing the first iteration of financial plans for 2023/24 submitted to NHS England at the end of February 2023, focused on the high-level income and expenditure assumptions across organisations and systems – and the derived gap. Members recognised that fast-moving nature of financial planning at this stage in the process, however wished to alert the Leeds Committee to the significant projected funding gap and therefore risk to achieving a balanced position for 2023/24 and consequent impact on capacity, quality and outcomes for service users in Leeds. The sub-committee also recognised the impact of cost pressures on the sustainability of the third sector in Leeds. - The sub-committee received the first round of Population and Care Delivery Board reports and welcomed the comprehensive and assuring content. **<u>The Leeds Committee of the WY ICB:</u>** a) **Received** the update.	
73/22	**Risk Management Report** TR provided an overview of the report. In reference to the initial financial plans for 2023/24 as discussed by the Finance and Best Value Sub-Committee, TR advised that an additional risk would be added to the risk register setting out the risk to achieving a balanced position for 2023/24, to be shared with risk colleagues across WY to ensure consistency. TR also noted that risks associated with prescribing costs had been mitigated to some extent since the report was written due to additional NHS England funding allocated to support. Dr John Beal (JB) noted the high scoring risk relating to emergency department waiting times and high performance in Leeds for ambulance transfers and queried the relationship between the two. PW advised that the waiting times for emergency care could be improved by keeping people in ambulances however the LTHT clinical opinion is that this is not the most safe and efficient option, however recognised that there is variability across the country in this view. The committee noted the increasing risk to the sustainability of third sector support in delivery of services in the context of system pressures and financial challenge, particularly in terms of reducing unplanned care. SG advised that the third sector workforce had reduced by a fifth in the last year, reducing capacity to support health and social care services to meet demand and preventative work to reduce unplanned care. PW noted that all unplanned care should not be perceived as a	

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	failure to deliver, because often emergency care is the most appropriate intervention, and therefore urged colleagues to be cautious with language and narrative. TR highlighted that the current work with Staten Island had evidenced the positive outcomes associated with utilising the third sector in a targeted way to prevent unnecessary unplanned care, which will support outcomes-based transformational work in Leeds moving forward. TS also advised the committee of the Enhance project to support older people leaving hospital in Leeds, which had been similarly successful in preventing readmissions. It was also noted that further work is taking place to reflect the risk to third sector support in delivery of services in existing risks aligned to Population and Care Delivery Boards, and members were advised of the high scoring corporate risk on the West Yorkshire ICB risk register relating to sustainability of Voluntary, Community and Social Enterprise (VCSE) services. **<u>The Leeds Committee of the WY ICB:</u>** 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.	
74/22	**Finance Update at Month 10 (January) 2022-23** TR provided an overview of the report, advising that Leeds Place continues to carry risks to balancing to plan for 22/23, with a potential gap of £3.7m that is likely to be covered across the ICB as a statutory organisation as the financial year closes. However, mitigations to even reach this position are based upon technical flexibilities and non-recurrent measures, which presents a greater challenge for the 2023/2024 financial year in terms of how far away we are from resource and the need to develop recurrent proposals to stabilise the position in Leeds. TR advised that the forecast for the next financial year is constantly evolving, with current predictions indicating a deficit of approximately £90m across the Leeds system. TR noted that currently there remains a £6bn gap against initial plans nationally, which shows the challenge faced across the NHS, not just locally. PW commented that the financial pressures present a challenge to achieve transformation work required and supported by the committee and reiterated the importance of continuing to drive change throughout periods of uncertainty. **<u>The Leeds Committee of the WY ICB:</u>** a) **Noted** the month 10 year to date and forecast financial position; b) **Noted** the additional key risks that may crystallise later in the year; and	

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	c) **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. TS left the meeting at 2:50 p.m. following discussion of this item.***	
75/22	**NHS Operational Planning 2023/24** TR introduced the report, providing an overview of the provided an update on progress made in the operational planning round 23/24 and self-assessment against the 31 National NHS objectives. TR advised that all local objectives/trajectories had been linked to the relevant Population and Care Delivery Board to look in further detail at each requirement. In reference to the bed occupancy objective, PW advised that 92% occupancy must be considered in relative terms to the five Covid-19 wards currently open in Leeds hospitals. In reference to the dentistry objective, JB expressed concern regarding the financial viability of dentists moving back to NHS with the current offered conditions. TR shared concerns, noting the small group of staff allocated to manage the dentistry contract and that ICBs must ensure that early engagement with practices takes place to avoid losing funding. The Chair queried how realistic and achievable the objective to reduce GP appointments is in the current climate and was advised that work is ongoing to widen access by non-traditional routes and standardise pathways of referrals to ease pressure on GPs. It was recognised, however, that challenges are presented by methods of data analysis determined by NHS England, for example, currently only face-to-face appointments can be counted against the objective. **<u>The Leeds Committee of the WY ICB:</u>** a) **Noted** and **commented** on the current position in terms of the operational planning round b) **Noted** that the leads place position will be shared to inform the WY NHS ICB system submission	
76/22	**Leeds Health and Wellbeing Strategy Refresh - a strategy to 2030** Tony Cooke (TC) introduced the report and draft strategy, advising members that significant engagement had taken place to date with different organisations across Leeds which had supported health inequalities remaining central to the strategy, building on evidenced based approaches, and aligning more closely with Healthy Leeds Plan and other local strategies. TC also noted that carers had been added to the strategy in recognition of the crucial role they play in supporting the system.	

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	JH sought assurance that the safeguarding boards and health protection boards in the city had been involved in the development of the strategy, noting that evidence indicates that many Leeds citizens do not feel safe and free from harm, which is a clear wellbeing concern. TC advised that Safer Leeds and both safeguarding boards had been engaged. Members welcomed the addition of carers to the strategy, and the approach taken to 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. **The Leeds Committee of the WY ICB:** a) **Noted** the updates on the refresh of the Leeds Health and Wellbeing Strategy; b) **Noted** the work that had been undertaken across the Partnership as part of the refresh of the Leeds Health and Wellbeing Strategy; and c) **Commented** on the attached working draft of the refresh Leeds Health and Wellbeing Strategy.	
77/22	**Urgent Decision: Practice Proposal - The merger of Fountain Medical Centre and Morley Health Centre** Sam Ramsey (SR) introduced the report and advised that 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. JH noted the intention for wound care to move to Morley Health Centre as part of the merger and urged colleagues to ensure the move is as seamless as possible, as the wound care service had historically been well used and therefore delays and disruption would have significant impact. **The Leeds Committee of the WY ICB:** a) **Ratified** 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.	
78/22	**Sub-Committee Annual Reports and Terms of Reference** SR introduced the report, providing an overview of the process undertaken for each of the sub-committees as set out within the report. SR also advised that the self-	

No.	Agenda Item	Action
	assessment for the Leeds Committee had been developed and coordinated at WY level and the process would begin next week. CH commented that the annual reports presented at each of the sub-committees had been well received and prompted good discussion, noting that themes were similar across each of the sub-committees, which is reassuring at this stage in their development. **<u>The Leeds Committee of the WY ICB:</u>** a) **Received** the annual reports; b) **Considered** any further actions to be taken to improve the effectiveness of the sub-committees; and c) **Approved** the amends to the terms of reference.	
79/22	**Items for the Attention of the ICB Board** The Chair outlined that the Committee would submit a report to the West Yorkshire ICB on items to be alerted on, assured on, action to be taken and any positive items to note. TR set out that the following items be added to the report: - The financial challenge for 2023/24 and work ongoing to consider the continued system pressures; - The need for a broader piece of work to consider some of the wider issues around neurodiversity demand; - The Leeds Health and Wellbeing Strategy refresh and Healthy Leeds Plan – a good example of genuine partnership in Leeds; - Third sector challenges, consequences and links into the overall work and pressures.	
80/22	**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. It was suggested that a Population and Care Delivery Board verbal update be added as an additional standing item to the forward work plan – with a single Board attending to present on a specific workstream, on a rotational basis. **ACTION** – To add Population and Care Delivery Board Update as a standing item to the forward work plan.	**HS**
81/22	**Any Other Business** No matters were raised on this occasion.	

No.	Agenda Item	Action
	Date and Time of Next Meeting The next meeting of the Leeds Committee of the WY ICB to be held at 1.15 pm on Wednesday 5th July 2023, at a venue to be confirmed.	
	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.	

Action Tracker

Leeds Committee of the WY ICB

Action No.	Meeting Date	Item Title	Actions agreed	Lead(s)	Accountable body / board / committee	Status	Update
12	**14/03/2023**	**Forward Work Plan**	To add Population and Care Delivery Board Update as a standing item to the forward work plan.	**Harriet Speight**	**LCICB**		**Complete** Added to the forward work plan
Completed Actions							
1	**14/07/2022**	**Sub-Committee Terms of Reference**	Amendment to be made in relation to quoracy and full membership.	**Sam Ramsey**	**LCICB**		**Complete** Amended. All terms of reference will be published on the Leeds Health & Care Partnership website.
2	**14/07/2022**	**Place Lead Update**	Leeds Prospectus Update & Leeds Place Pilot to be added to forward work plan for September 2022.	**Sam Ramsey**	**LCICB**		**Complete** Added to forward work plan.
3	**14/07/2022**	**Financial Business Case**	Letter of support to be drafted and circulated to Committee members for comment.	**Visseh Pejhan-Sykes**	**LCICB**		**Complete** Circulated for comments and final letter sent to LTHT on 22/07/22.
4	**14/07/2022**	**Summary & Reflections**	Email to be circulated to Committee members for reflections on the Committee meeting and any items for the forward work plan.	**Sam Ramsey**	**LCICB**		**Complete** Email circulated with action tracker on 22/07/22.

Action No.	Meeting Date	Item Title	Actions agreed	Lead(s)	Accountable body / board / committee	Status	Update
5	**22/09/2022**	**People's Voice**	To determine appropriate sub-committee for variation across primary care services to be considered and add to the relevant forward work plan	**Sam Ramsey / Harriet Speight**	**LCICB**		**Complete** The Delivery Sub-Committee (17 Nov) considered a comprehensive report detailing the data, insight and work programmes associated with improving access to primary medical services.
6	**22/09/2022**	**People's Voice**	To add an item to the forward work plan of the to understand how the Better Care Fund is currently utilised to support system flow	**Sam Ramsey / Harriet Speight**	**LCICB**		**Complete** Better Care Fund Update incorporated into Place Lead Update at Item 45/22
7	**22/09/2022**	**Place Lead Update**	Future Place Lead Update reports to include input from PEG	**Tim Ryley / Manraj Khela**	**LCICB / PEG**		**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
10	**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

Action No.	Meeting Date	Item Title	Actions agreed	Lead(s)	Accountable body / board / committee	Status	Update
11	**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

Meeting name:	Leeds Committee of the West Yorkshire Integrated Care Board
Agenda item no:	LC 08/23
Meeting date:	5 July 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 performance challenges. Whilst performance has improved in a number of areas there remain real challenges around access to mental health, neuro-diversity diagnosis, waiting times, emergency department, system flow pressures and Tier 3 Weight Management services. The financial challenges for next year are significant and planning work continues to address these.

The report also provides how Leeds has now declared itself a Marmot City and how we will be working with Public Health in Leeds to address collectively wider determinants of health and address the inequalities in health outcome.

The report then describes the work to review the underlying Operating model for the West Yorkshire ICB, which is to be in place by April 2024. It also provides an update on the Leeds Health and Care partnership.

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
None.
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. There are still several strikes being undertaken and planned. Whilst the NHS is managing the on the day risks that these create, they are having a significant impact on waiting times and are an additional financial pressure to trusts involved.

1.2. Leeds and the West Yorkshire ICS delivered financial balance in 2022-23. However, the picture for 2023-24 looks much more challenging as the finance report indicates. This is a national picture and there will be considerable and increasing pressure from NHS England as the year progresses if the picture does not improve.

1.3. The financial challenge along with a national focus on a few key areas will shape the year ahead at a national level. The areas that remain at the top of the agenda include 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 continue to be a high political priority.

1.4. Increased demand for services in nearly every area and issues of inequality post pandemic continue to impact on the NHS at a national and local level. This is especially true in Mental Health and Social Care. The continuing cost of living crisis with high inflation and interest rates will be a further factor impacting on health care. These will have to be addressed, but as yet there is less attention on these politically.

1.5. The Hewitt Review was published at the end of March and the government has now responded to the Hewitt Review. The Hewitt Review was undertaken on behalf of the Chancellor and was generally well received across the NHS. The response has been muted though with generalised agreement and few of the recommendations have been taken-up. However, it is clear that ICS and ICB are going to stay and that there is a desire nationally to make them work.

2. Leeds Performance Challenges

2.1. In most areas performance is improving and given the challenges of the last few years this needs to be noted. There is more detail in the performance report.

2.2. There remain a few areas of concern including:

2.2.1. 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.

2.2.2. One particular concern is the waiting times for neurodiversity (autism, ADHD etc) particularly among children. This is a wider national issue and is being looked at both within Leeds and through a West Yorkshire lens.

2.2.3. 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.

2.2.4. We continue to see improving performance in our desired standards in the A&E departments. 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.

2.2.5. There are very significant pressures on Tier 3 weight management services with long waits leading us to consider suspending access temporarily. There is a general increase in demand for weight management services more widely and at the same time there have been reductions in the Tier 1 and Tier 2 services offered through the Local Authority as they face tough decisions on funding. Given the Leeds financial position we are not able to fund increased capacity.

3. Financial Challenge in Leeds

3.1. The Leeds Health & Care System is facing significant financial challenges this year and is in-effect in deficit. These are set out in more detail in the financial report and have been reviewed by the Leeds Finance and Best Value Sub-Committee. These are challenges facing both the NHS and Leeds City Council and consequently there are implications for our wider partners in the city in primary care, the third sector and the independent sector.

3.2. Each of the NHS statutory partners have cost improvement plans of between about 4 and 8%. This equates to about £136m and is driven by both demand and contract agreements. The council needs to find £65m. In addition, there remains an underlying gap of about £30m in the NHS with considerable further risks of about £15m, for example the Neurodiversity issue described above.

3.3. The work required to address the gap is requiring several difficult decisions to be made. These include deferring the spend of Core20Plus5 health

inequalities funding this year until the deficit position has improved. Members of the Leeds Committee of the WY ICB are asked to note the pressures ahead of wider discussions at the meeting today.

4. Marmot City

4.1. Leeds has declared itself a Marmot City and under the leadership of Public Health in Leeds City Council we will be working together to look at how we best address collectively wider determinants of health and address the inequalities in health outcome. Michael Marmot and his team joined us for the launch event of this programme of work on June 12th.

4.2. Leeds City Council and University College London's Institute of Health Equity (IHE) are working together with wider partners over two-years to tackle health inequalities and the part they play in causing illness and lowered life expectancy. We will start with a focus on two areas - giving every child the best start in life and creating healthy and sustainable communities with good quality housing. NHS partners are fully committed to working with Leeds City Council to play our part as Anchor institutions and as providers of care to children and young people.

5. West Yorkshire Operating Model

5.1. All 42 ICB's in England have been informed that their running cost allocation will be reduced by 20% from April 2024 and a further 10% from April 2025. This is absolute and is above wage inflation. This is a reduction across West Yorkshire of about £10-12m. The running cost allocation pays for many of the functions undertaken by the ICB on behalf of the system.

5.2. The ICB in West Yorkshire has decided to review its underlying Operating Model rather than just undertake a crude-cost cutting exercise. This programme is being led by the Leeds Place ICB Accountable Officer. The new operating model will be in place from April 2024.

5.3. The commitment to subsidiarity and the importance of place will remain at the heart of the new operating model. Several options were considered from full consolidation of all staff in a central team through to what is currently in place, an ICB team in each place and further to Place Based Partnerships being delegated responsibilities and resources. The ICB executive team and WY ICB Board have agreed the delegation to place-based partnerships as the destination and asked for an operating model that permits this in future.

5.4. This is in line with conversations we have been having over the last two-years in Leeds as we strengthen the collaboration we have and increase the depth of the integration. This is an opportunity for Leeds and there are conversations with executive colleagues across the city in how we make the most of this opportunity.

5.5. The ICB team in Leeds as part of the review is developing a model that provides three broad capabilities to the Leeds Health & Care Partnership – Population Health Planning, Transformation Capability and System Co-ordination and Development. There will be impacts for individuals in the team, the committee, and the partnership. These will emerge over the next 12 months.

6. Leeds Health and Care Partnership

6.1. The Leeds Health & Care Partnership wants to say thank you to Thea Stein for all work in the city as the Chief Executive of Leeds Community Healthcare (LCH). We also want to congratulate her on her appointment as Chief Executive of the Nuffield Trust and wish her well in the future.

6.2. 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 are planning to host a visit from the Staten Island team in September.

6.3. On a positive note, Leeds Teaching Hospitals Trust (LTHT) have been given the green light by the national New Hospitals Programme. This means that work can continue to develop the new build and innovation hub in line with the plans presented. This is an exciting programme for the people of Leeds and the surrounding region who use the hospital's services. Through the innovation hub it also contributes to the economy of Leeds more broadly. There are several years of further work to do before completion and the Leeds Health & Care Partnership commits itself to supporting LTHT in ensuring the new build delivers the benefits intended.

6.4. In partnership with the Department of Health and Social Care (DHSC), organisations across sectors in Leeds including the NHS, local government, universities and the third sector are working together on key areas of work to tackle health disparities and improve employment opportunities in the city, through the Leeds Health and Social Care Hub, focusing on three key areas: People and Talent; the Health and Social Care Economy and Policy Collaboration.

6.5. A range of successful engagement and collaborative opportunities have been developed recently including the very first DHSC Policy in Leeds Day, which brought together colleagues to foster and strengthen excellent working relationships, and to improve health and social care policy making in Leeds. On June 8th, public health experts across Leeds and West Yorkshire came together at Leeds Beckett University on for the 'Public Health in Leeds Day'. This event was led by the DHSC Permanent Secretary, Sir Chris Wormald and England's Chief Medical Officer, Professor Chris Witty, showcasing the

‘local agencies in progressing health care, and to make the case for evidence, research and prevention in the Public Health space’.

6.6. The Health and Social Care Hub will continue its work in tackling health inequalities through partnerships at national and city level, focusing on key areas related to Oral Health and Elective Care.

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

1. **NOTE** and **CONSIDER** the report; and
2. **ADVISE** on future content

Committee Escalation and Assurance Report – Alert, Advise, Assure

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

Date of meeting: 7 June 2023

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

Date of meeting reported to: 5 July 2023

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

Key escalation and discussion points from the meeting
Alert:
There were no issues to alert which require further action by the Leeds Committee of the West Yorkshire Integrated Care Board.
Advise:
<u>Learning Disability Mortality Review (LeDeR) Annual Report 2021/22</u> The Quality & People's Experience Subcommittee (QPEC) received the first LeDeR annual report for the WY ICB for 2021/22; previous LeDeR annual reports had been produced by individual Clinical Commissioning Groups (CCGs). In Leeds, 42 deaths had been reported to LeDeR in 2021/22, with the average age of death for people with a learning disability in Leeds being 59 years. Of the 42 deaths, 88% of people had two or more health conditions and 31% had five or more health conditions. It was noted that 5/10 people with a learning disability died before they were 65 years old, contrasting with 1/10 for the general population. Members were informed that 85% of deaths involved do not attempt cardiopulmonary resuscitation (DNACPR) decisions. Members requested additional assurance that the high rate of DNACPR decisions was being addressed. Members noted that Leeds Teaching Hospital NHS Trust (LTHT) had developed a process for surgical prioritisation for people with a learning disability or autism based upon need. The process took into account individual factors and included the Getting Ready for Surgery programme to reduce the possibility of deterioration prior to surgery. **<u>Patient Safety Strategy: Implementation of the New Patient Safety Incidence Review Framework (PSIRF)</u>** Members were updated on the PSIRF which would replace the Serious Incidence (SI) framework and was targeted at systems as opposed to services. Challenges to implementation of PSIRF were discussed including the requirement for 5-6 days

training, with no additional resource to support training and time taken to carry out investigations and developing Patient Safety Incident Response Plans (PSIRPs). With regards to governance around the framework, patient safety progress would be reported via the West Yorkshire Quality Committee and the West Yorkshire System Quality Group. Further discussions would be undertaken in relation to the governance associated with the oversight and sign off of PSIRPs. The subcommittee noted that PSIRF was not mandated in social care, primary care and third sector organisations.

Assure:

Population and Care Delivery Board Biannual Reports

The subcommittee received biannual reports from the Frailty Board, End of Life (EoL) Board, Mental Health Board and Learning Disabilities (LD) and Neurodiversity Board. With regards to the Frailty Board report, members commended positive outcomes in reducing falls. The number of falls (per 100k population) resulting in an emergency admission between the first three quarters of 2021/22 and 2022/23 had reduced by 23%. When both frailty and dementia were included in the data, the reduction in falls was 37%. A positive outcome was also noted with a 49% increase in the number of people living with severe frailty and dementia who had received a Collaborative Care and Support Plan (CCSP) review between August 2022 and March 2023.

With regards to the EoL population, it was noted that only 3.5k people in the city were identified in the cohort, despite 7k people dying per year in Leeds. Assurance was given that the EoL Population Board were working with other Population Boards to ascertain how EoL cohorts were being identified as part of the Board's ambition to close the gap.

The subcommittee noted the priorities of Mental Health Population Board which included inpatient care, MH transformation, access to timely crisis support and proactive community personalised care for people with severe mental illness including their physical health needs. Within the LD and Neurodiversity Population Board report, members noted the increased levels of demand for diagnostic and support pathways for autistic people and people with ADHD.
QPEC members welcomed the Population Boards' comprehensive reports and commended the teams on their work.

Quality Highlight Report

The subcommittee received the Quality Highlight report which provided a healthcare system overview of key highlights of quality across the Leeds place, including providers' regulatory status, as identified up to 23 May 2023.

Following the Care Quality Commission (CQC) reinspection of Shadwell Medical Centre and its rating of 'good overall', assurance was given that no General Practices in Leeds were rated 'inadequate'.

Risk Report

Members received the risk register for risk cycle 1. Nine risks were aligned to the subcommittee with five high scoring open risks scoring 12 or above. Two new risks

had been added: delays in access to timely diagnoses of neurodiversity; and limited growth in primary care resources. Members noted the reduced risk score for Intermediate Care Patient Medication which reflected ongoing improvement work. Work had focussed on adopting a more proactive approach to self-medication and members were assured by the reduced risk score.

Committee Escalation and Assurance Report – Alert, Advise, Assure

Report from: Leeds Delivery Sub-Committee

Date of meeting: 14 June 2023

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

Date of meeting reported to: 5 July 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>Mental Health Risks: Deep Dive</u> The sub-committee received its first deep dive report into mental health risks, following request at the last meeting. Members were advised that the risk was currently scored at 16 (high) with a target risk score of 12 (moderate), and despite some improvements in recruitment and planned remodelling of operational plans, ongoing challenges had delayed progress at the rate required. Members recognised the clear health inequalities in prevalence of mental health conditions, noting that poverty and deprivation inequality intersects with other disadvantages such as those caused by structural racism. The Chair also highlighted the consistent theme around ongoing staffing and recruitment challenges throughout reports received at the meeting and wished for this to be raised as an alert to the Leeds Committee.
Advise:
<u>Refresh of the Healthy Leeds Plan / Joint Forward Plan</u> The sub-committee received an update on the refresh of the Healthy Leeds Plan and was supportive of the work undertaken to date. It was highlighted that partner boards had not been engaged in the development of the plan, however recognised that all partners had been continuously engaged through Partnership Executive Group (PEG). The sub-committee recommends that Leeds Committee members ensures that key strategic messages are shared with their respective organisations for awareness and buy-in across the Leeds Health and Care Partnership. **<u>Children and Young People Core20PLUS5 Data Report</u>**

The sub-committee received a report and presentation detailing health inequalities data for children and young people in Leeds, including several key overarching demographic trends, including that 34% (60k) of 0-17 year olds live in an area ranking in the 10% most deprived nationally. The presentation highlighted specific trends related to each of the 'PLUS' groups, including ethnic minority communities, inclusion health groups, people with a learning disability and autistic people, people with multi-morbidities, and protected characteristics.

Several members commented on the radical change required to tackle the significant issues surrounding oral health. Members noted the upcoming transfer of dental care commissioning responsibilities from NHS England to ICBs, which was expected to provide opportunity for more targeted work to address issues highlighted in the report. Members were also advised that discussions had taken place at WY ICB level, and suggestions had been taken forward to introduce preventative oral care in schools. An update on this work would be welcomed by the sub-committee.

Assure:

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 had been improving and that there were plans in place to address gaps, in the context of continuously stretched resources.

Risk Management

The sub-committee received the updated risk register and noted assurance that the steady reduction in risk levels appeared to be in line with the narrative from the Delivery Performance report. The sub-committee wished to highlight to the Leeds Committee that future risks setting and management approaches would align across West Yorkshire ICB five places, to ensure consistency.

Population and Care Delivery Board Bi-annual Reports

The sub-committee received reports submitted by the following four Population and Care Delivery Boards:

- Mental Health
- Learning Disability and Neurodiversity
- Frailty
- End of Life

The sub-committee welcomed the more succinct format of the reports and noted assurance of the work undertaken to date. Members specifically highlighted the key role the third sector play in supporting the work highlighted in neighbourhoods to support people with non-clinical issues.

Committee Escalation and Assurance Report – Alert, Advise, Assure

Report from: Leeds Finance and Best Value Sub-Committee

Date of meeting: 21 June 2023

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

Date of meeting reported to: 05 July 2023

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

Key escalation and discussion points from the meeting
Alert:
<u>Finance Update at Month 2 (May) 2023-24</u> The sub-committee received the finance update. Members were advised that at Month 2, Leeds Place was carrying risks to balancing to plan for 23/24, with a best-case scenario of a £8.5m gap, and a more likely position of a £15.7m gap, required to be corrected by October 2023. Members were advised that several emerging risks had been identified and were presenting cause for concern, particularly given the underlying deficit position and lack of technical flexibilities to mitigate. It was also highlighted that investments into reducing health inequalities had been temporarily halted to reduce cost pressures, and the potential impact of this if continued into the next financial year. **<u>Community Diagnostics Centre (CDC) Phase 1 & Phase 2 Update</u>** The sub-committee received an update on the Community Diagnostics Centres (CDC) programme, following an earlier presentation in September 2022. Members were advised that since then, the Phase 1 scheme had been approved and funds received from NHS England to proceed. Members were advised, however, that it had been recommended that one of the three sites, Armley Health Centre, will no longer be used due to unforeseen costs. Members highlighted the potential health inequalities impact associated with this and the need for the availability of services in the area to be well communicated to communities, whilst recognising that the services in Armley had not yet been established and therefore there would not be a reduction of service in the area. Members were also presented with the recently submitted business case for Phase 2 for additional funding from NHS England, however also alerted to the key risk of availability of workforce and the arrangements for future funding beyond 2024-25. The sub-committee raised concern regarding the £3m annual recurrent funding required by the ICB in the future if NHS England do not commit to fund beyond 2025, and the need to assess the value of the benefit of earlier intervention compared to current diagnostic pathways. The sub-committee highlighted the wider

need for robust medium term financial planning to ensure that the system can continue with such schemes when external funding ceases. The matter was escalated to the Leeds Committee for consideration.

Advise:

Financial Planning 23-24

The sub-committee received a report detailing the current financial plans for 2023/24, focused on the high-level income and expenditure assumptions across organisations and systems – and the derived gap.

(QIPP) schemes for 2023-24 were identified and agreed by Executive Management Team (EMT) and the Senior Team via the EMT and QIPP Steering Group meetings in April and May, to allow the ICB in Leeds to submit plans in early May. For 2024-25, the Population and Care Delivery Boards had been tasked with identifying QIPP schemes and any other areas where potential savings could be made early in the year, to present to EMT for agreement by the end of June 2023 and for engagement and implementation in advance of 1 April 2024. Members agreed that this should become a continuous all year-round process for population boards to engage with. Although members recognised the tight timescales to submit plans for 2023-24, the sub-committee requested further oversight of the process for 2024-25 in advance of agreement for implementation by EMT.

Assure:

Population and Care Delivery Board Bi-annual Reports

The sub-committee received reports submitted by the following four Population and Care Delivery Boards:

- Mental Health
- Learning Disability and Neurodiversity
- Frailty
- End of Life

The sub-committee welcomed the clear focus on financial impacts in the presentations of each report. Members requested that the next iteration of reports focus around explicitly setting out financial resources that are engaged in the respective areas of work, particularly in terms of improving value and any future risks to the system anticipated due to funding streams ceasing – in line with the ongoing QIPP work highlighted in the Financial Planning 23-24 report.

Meeting name:	Leeds Committee of the West Yorkshire Integrated Care Board
Agenda item no.	LC 13/23
Meeting date:	05 July 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) – 09 June 2023 (email)

Delivery Sub-Committee – 14 June 2023

Finance and Best Value Sub-Committee – 21 June 2023

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

Executive summary and points for discussion:

This paper presents the ICB in Leeds High-Scoring Risk Report (risks scoring 15+) for the current risk review cycle (Cycle 2 2023/24). All risks have been reviewed by the Risk Owner, the allocated Senior Manager and by the EMT of the ICB in Leeds.

Due to the WY ICB risk review and reporting cycle being bi-monthly and the ICB in Leeds reporting cycle being quarterly, risk cycle 1 of 2023/24 has not been reported to the Leeds Committee of the ICB, the last reported risk position to the Leeds Committee was at the end of risk cycle 4 (2022/23). However, risk cycle 1 has been reported to the sub-committees of the Leeds Committee and for completeness, this report sets out the changes to the risk position since risk cycle 4 (2022/23).

In addition to the high-scoring risks (15+), risks scoring 12 and above that are directly aligned to the Leeds Committee (rather than to the sub-committees) are highlighted in the report.

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

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

☒ Improve healthcare outcomes for residents in their system

☒ Tackle inequalities in access, experience and outcomes

☒ Enhance productivity and value for money

☒ Support broader social and economic development
Recommendation(s)
1. <u>The Leeds Committee of the West Yorkshire ICB is asked to:</u> 1. R**ECEIVE** and **NOTE** the High-Scoring Risk Report as a true reflection of the risk position in the ICB in Leeds, following any recommendations from the relevant committees. 2. **CONSIDER** whether it is assured in respect of the effective management of the risks aligned to the Committee and the controls and assurances in place.
Does the report provide assurance or mitigate any of the strategic threats or significant risks on the Corporate Risk Register or Board Assurance Framework? If yes, please detail which:
This report provides details of all high-scoring risks and risks aligned to the Leeds Committee on the Risk Register. The Risk Register supports and underpins the ICB Board Assurance Framework and relevant links are drawn between risks on each.
Appendices
Appendix 1: Risk Register extract (High Scoring risks and risks aligned to the Leeds Committee) Appendix 2: West Yorkshire ICB Risk Report Extract 16 May 2023 Appendix 3: Leeds Health and Care Partnership Partner Top Risks Appendix 4: Risk on a Page Report
Acronyms and Abbreviations explained
2. ICB – Integrated Care Board

What are the implications for?

Residents and Communities	Any implications relating to individual risks are outlined in the Risk Register.
Quality and Safety	
Equality, Diversity and Inclusion	
Finances and Use of Resources	
Regulation and Legal Requirements	
Conflicts of Interest	None identified
Data Protection	Any implications relating to individual risks are outlined in the Risk Register.
Transformation and Innovation	
Environmental and Climate Change	
Future Decisions and Policy Making	
Citizen and Stakeholder Engagement	

1. Introduction

1.1 The report sets out the process for review of the Leeds Place risks during the current review cycle (Cycle 2 of 2023/24) which commenced on 18 May and ends after the West Yorkshire ICB Board meeting on 18 July.

1.2 The last risk report provided an update on the risk position during risk cycle 4 of 2022/23. Due to the WY ICB reporting cycle being bi-monthly and the ICB in Leeds reporting cycle being quarterly, risk cycle 1 of 2023/24 was not formally reported to the ICB Leeds Committee. For completeness, this report sets out the changes to the risk position during risk cycles 1 and 2.

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

2 Leeds Place Risk Register

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

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

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

2.2 All high-scoring place risks, corporate risks, and all risks common to more than one place are reported to the WY ICB Board. An extract of the risk report presented to the West Yorkshire ICB Board on 16 May 2023 is attached at Appendix 2 to provide visibility of the corporate and the common risks.

As part of the risk cycle process the WY ICB Director of Corporate Affairs meets with the Risk Management Operational Group to review the risks on each place risk register. This supports the identification of place risks scoring 15+ and common risks on the registers. The detailed review and mapping of the risks also enables the flagging of potential anomalies in

scoring or wording between different places, supporting the discussions that ensure the continued evolution of the risk register.

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

- West Yorkshire ICB Quality Committee – 27 June 2023
- West Yorkshire ICB Finance, Investment & Performance Committee – 27 June 2023

And will be presented to the WY ICB Board on 18 July 2023.

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

The Place Risk Register will not capture risks which are owned by ICS System Partners, that they are accountable for via their individual statutory organisations. However, in order to support triangulation of risks and provide visibility of the risk profile across the Leeds Health and Care Partnership, System Partners have been requested to provide their highest scoring risks that they want the membership of the Leeds Committee to be sighted on. The approach taken by system partners to identify risks for inclusion has included consideration of risks that require partnership working and a system-based solution and has also involved the senior management / leadership teams within the partners. The top risks identified by system partners are provided at Appendix 3.

Partners are also consulted when populating and managing the Population and Care Board risk register (see 2.5 below).

2.5 Work has continued 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 corporate governance team 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.

2.6 There are currently 22 risks on the Leeds Place Risk Register, two of which are marked for closure, leaving a total of 20 open risks.

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

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

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

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

Due to the WY ICB risk review and reporting cycle being bi-monthly and the ICB in Leeds reporting cycle being quarterly, and the timing of the Leeds sub-committees, the Leeds Committee and the ICB Board committees, risk cycle 1 of 2023/24, which ended on 16 May 2023 was reported to the sub-committees of the Leeds Committee on the following dates and risk cycle 2 is being reported to the Leeds Committee:

a) All aligned quality risks were reviewed by the Quality and People's Experience Sub-Committee on 7 June 2023.
b) All aligned delivery risks were reviewed by the Delivery Sub-Committee on 14 June 2023
c) All aligned finance risks were reviewed by the Finance and Best Value Sub-Committee on 21 June 2023.

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.

2.9 **High Scoring Risks**

The last report to the Leeds Committee of the WY ICB provided an

update on the risk position during risk cycle 4 (2022/23). The following changes have taken place during 2023/24 risk cycle 1 and 2:

Risk	Cycle 4	Cycle 1	Cycle 2	Movement since Cycle 4
2158 – Prescribing Costs	16	12	12	Risk Reducing (cycle 1) - Total cost pressure on the prescribing budget has reduced month on month since a historic peak in December 22. Although this remains high the trend has been reversed. Prescribing budgets for next financial year have been calculated on month 11 outturn which means that for next financial year cost pressures from this year will have been consolidated. There still remains a high level of uncertainty around unexpected cost pressures related to national and international factors impacting supply and price of drugs but a greater element of this has been factored into budget setting for next year.
2014 – Leeds System Financial Position	9	20	20	Risk Increased - risk has been re-assessed for 2023/24. The financial plans for 23-24 for the Leeds ICB reflect a significant underlying deficit position of C30m and identified risks of £13m against which £16m of QIPP schemes have been identified but have yet to be delivered. There will be a series of reviews and interventions by local ICB and regional colleagues to test the basis of the plans and the level of risk, QIPP, efficiencies etc in the Leeds system. This will be a common risk across the ICB and will be updated following guidance from the ICB Director of Finance.
2016 – Risk of Harm – Elective /	16	12	12	Risk Reducing (cycle 1) - the likelihood score has reduced based on the reduction in long waiters and trajectories in terms

Risk	Cycle 4	Cycle 1	Cycle 2	Movement since Cycle 4
Cancer Waiting Lists				of future management during 2023/24. In addition, LTHT have provided re-assurance relating to the process which has now been established to implement risk harm reviews for long waiting patients and request for the ICB to receive quarterly updates. KPIs are being agreed through WYAAT to manage long waiters in line with ERF allocations and oversight/ potential areas of concern will be shared with the ICB monthly starting June 2023.
2017 – Risk of Harm – Long Term Conditions / Frailty / Mental Health Conditions	15	15	15	Static Risk - This risk was reviewed by the Leeds Long Term Conditions Population Board at its 18th May meeting. It was agreed that the score must remain the same. There was agreement that there has been some improvement in overall key performance for LTCs for example annual health check numbers, annual reviews and referrals into NDPP, etc. There is however concern with regards to whether this sustainable given pressures on Primary Care and the current financial pressures that the system finds itself operating within.
2018 – Risk of Harm - Mental Health Access	20	16	16	Risk Reducing (cycle 1) – CMHTs no longer in business continuity- redeployment has initially stabilised the increased vacancy factor rate (which was proportionally greater than other Places across WY ICB), alongside a detailed plan for ongoing sustainable recovery - tracked through the MH Population Board. Risk rating reviewed and decreased in line with this In cycle 2 the risk is static, the rationale for this is that whilst a number of additional

Risk	Cycle 4	Cycle 1	Cycle 2	Movement since Cycle 4
				improvements in completion of actions and gaps in assurance have progressed, these won't have immediate impact on the risk reducing. This is also alongside ongoing significant pressures remaining on the community and crisis services due to vacancies and short-term sickness absence, and the number of out of area placements have increased from the last review cycle.
2019 – Risk of Harm – System Flow	20	20	20	Static Risk - The risk is moving towards a reduction to 16 (reduction in the likelihood from 5 to 4). Home for Assessment pathway developed in the interim to support the city's Home First ambition, while the Active Recovery service eligibility criteria is expanded. Improvements in the waiting times for pathway 3 have been made by process changes. However, surge wards at LTHT remain open in May 2023 - plans for closure are reliant on the Home for Assessment pathway and improvements in Pathway 3 waiting times.
2301 – Neurodevelopmental Diagnosis Waiting Times	12	12	15	Increased Risk - New Risk added during risk cycle 1 for visibility at Leeds place level – this is a common risk across the WY ICB and in Leeds is overseen by the Children and Young Peoples Population Board. The risk score has increased during risk cycle 2 based on an increased likelihood of delay in diagnosis and support because of the levels of demand.

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.

2.10 Risks Aligned to the Leeds Committee

There are four risks aligned to the Leeds Committee, which comprise 18% of total risks currently on the ICB Risk Register. Of these risks:

a) One risk has reduced from 12 to 9 (see below)
b) and there are no open risks scoring 12 or above.

Risk Number and Risk Title	Cycle 4	Cycle 1	Cycle 2	Movement
2225 Leeds System Workforce	12 (New)	12	9	Risk Reducing (cycle 2) - Overall city workforce risk has reduced slightly as recruitment activity continues to support priority areas and the impact of winter pressures has eased. Where shortages occur, the impact is still significant.

3 Next Steps

3.1 Subsequent to 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 18 July 2023.

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

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

4. **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.

Appendices

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

Appendix 2: West Yorkshire ICB Risk Report Extract 16 May 2023

Appendix 3: Leeds Health and Care Partnership Partner Top Risks

Appendix 4: Risk on a Page Report

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

Risk ID	Date Created	Risk Type	Risk Rating	Risk Score Components	Target Risk Rating	Target Score Components	Risk Owner	Senior Manager	Principal Risk	Key Controls	Key Control Gaps	Assurance Controls	Positive Assurance	Assurance Gaps	Risk Status
High-scoring Risks (15+)															
2019	30/06/2022	Both Delivery and Quality and People's Experience	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, acuity and length of stay of inpatients and the time spent by people in hospital beds with no reason to reside, resulting in poor patient quality and experience, failed constitutional targets and reputational risk.	7 Additional wards open at LTHT and strong surge plan in place Transfer of Care hub completely staffed and working 7 days Home First Programme refreshed and overseen by LTHT Chief Exec as System SRO Detailed seasonal surge plans developed and overseen by PEG through System Resilience Operational Group (SROG) & System Coordination Group informed by LTHT short-term COVID modelling System Escalation Actions and Processes revised continuously OPEL & System Pressures Reporting Regime Communications work with Public to suggest alternatives to ED Home First programme well underway Investment in Home First services and in assessment capacity through Adult Social Care Discharge Fund	Key controls in place responding to high levels of demand. Current controls are still not sufficient to reduce the risks when there is exceptionally high demand on the system or where outflow is constrained through Industrial Action or other absence	Health & Social Care Command & Control Groups: System Resilience Operational Group (Bronze), System Coordination Group (Silver) and System Resilience and Reset Assurance Board (Gold) Integrated Commissioning Executive Partnership Executive Group Quality and Performance Committee New System Visibility Dashboard being implemented to support assurance and decision making	Weekly meeting in place for services to report on capacity /demand Reviewed Silver Action cards System Visibility dashboard in place and driving change strong programme of Home First work in place Home for Assessment pathway developed in the interim to support the city's Home First ambition, while the Active Recovery service eligibility criteria is expanded. Improvements in the waiting times for pathway 3 have been made by process changes	OPEL reporting system under development for ASC but not yet finalised or shared. Recruitment and retention remain significantly challenging and limit the ability to create additional capacity, particularly in the Reablement service. Surge wards at LTHT remain open in May 2023 - plans for closure reliant on the Home for Assessment pathway and improvements in Pathway 3 waiting times Still people over 6 and over 12 hours in ED which we know is linked to risk of harm	Static - 5 Cycle(s)
2014	29/06/2022	Finance and Best Value Committee	20	(I4xL5)	6	(I3xL2)	Gareth Winter	Visseh Pejhan-Sykes	There is a risk that the financial position across the Leeds system will not achieve financial balance due to the combination of undelivered QIPP and new cost pressures in 2023 – 24. This could result in the system as a whole not meeting the statutory duties.	Budgetary reporting and control stepped up to weekly EMT meetings as part of a turnaround approach across the Leeds ICB and the wider WY ICB. There are established fortnightly forums covering senior tier management across the ICB. A list of opportunities has been developed for wider system decision making and progress. CEOS/AOs and FDs are meeting fortnightly to develop the Leeds based recovery plan.	Active turnaround approach adopted across the ICB in Leeds and the wider WY ICB since October means that all parts of the WY system are actively looking at opportunities to ensure that the ICB finance balance by the end of 22-23. However, these are pitched against new cost pressures emerging and many measures are only non-recurrent whereas the cost pressures are recurrent. This means that our exit position from 22-23 to 23-24 is developing a growing financial gap all the time. There needs to be a deeper commitments across the organisation and ownership of returning to financial balance beyond the finance and top leadership level	Policies and Procedures Audit of Procedures fortnightly AO/CEO and FDs meetings Weekly assessment and reporting to EMT Bi-Weekly meetings with senior leads Leeds NHS DoFs liaising every two weeks re Leeds position	The majority of efficiencies will not be realised recurrently this year but the ICB in Leeds has had sufficient reserves to mitigate - albeit only non-recurrently. This will not be the case in 23-24. We are starting the financial year with a £30 -£35m deficit posted which is disproportionately the largest across the ICB.	The ICB in Leeds is still a little off plan for 22-23, having needed to rely on c £20m of non-recurrent resources to balance up for the year. Entering 23-24, this underlying gap is now significant. The ICB / CCG in Leeds has repeatedly failed to achieve it target QIPP programme for the past several years. 2022-23 had the largest QIPP programme of £18m of which a significant proportion relied on pathway changes that have not taken place. unless this can happen in 23-24, QIPP schemes need to primarily focus and rely on the cessation of discretionary spend in 23-24	Static - 1 Cycle(s)
2018	29/06/2022	Both Delivery and Quality and People's Experience	16	(I4xL4)	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	Review of MH crisis pathways to optimise value of investment (March 23) Evaluation of Crisis alternatives models Discharge Challenge plans- MADE event planned (02 May 2023) 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. Evaluation of Oasis-Leeds VCSE Crisis House has evidenced positive outcomes , although lower occupancy levels than anticipated have indicated current model of delivery requires further improvement- redesign work to be taken forward to to further integrate model with LYPFT crisis team- to commence delivery by Q4 23/24 Access to Early Intervention in psychosis services in Leeds maintains performance above access target.67.2% against target of 60% in March 23 (most recent available data LYPFT community mental health teams no longer in business continuity; re-deployment of staff to stabilise capacity has taken place, and ongoing recovery mobilisation plan in place. Expansion of capacity through CMH transformation funding recruitment to new clinical roles, including advanced practice, psychological therapy practitioners, and specialist MH pharmacy- proportion of these have been recruit to train roles to "grow" workforce internally- full impact of these roles wont be seen until completion of training Crisis team has maintained improvement against the 4 hour urgent crisis assessment target- although vacancies and short-term sickness continue to impact slower improvement to achieving the target.	Mental health pressures remain consistently at OPEL 3E, 23 Acute Mental Health out of area placements as of 24.05.23: 15 adult acute, 1 Older Adults MH; 6 PICU, I 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 IAPT: 2,622 people on the waiting list and average step 3 /CBT waiting times at 18 months	Static - 1 Cycle(s)
2301	16/05/2023	Both Delivery and Quality and People's Experience	15	(I3xL5)	6	(I3xL2)	Jayne Bathgate-Roche	Helen Lewis	There is a risk of CYP being unable to access a timely diagnostic service for neurodevelopmental conditions (Autism and ADHD) due to rising demand for assessments and capacity of service to deliver this (ICAN for under 5, CAMHS for school age). Delays in access to timely diagnosis may impact upon access to other support services across health, education and social care but also no compliance with NICE standards for assessment within 3 months from referral.	Development of "ND - thinking differently case" presented to PEG in March and outlining the need to think about a needs based approach to providing support to CYP who are neurodivergent Priority workstream for year 1 within SEND Inclusion plan Development of pre assessment support (MindMate ND hub, pilot delivering ND support with a cluster for 23/24) Links made to West Yorkshire ND programme of work particularly looking at how we as a WY ICB address the rising demand around the right to choose agenda and ensure a consistent method of delivery across the ICB>	Development of ND governance under development to include working group to develop and set out strategy for plans over next year	Data from LCH on waiting times Once working group established this will report regularly to SEND Partnership board and CYP population board Meeting in place with ICB, LCH and LCC to determine development plan and shared position statement	To follow	no funding attached to transformation team and so dedicated resource not yet identified Mechanism for reporting on project progress not yet established (planned development for May-June) Due to CAMHS cyber incident no regular data flowing on waiting times available funding and workforce will make rapid improvements difficult	Increasing
2017	29/06/2022	Both Delivery and Quality and People's Experience	15	(I3xL5)	9	(I3xL3)	Lindsay Mcfarlane	Helen Lewis	There is a risk of harm to patients with long term conditions (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 23/4. 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 - good rate of referrals 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 into 23/4	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 (CCSP) reviews in primary care and key waiting time trajectories 6 x LTC Health Inequalities projects funded and being implemented Uncertainty regarding 23/24 primary care contract / Quality Improvement Scheme (QIS) / Quality and Outcomes Framework (QOF), etc and implications on this risk	Continue to use Primary Care Quality Improvement (PQI) dashboard 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 clinical directors (CDs), Practice Managers (PMs) and the Leeds Medical Committee (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 Investment and Impact Fund (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 Uncertainty regarding 23/24 primary care contract and implications on this risk if it only focuses on reactive and on day services Funding for obesity services and other preventive service remains a challenge	Static - 5 Cycle(s)
Risk Aligned to the Leeds Committee (12+)															
2225	31/01/2023	Leeds Committee of the WY ICB	9	(I3xL3)	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 coordinating more systematic tracking of shared workforce risk to improve visibility for partner organisations, and developing more integrated operational workforce planning.	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 System Coordination Group 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.	Decreasing from 12

CORPORATE RISK REGISTER (AS AT 4 MAY)

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
2232	09/02/2023	Both FPC and QC	Improve healthcare outcomes for residents	20	(I5xL4)	12	(I4xL3)	Adrian North	Jonathan Webb	There is a risk that the needs and demands for NHS infrastructure investment in West Yorkshire is greater than the resources being made available to the ICB. This is due to the specific environmental and building issues prevalent in the West Yorkshire system and the finite capital resource being made available from HMT / DHSC / NHS England Resulting in poor quality estate and equipment, with resultant risks to safety, quality, experience and outcomes.	1. Oversight at WY ICS Finance Forum, supported by Capital Working Group 2. Utilisation of organisational and place / system risk registers to generate action 3. Risk based approach to prioritisation of operational capital (within our envelope) 4. Risk based approach to lobbying for strategic capital	1. Shared understanding / discussion of the risks arising through the prioritisation process for operational capital.	1. Individual risks flagged through place based risk registers 2. Overview of strategic capital and progress at WY ICB FIPC	1. Presentation of capital information through WY Capital Working Group, and reporting of capital position including forecast and risk highlighted at WY ICB FIPC. 2. Capital position relating to both operational and other capital reported to WY ICB FIPC and WY ICB Oversight and Assurance Group SLT	Assurance provided through WY FIPC.	Static - 1 Archive(s)
2194	29/11/2022	Finance, Investment and Performance	Enhance productivity and value for money	20	(I4xL5)	6	(I3xL2)	Suzie Tilburn	Kate Sims	There is a risk of disruption to current service delivery and a delay in future service transformation programmes due to the imminent commencement of a period of industrial action across the Health Service, resulting in colleagues participating in strike action and therefore not being available to undertake their normal work and for other colleagues in terms of their priority focus on planning for and responding to service critical requirements around strike days.	- Industrial Action preparedness self-assessment documents from each health provider and the ICB - Industrial Action plans per organisation and data reporting during strike action via the EPRR team - Ongoing communications to organisations and workforces - Ongoing communications with unions - Industrial Action Incident Management systems	None identified at this time	- Outcome of ballot letters from the national health unions and the understanding from this of which unions and organisations might be affected. - Industrial Action preparedness self-assessment documents submission to NHS England via regional team - Industrial Action plans per organisation and data reporting during strike action via the EPRR team - Social Partnership Forum agenda and minutes	- Outcome of ballot letters from the national health unions and the understanding from this of which unions and organisations might be affected. - Industrial Action preparedness self-assessment documents - Social Partnership Forum agenda and minutes - 8 November 2022, 13 December 2022, 1 February 2023 and 23 March 2023.	None identified at this time	Static - 2 Archive(s)
2166	16/10/2022	Finance, Investment and Performance	Enhance productivity and value for money	20	(I4xL5)	12	(I4xL3)	Dawn Greaves	James Thomas	There is a risk of a successful cyber attack, hack and data breach. Due to the escalating threat of cyber crime and terrorism across all sectors, and at a global scale. Resulting in financial loss, disruption or damage to the reputation of the ICB from some form of failure in technical, procedural or organisational information security controls.	Technical and Operational controls, including policies and procedures together with routine monitoring to ensure compliance are in place which meet or exceed NHS Data Security and Protection standards. Dedicated cyber security resource/expertise utilising national alerting and reporting. Regular mandatory data security training (which include this risk area) and updates for staff provided by IG team and Counter Fraud Team (particular focus on the risks from phishing). Monitoring completion of the NHS Digital Data Security Centre Data Security Onsite Assessment Disaster recovery Business continuity plans are in place in the event of a prolonged IT system issue.	Investment in replacement of legacy infrastructure. Review of business continuity arrangements due to a successful cyber incident in August 2022 which affected partner organisations critical IT systems.	Annual DSPT self assessment submissions and PEN testing Regular reporting on progress with DSPT annual self assessment to WY ICB Audit Committee and internal audit assurance of DSPT submission	No successful cyber attacks, hacks or data breaches resulting in financial loss, disruption to services or damage to the reputation. Regular phishing exercises and resultant action plans.	None identified	Increasing
2120	07/09/2022	Both FPC and QC	Improve healthcare outcomes for residents	20	(I5xL4)	12	(I4xL3)	Jo-Anne Baker	Ian Holmes	There is a risk of loss of VCSE services across WY due to lack of long-term funding & investment resulting in damage to the ICB mission, poorer health outcomes and increasing health inequalities, alongside ICS reputation for working with VCSE There is a risk of loss of VCSE services across WY due to lack of long-term funding & investment, and cuts to existing funding, resulting in damage to the ICB mission, poorer health outcomes and increasing health inequalities, alongside ICS reputation for working with VCSE. For context we have an estimated 11,996 VCSE organisations in WY delivering services and support to local communities reducing pressure on GPs and other health services.	Principle of consideration and investment in the VCSE included in WY Finance Strategy. Prioritisation of the VCSE in finance allocation with winter pressures, health inequalities and transformation funding.	Control Gaps highlighted as part of the development of the WY Finance Strategy, whichincludes: - a long term investment model for a sustainable VCSE sector across WY with an identified WY finance lead - delivering on the shift of investment to prevention which includes moving a proportion of budgets from traditional service delivery models to the VCSE sector - re-designing commissioning processes by co-creating them with the VCSE sector - ensuring all place based VCSE infrastructure organisations have sufficient investment at Place - developing shared principles and a plan for how each Programme works with the VCSE sector	Intelligence from HPoC Leadership Group members and VCSE sector commissioned research such as the Third Sector Trends Survey and State of the Sector reports. ICB place based committees oversight HPoC governance structures also provides the space to be sighted on and responsive including VCSE representation on the WY ICB and Place Committees of the WY ICB	VCSE involvement in shaping and influencing ICS strategies and plans. Intelligence from HPoC Board members.	Clarity on total funding provided to the VCSE sector at an ICS and Place level. Lack of insight and data leading to an inability to understand and respond to changes that may impact sustainability of the sector at a local community, Place and ICS level.	Static - 4 Archive(s)
2119	07/09/2022	Finance, Investment and Performance	Enhance productivity and value for money	20	(I5xL4)	6	(I3xL2)	Adrian North	Jonathan Webb	There is a risk that the ICS / ICB will not be able to agree a financial plan for 2023/24 that meets NHS England's requirements not to exceed its revenue resource limit. This is due to the significantly challenging financial environment driven by the local position in relation to the financial underlying position, national efficiency expectations, and ability / capacity to deliver the levels of productivity and efficiency needed to develop a balanced plan. This will result in NHS England intervention, a lower System Oversight Framework (SOF) assessment, reputational impact, and more importantly consideration of actions to live within our means which may impact detrimentally on achieving the ICB's strategic objectives and 10 big ambitions.	The ICB has a number of controls in place 1. Comprehensive reporting and escalating issues to the FIPC and wider ICS/ICB system 2. Investments that are in place or are introduced during the current financial year are affordable, deliver efficiency in the system and are considered as part of wider system investment 3. Functioning WY ICS Finance Forum, and developed and agreed Financial Framework. 4. Escalation of issues for consideration by Board of NHS WY ICB.	1. Working to develop a Efficiency Programme during the current financial year that is in place to reduce costs in 22/23 and beyond 2. Review of the underlying position in a consistent way across the ICB and the ICS, to create a clearer view on gaps, risks and mitigations	1. Efficiency "committees" at place to identify savings in future years; 2. Oversight of finance strategy and medium-term financial planning framework at the WY Oversight & Assurance System Leadership Team and the WY ICB Finance, Investment and Performance Committee	None identified	1/ Full understanding of the ICB underlying position 2/ Creation of draft Medium Term Plans with high level assumptions and sensitivity testing to provide a small number of scenarios of potential future pressures based on variable assumptions of growth, inflation and efficiency.	Static - 0 Archive(s)

2036	07/07/2022	Quality	Improve healthcare outcomes for residents	20	(I4xL5)	9	(I3xL3)	Laura Siddall	Anthony Kealy	RAAC (reinforced, autoclaved, aerated concrete) AT AIREDALE - There is a risk of disruption of service provision at Airedale Hospital due to structural RAAC deficiencies resulting in widespread impact across WY as services and patients may need to be reallocated. A planned evacuation could occur due issues at other RAAC sites across the country or safety concerns raised specifically at Airedale Hospital. There is also a risk of a collapse (which could cause injuries to patients and/or staff) and would result in an unplanned evacuation. Severe weather, such as extreme heat or heavy rain or snow, all increase the risk of a RAAC panel becoming unstable and so would result in the ICB having to manage concurrent incidents.	*Airedale NHSFT is undertaking a continuous programme of actions to monitor and manage the risk of RAAC (regular inspections take place and, if issues are identified, actions are undertaken to ensure that the area is safe). * There is a national programme for NHS RAAC sites to ensure that learning and risk is shared nationally and a common approach is taken. * ANHSFT has built a number of modular wards so that patients can be decanted out of RAAC areas while repair work takes place and can be used if areas need to be evacuated. A further delivery of 60 units arrived in Feb 2023.	- It remains uncertain whether the national funding required to build a new hospital for ANSHFT will be approved. - Research into the properties of RAAC, such as flammability, is still ongoing and so there are a number of unknowns as to how resilient RAAC is. - NHS England is leading a programme to develop plans for how the Yorkshire health and care system would manage a partial or full evacuation of the Airedale General Hospital site. WY ICB will be responsible for signing off the regional RAAC system plan. WY ICB is leading the development of a multi-agency RAAC response protocol. Both of these plans are in development and not yetfinalised. - Further work is needed to test the ability of plans to react to concurrent incident, for example an evacuation at Airedale Hospital due to a RAAC failure and heavy snow.	Update (19/04/2023) - Risk has been reduced following discussion by ICB EMT, acknowledging that system impact will be less severe than at Trust and place levels. An exercise is being organised to test the multi-agency response protocol. Update (25/01/2023) - Risk has been updated following advice from the governance team. A multi-agency meeting with WY Local Resilience partners took place on 30th November to develop the multi-agency response protocol to an evacuation of Airedale Hospital. Work is now beginning ti test this protocol with a multi-agency exercise. Airedale NHS FT has confirmed that the Airedale Hospital building will not be viable beyond 2030. There is no further update nationally on whether Airedale NHS FT will qualify for funding for a new build. NHS West Yorkshire ICB is carrying a risk that there will be the loss of services provided by Airedale NHS FT by 2030 (or earlier if a significant RAAC incident occurs) and no mitigating plans to ensure that services remain available to the Bradford district and Craven population. Winter is a period of heightened risk for RAAC panel failures due to the impact of severe weather.	- The trust's monitoring programme has detected areas of weaknesses at an early stage before significant collapses have occurred.	- The risk of RAAC is difficult to quantify due to unknown information (currently, further research is being carried out into the resilience of RAAC). This makes it difficult for the WY ICB to balance the option of commissioning services from ANHSFT (and exposure to RAAC risk) versus the option of not commissioning services from ANHSFT (to avoid RAAC risk) and the subsequent risk to patient care by overburdening the health system across Yorkshire through reduced capacity. - It is unknown how the public and staff would react if a collapse happened at another RAAC site or part of Airedale General Hospital needed to be evacuated. The public and staff may lose confidence and choose not to attend Airedale General Hospital, putting pressure on the Yorkshire health system.	Static - 4 Archive(s)
2268	11/04/2023	Both FPC and QC	Improve healthcare outcomes for residents	16	(I4xL4)	4	(I4xL1)	Vanessa Hails	James Thomas	There is a risk that current work programmes both at Place and within the Long Term Conditions and Personalisation Function are now at risk, due to reduced programme funding in 2023/24. Resulting in a need to review objectives of the LTC&P team and place teams and review ways of working within Place. We have received 90% LESS for Diabetes and CVD funding compared to 2022/23 Stroke – to be confirmed Personalisation – no funding 2023/24 Unpaid carers – no funding 2023/24	Letter has been sent to NHSE to raise concerns that such a significant reduction has been made Programme Managers are working with Place Leads to review programmes of work and agree priorities for the coming year.	Further guidance on funding is expected to be received shortly	The funding reduction will necessitate a need to review objectives of the LTC&P team and review ways of working within Place	None identified	None identified at this stage	New - Open
2176	17/10/2022	Quality	Improve healthcare outcomes for residents	16	(I4xL4)	12	(I4xL3)	Lucy Cole	James Thomas	Non-surgical oncology - There is a risk that service delivery cannot be sustained before a new model is implemented due to the time required to implement a new model. This would lead to severe capacity pressures within the system and an inability to treat patients in a timely manner.	NSO programme in place to design and implement a sustainable NSO model for West Yorkshire & Harrogate. Implementation of some joint posts for medical staff and implementation of international recruitment options (advert now live). Operational group in place to transact mutual aid to ensure gaps in provision are covered whilst the new model is designed and implemented.	Additional workforce / service pressures emerging whilst new model is implemented. New workforce model will take 3-5 years to be fully implemented. Unclear if public consultation process will be required which will extend the timescales for implementation of a new model.	Fortnightly operational level meetings whose governance provides routes of escalations to the Steering group and to WYAAT Chief Operating Officers via the lead COO for cancer. The agreed governance model has representation from all WYAAT providers. Oversight through WYAAT governance and WYH Cancer Alliance Board.	None identified	None identified	Static - 3 Archive(s)
2175	17/10/2022	Both FPC and QC	Improve healthcare outcomes for residents	16	(I4xL4)	12	(I4xL3)	Lucy Cole	Anthony Kealy	There is a risk that the increasing the number of patients in WYAAT hospitals without a reason to reside due to capacity in social care and community services, will add extra pressure on the workforce and reduce elective activity due to inadequate bed capacity. This could result in increased backlogs, delays to patient care, reduced functioning / deconditioning of patients, and reputational damage across WYAAT members.	Focus by WYAAT trusts on improving hospital-based discharge pathways and reducing delays has been successful. Place focus through Multi-Agency Discharge Events (MADE) to reduce numbers of patients with No Reason To Reside. Participation in the West Yorkshire ICS Discharge programme development and implementation. Bed capacity funding included in 23/24 allocation. Independent Sector group and approach established across WYAAT to maximise independent sector activity. Planning for protected elective hub sites in progress to enable continuation of elective activity during periods of significant non-elective activity.	Workforce capacity gaps in social care services remain high. Despite mitigations, no significant or sustained reductions in patients in hospital without a reason to reside. This is reflected in the draft 23/24 plan which does not meet the 92% G&A bed occupancy target.	Oversight through Finance, Investment and Performance Committee and Quality Committee.	None identified	None identified	Static - 3 Archive(s)
2174	17/10/2022	Both FPC and QC	Improve healthcare outcomes for residents	16	(I4xL4)	12	(I4xL3)	Lucy Cole	Anthony Kealy	There is a risk that future covid waves, urgent and emergency care pressures and continued industrial action will negatively impact the delivery of all elective care, due to reduced workforce and bed capacity. This will lead to reduced elective capacity, increased backlogs, delays to patient care, and implementation of new models of working to address backlogs across WYAAT.	- Regular review and planning across WYAAT through weekly elective coordination group meetings to support treatment across organisations. - Independent Sector group and approach established across WYAAT to maximise independent sector activity. - Planning for protected elective hub sites in progress to enable continuation of elective activity during periods of significant non-elective activity. - System Control Centre (SCC) established by ICB from 1 December 2022 to balance clinical risk over Winter. SCC capability being enhanced with roll-out of UEC RAIDR app from February 2023. - ICB campaigns and programmes of work in place to mitigate risk including discharge programme, vaccination programme and campaigns, staff health and wellbeing hub, and public campaign to 'choose the right service'.	Further industrial action subject to national negotiations.	Oversight through WYAAT governance structures of pressures impacting elective activity.	None identified	None identified	Static - 3 Archive(s)

2296	04/05/2023	Both FPC and QC	Improve healthcare outcomes for residents	12	(I4xL3)	4	(I4xL1)	Sarah Brewer	Ian Holmes	There is a risk that YAS will not be able to fully implement the plans which would deliver the Operational Planning target of a 30 mean response time for CAT 2 999 calls due to the high level of recruitment required to grow capacity within YAS and also full implementation of actions across the WY system which would contribute to delivery of the CAT 2 target	WY system plans being agreed to support YAS delivery of CAT 2 which includes a focus on expanding alternative pathways and reducing hospital handover delays YAS Transformation is an agreed priority of the WY UEC Programme Board for 2023/24 National funding YAS to increase capacity to support delivery of the CAT2 30min mean target	None identified	Monthly assurance of delivery against operational plan through Y&H ICF which include progress against workforce recruitment trajectories Monthly oversight of delivery of WY system plans to support delivery of CAT2 through the WY UEC Programme Board National NHS assurance through monthly report by YAS on performance against plan	To be confirmed	None identified	New - Open
2294	03/05/2023	Both FPC and QC	Enhance productivity and value for money	12	(I4xL3)	6	(I3xL2)	Tim Ryley	Tim Ryley	There is a risk to the operational effectiveness and staff morale of the ICB and ICS programmes due to uncertainty, potential disruption and loss of capacity resulting from the review of the operating model and required reduction in the running cost allowance.	1) Committed to undertake in one year to minimise period of uncertainty 2) Dedicated SRO, Programme Board and Team established 3) Programme Plan in place 4) Capacity reductions spread across all operations rather than focussed just on running costs 5) Well established leadership and management structures in place 6) Weekly transparent all staff communication and monthly briefing 7) Wide engagement with all stakeholders	None identified at this stage	Critical path and associated milestones for delivery regularly reviewed and updated	None identified at this stage	None identified at this stage	New - Open
2237	10/03/2023	Both FPC and QC	Improve healthcare outcomes for residents	12	(I4xL3)	4	(I2xL2)	Frank Swinton	Ian Holmes	There is a risk of contributing to climate change effects due to health and social care paying insufficient notice to the environmental impact of their processes. This will result in breach of legal responsibilities, inability to recruit and retain staff and adverse publicity.	• National Greener NHS team with targets/expectations around carbon reduction • National net zero carbon target of 2050 • Leeds Region net zero carbon target of 2038 • Education available to all staff/volunteers in health and social care in West Yorkshire • Several professional networks up and running	• Climate change team is 1.4 WTE (plus some other helpers). It is an agitation team and not a delivery team. Some organisations have plans and are taking action but some are not. • Greener NHS team is focused largely on carbon reduction in hospitals. Carbon emissions from other aspects of health and social care (such as primary care and social care) are missed, as are other dimensions of sustainability such as biodiversity loss, air pollution and ocean acidification. • Approximately half the organisations in WY ICB have not identified a Board level lead • Climate Change is not seen as a key metric when making decisions across the ICB.	Regular data collections/updates provided to Greener NHS Sustainability strategy in place (Refreshed strategy to go to Partnership Board in March 2023) ICS Green Plan in place to manage Greener NHS targets All Trusts have a Board approved Green Plan Monthly updates provided to Improving Population Health Board	Desflurane reduction in every hospital in the region Every hospital trust has a green plan. Networks meet regularly to share ideas, resource and frustration. Strong support from Partnership Board on 7th March 2023	No robust mechanism in place to measure carbon footprint (currently using surrogates) No mechanism in place to assure biodiversity net gain No mechanism in place to assure focus on prevention / reduction of inequalities, to reduce demand for services No mechanism in place to highlight the need for everyone to take action No mechanism in place to highlight inaction from organisations No mechanism in place to ensure organisational engagement (Board level leads)	Static - 1 Archive(s)
2236	10/03/2023	Both FPC and QC	Improve healthcare outcomes for residents	12	(I4xL3)	4	(I2xL2)	Frank Swinton	Ian Holmes	There is a risk that the West Yorkshire ICS due to the work it undertakes, the decisions it makes and processes it carries out will increase climate disruption, causing impact to our natural environment. This will result in increased internal and external migration, increased demand for our health and mental health services, disruption to our supply chains and increased caring burden on our staff leading to them being unable to work. Alongside detrimental impact to our environment and the long term impact of health needs of our population.	• ICB Climate Change team in situ • Education available to all staff/volunteers in health and social care in West Yorkshire • Several professional networks up and running	• Climate change team is 1.4 WTE (plus some other helpers). It is an agitation team and not a delivery team. • Some organisations have plans and are taking action, but some are not. • Approximately half the organisations in WY ICS have not identified a Board level lead. • Climate Change is not seen as a key metric when making decisions across the ICB. • The impact on the environment and sustainability is not considered when making transformation and investment decisions	• Sustainability strategy in place (Refreshed strategy received well at Partnership Board in March 2023) • Monthly updates provided to Improving Population Health Board • Net zero meeting leads	• Networks meet regularly to share ideas, resource, and share experience of challenges they are facing to promote the agenda within the Health Sector • Develop of wider system work with partners is starting to evolve	• Currently no ICB, Place or organisational adaptation plans in place to consider the impact on the risk • No mechanism in place to highlight the need for everyone to take action to support and promote the climate agenda • No focus currently in place to monitor from a ICS level on the engagement of the climate agenda in organisations and places • No mechanism in place to ensure organisational engagement (Board level leads)	Static - 1 Archive(s)
2233	17/02/2023	Finance, Investment and Performance	Enhance productivity and value for money	12	(I4xL3)	12	(I4xL3)	Dawn Greaves	James Thomas	There is a risk of a successful cyber attack, hack and data breach. Due to the escalating threat of cyber crime and terrorism across all sectors, and at a global scale. Resulting in financial loss, disruption or damage to the reputation of the ICB from some form of failure in technical, procedural or organisational information security controls.	Technical and Operational controls, including policies and procedures together with routine monitoring to ensure compliance are in place which meet or exceed NHS Data Security and Protection standards. Dedicated cyber security resource/expertise utilising national alerting and reporting. Regular mandatory data security training (which include this risk area) and updates for staff provided by IG team and Counter Fraud Team (particular focus on the risks from phishing). Monitoring completion of the NHS Digital Data Security Centre Data Security Onsite Assessment Disaster recovery Business continuity plans are in place in the event of a prolonged IT system issue.	Investment in replacement of legacy infrastructure. Review of business continuity arrangements due to a successful cyber incident in August 2022 which affected partner organisations critical IT systems.	Annual DSPT self assessment submissions and PEN testing Regular reporting on progress with DSPT annual self assessment to WY ICB Audit Committee and internal audit assurance of DSPT submission	No successful cyber attacks, hacks or data breaches resulting in financial loss, disruption to services or damage to the reputation. Regular phishing exercises and resultant action plans.	None identified	Closed - Duplicate (please link to original risk)
2202	01/12/2022	Finance, Investment and Performance	Enhance productivity and value for money	12	(I4xL3)	6	(I3xL2)	Adrian North	Jonathan Webb	There is a risk that measures being taken to control expenditure in WY councils will have an impact on other place partners. Due to the financial pressures being experienced by most councils across West Yorkshire and their statutory requirement not to overspend against budgets Leading to a potential impact on hospital discharges resulting in higher costs being retained within the WY NHS system (additional costs borne by NHS provider organisations for which there may not be mitigations, thereby resulting in adverse variances to plan) and the management of winter pressures.	1. Working with councils in ICB places to understand the issues, options being considered and the potential impact on system partners. 2. Review use of intermediate care capacity 3. System leadership oversight and consideration of options to minimise impact	1. WY councils are separate statutory organisations with no NHS oversight 2. Lack of clarity on funding options	1. System oversight of wider health and care financial position	1. Close working relationships between the NHS and councils in place and representation of councils on system partnership board 2. Additional government funding to support social care pressures - £500m national discharge / socil care funding recently announced 3. Establishment of ICS discharge group considering all options across the system	1. Potential pre-commitments in councils and in the NHS on the use of additional funding unclear.	Static - 2 Archive(s)
2167	16/10/2022	Quality	Tackle inequalities in access, experience, outcomes	12	(I4xL3)	8	(I4xL2)	Fatima Khan-Shah	James Thomas	There is a risk of non-delivery of programmes within the function due to gaps in capacity through recurrent vacancies resulting in the inability to effectively support Places to deliver on programme priorities within the Partnership strategy	Robust management of workforce (sickness/annual leave) Ongoing recruitment and review of roles to ensure they are attractive to applicants when advertised Revision of roles and responsibilities of colleagues within the function to ensure the available capacity is targeted at programme priorities and Place support Review of programme plans and Stop/Start plan agreed with SROs to ensure the focus on mandated deliverables Engaging with NHSE to identify additional interim support in the short term until recruitment completed	Fixed term/temporary nature of roles is a potential barrier to applicants Place leads for programmes still to be established within new emerging ICB structures	Ongoing review of structure and Finances to provide stability and sustainability to the function Revisiting and re-engaging with Place following inaugural Programme Board to establish communication and collaborative arrangements	None identified	None identified	Static - 3 Archive(s)

2165	16/10/2022	Finance, Investment and Performance	Enhance productivity and value for money	12	(I3xL4)	9	(I3xL3)	Dawn Greaves	James Thomas	There is a risk that place IT teams have insufficient capacity to implement regional solutions. Due to increasing demands for digital solutions and the prioritisation of local vs regional projects. Resulting in delays to progression of regional solutions, impacting delivery of benefits or reduced opportunities to implement regional solutions at scale	Ensuring organisational IT teams are provided with sufficient notice to plan for regional implementations. Seeking additional funding for resources to bring in additional capacity or to backfill key resources.	Digital investment to be increased within individual organisational budgets to enable increase capacity in the in-house teams, with dedicated time allocated to regional programmes	Regional digital projects are well planned with resources allocated. No milestone delays due to resource constraints.	None identified	None identified	Static - 2 Archive(s)
2122	07/09/2022	Quality	Tackle inequalities in access, experience, outcomes	12	(I4xL3)	6	(I3xL2)	Jo-Anne Baker	Ian Holmes	There is a high risk of poorer patient outcomes and experience and missed opportunities due to lack of agreed information sharing processes and systems which VCSE partners delivering services can access and input essential data and information. This results in gaps in provision, missed opportunities and a risk of patients not receiving the full range of available services to meet their needs.	None currently	Development, adoption and implementation of consistent agreed information sharing processes and systems at ICS and Place levels with the VCSE sector. Appropriate referrals and information sharing between VCSE organisations and the health and care system. Capacity to analyse information sharing agreements with VCSE.	ICB Place Based Committees oversight	Appropriate referrals and information sharing between VCSE organisations and the health and care system. Intelligence from HPoC Leadership Group members.	Capacity to analyse and monitor information sharing agreements between the VCSE sector with the health and care system across the ICB and Place.	Static - 3 Archive(s)
2121	07/09/2022	Finance, Investment and Performance	Improve healthcare outcomes for residents	12	(I4xL3)	6	(I3xL2)	Jo-Anne Baker	Ian Holmes	There is a risk of the VCSE sector being left behind digitally due to lack of capacity, resource and understanding at statutory level as to what is needed by VCSE, leading to a direct impact on those using VCSE services as VCSE organisations are unable to record and share information digitally either with patients or health and care services.	HPoC lead for Digital is in place working with the Digital Programme Board. VCSE sector being reflected within the WY Digital Strategy as an equal partner with ongoing work between HPoC and the Digital Programme.	Strengthening work within the Digital Programme and ensuring the VCSE sector are supported and resourced to be part of changes. Analysis of VCSE sector in relation to digital at ICS and place levels. Absence of a plan to address this.	Digital Board oversight	Ability for HPoC to be proactive and responsive in shaping and influencing Digital strategies and plans.	Analysis of the VCSE sector in relation to Digital at an ICS and Place levels.	Static - 3 Archive(s)
2113	25/08/2022	Finance, Investment and Performance	Enhance productivity and value for money	12	(I3xL4)	9	(I3xL3)	Keir Shillaker	James Thomas	There is a risk that pilot work or services set up using transformation funding within the MHLDA programme are not supported recurrently due to lack of national clarity on funding or difficult local prioritisation decisions. This would result in a reduced service offer or closure of some services. This includes work such as the staff mental health and wellbeing hub at system level and CYPMH ARRS roles being developed within primary care in our places The impact of this would be to delay achievement of the ICB mission and will probably occur in most circumstances	Agreement in principle to support recurrent funding from within WY envelopes where possible (ie wellbeing hub) Providing clarity of expectations and realistic assumptions regarding funding to places WY programmes monitor utilisation of non-recurrent funding and its impact, as do places with their local funding	There is no agreed standardised process for how places or the system is assured of the full application of transformation funding - or whether this is an agreed expectation through the operating model. This work is part of wider development of the finance functions and expectations within the ICB.	WY wide initiatives are reviewed by the MHLDA Partnership Board, with some decision escalated to WY SLT level Place initiatives are reviewed by local MHLDA partnership forums/alliance meetings as determined locally	None identified	The MHLDA Partnership Board is not set up to, nor constituted in its terms of reference to hold the ring on all WY MHLDA spend beyond reviewing overall delivery against the Mental Health Investment Standard.	Static - 2 Archive(s)
2111	25/08/2022	Both FPC and QC	Tackle inequalities in access, experience, outcomes	12	(I3xL4)	6	(I3xL2)	Keir Shillaker	James Thomas	There is a risk that there is reduced effectiveness of delivery due to the scale of the programme ambition and volume of possible workstreams. This would result in a dilution of improvement in the areas that most need it. This includes the tension of delivering national LTP targets, against known quality improvement initiatives (ie Edenfield response) and other locally determined priorities (such as Neurodiversity Deep Dive, new work on Older People's Mental Health) The impact of this would be to contribute to a delay in achievement of the ICB mission and will probably occur in most circumstances	Agreed permanent funding for the core WY team via the ICB. Utilising maximum available non-recurrent funding sources (including NHSE, HEE and legacy ICS funds) to appoint to non-recurrent project roles Process for identification of WY priorities remains by agreement with all WY places to ensure they are necessary	There is no formal process for either places or the system to prioritise which initiatives take precedence over another, or an agreed framework for doing so No comprehensive mechanism for understanding totality of the WY staffing offer to know whether capacity can be moved around to support agreed priorities - either between places and system or between/within programmes	MHLDA Partnership Board maintains oversight of all WY priorities, as does the NEY Regional Programme Board. The MHLDA collaborative Committees in Common oversees specific responsibiilties delegated to that collaborative and wider arrangements for collaboration between the Trusts	None identified	The MHLDA Partnership Board or local place committees do not regularly review capacity allocated to each priority or workstream. From a system point of view this will be particularly needed when non-recurrent funding ends and 6+ project roles finish by March 24	Static - 3 Archive(s)
2109	23/08/2022	Both FPC and QC	Improve healthcare outcomes for residents	12	(I3xL4)	1	(I1xL1)	Jason Pawluk	James Thomas	Clinical Outcomes: Cancer Risk - There is a risk that the ambition to deliver the national ambition in early stage cancer diagnosis (reflected in ICS Ambition 3) will not be achieved due to workforce, capacity, technological, and other resourcing constraints - including the direct impacts of the Covid-19 pandemic, secondary mortality factors and delays to new asset investments such as Community Diagnostic Centres. This would mean that one and five year survival rates for patients affected by cancer would not improve at the pace expected towards European comparators.	The Cancer Alliance receives Service Development Funding to support a range of initiatives seeking to promote earlier presentation and diagnosis of cancer, associated with improved prognosis - this includes a whole-pathway prospectus. This complements funding made available to places for core service delivery and funds accessible from the research and third sectors. Section 7a commissioners receive funding to deliver the national cancer screening programmes, which are associated with facilitating earlier presentation and diagnosis of cancer in breast, bowel and cervical. The Targeted Lung Health Checks programme is also being rolled out in particular WY&H geographies based on health inequalities. A liver cancer surveillance programme is under development and local trials under consideration for kidney cancer. Data from NHSE indicates that referrals have recovered to the level expected notwithstanding the pandemic, however services remain challenged due to the concurrent impacts of managing elective recovery measures alongside cancer.	None identified.	Actively exploring research for evidence that additional interventions will have the desired impact.	Most recent Rapid Registration data from national data sources suggests a modest improvement in cancer stage of presentation, although not delivering the trajectory set out in the NHSLTP.	None identified.	Static - 3 Archive(s)
2108	23/08/2022	Finance, Investment and Performance	Improve healthcare outcomes for residents	12	(I3xL4)	1	(I1xL1)	Jason Pawluk	James Thomas	Cancer Workforce Risk: There is a risk that the ambitions set out in the Cancer Workforce Plan will not be delivered in WY&H arising out of insufficient supply, retention, and training provision across key priority areas. Failure to deliver the Cancer Workforce Plan would likely have adverse effects on quality of care; delivery of access standards/performance; effective financial control; innovation priorities (lung, colorectal, and prostate), and ICB reputational standing.	Working with HEE actively and the ICS/H&CP workforce group (as well as the LWAB) • Appointment of an HEE funded cancer workforce lead for WY&H • Influencing content of the forthcoming NHS People Plan through system leaders • Actively looking at skill mix as part of system work on non surgical oncology and diagnostics. • HEE cancer workforce lead supporting Gynae OPG with CNS workforce census and skill mix review.	None identified.	Working with HEE actively and the ICS/H&CP workforce group (as well as the LWAB) .• Appointment of an HEE funded cancer workforce lead for WY&H • Influencing content of the forthcoming NHS People Plan through system leaders • Actively looking at skill mix as part of system work on non surgical oncology and diagnostics. • HEE cancer workforce lead supporting Gynae OPG with CNS workforce census and skill mix review.	None identified.	None identified.	Static - 3 Archive(s)

2106	23/08/2022	Quality	Tackle inequalities in access, experience, outcomes	12	(I4xL3)	1	(I1xL1)	Jason Pawluk	James Thomas	Cancer Health Inequalities: There is a risk that prevailing health inequalities for people affected by cancer will get worse unless Place-based capacity and priority setting for cancer care is fully aligned to the ICB strategic priorities across all geographies in WY&H.	ICS coordination of plans across places and requirement to respond to the Planning Guidance. Work of the Cancer Alliance developing system level plans. Role of the acute provider collaborative. Provision of SDF to places to deliver cancer priorities. Collaboration between ICS partners and Cancer Alliance and Core20Plus5.	None identified.	Design work for ICS provides opportunity to work differently across the Alliance with shared common aims and sharing of resource where appropriate to level up. Coordination of planning across the ICS. Cancer Alliance dashboards providing consistency of data analysis to highlight variation and priorities for system action.	Cancer Alliance dashboards providing consistency of data analysis to highlight variation and priorities for system action.	Evidence of place-based investment profiles for cancer health inequalities, linked to Core20Plus5.	Increasing
2105	23/08/2022	Both FPC and QC	Improve healthcare outcomes for residents	12	(I4xL3)	8	(I4xL2)	Keith Wilson	Ian Holmes	There is a risk to continuing the operational delivery of the West Yorkshire Clinical Assessment Service. Without this service this would result in additional activity in the NHS 111 services and increased referrals to Emergency Departments.	Following a briefing paper on '1 & 2 hours GP Speak to' and 'NHS111 online ED validation', WY Chief Finance Officers had approved funding for the schemes for 2022/23, supported by UEC Programme Board and WY UEC Place Leads. With the help of UEC Place commissioners a briefing paper with proposals to continuining the existing service was prepared and shared across WY UEC system leads and finance leads. The briefing paper recommendations have the full support from UEC Place leads and has been forwarded to finance leads to agree for 2023/24	A decision needs to be made in relation to supporting the service 2023/24.	Urgent and Emergency Care Board are sighted on the risk, and CFOs are sighted on the detailed modelling for the WY CAS.	CFOs had already agreed funding for 2022/23 based on current modelling and evidence of outcomes and the UEC Place leads have supported the recommendation to continue the same model in 2023/24.	None	Static - 2 Archive(s)
2102	23/08/2022	Quality	Improve healthcare outcomes for residents	12	(I3xL4)	4	(I4xL1)	April Daniel	Beverley Geary	There is a risk to the delivery of safer maternity and neonatal care. This is due to the inability to recruit and retain staff; linked to sickness, morale and well-being, the impact of covid and maternity leave. Due to these workforce challenges the system is unable to release staff to partake in transformational work. This then also impacts on the ability to train staff and delivery new models of care e.g. continuity.	Working with National Team, HEE and WY HCP People's Directorate. Engaging with staff support mechanisms. Working with those leading the wellbeing hub to address the requirements for maternity specific work Working with HR departments on joint recruitment Working with the regional Recruitment & Retention Lead in collaboration with the Trust R&R midwives Ensure international recruitment is in place in each Trust Working collaboratively with the ICB Retention Group Work with the neonatal ODN to ensure the Neonatal Workforce is understood and reported Connect the regional OND team with the ICB workforce group An event with partners is planned which will utilise the 'star approach' Working with Trusts through the Workforce Steering Group Group which includes supporting the Recruitment and Retention leaders in each organisation The LMNS are facilitating work on the escalation policy with maternity and clinical leaders The LMS Preceptorship pack to support Newly Qualified Midwives. Professional Midwifery Advocates in each Trust to support all staff. NHSE funded Midwifery Recruitment & Retention Role are in each Trust.	Work required with communities to develop an interest in midwifery and neonates as a career Need to consider how to be creative to recruit into West Yorkshire (this would include all the workforce) Trusts are unable to share staff which was previously used to manage the risk across the LMNS	Close working with the maternity leads in HEE and the regional team who provide updates on staffing levels, student numbers, and feedback from Heads of Midwifery who undertake exit interviews on all staff. Staffing appears across the each of the Trust's within the LMNS risk registers, at varying risk ratings (2 Trusts at 20, other Trusts varying from 15 to 9). The rating of this risk reflects these risks. Each LMNS Trust has risks in relation to midwifery, obstetric, administrative and other health professionals staffing. Issues are raised at the Maternity Quality Oversight Group. The Maternity Strategy was submitted to the LMNS Board February 2023.	Report to the LMNS Board and Quality Committees on a Bi-monthly basis includes measures against birth-rate +, vacancies, sickness, maternity leave, attrition from training international recruitment and leavers.	There is no tool for measuring obstetric and neonatology staff.	Static - 2 Archive(s)
2295	03/05/2023	Quality	Improve healthcare outcomes for residents	9	(I3xL3)	6	(I2xL3)	Laura Siddall	Anthony Kealy	There is a risk that the ICB does not have effective business continuity plans and arrangements in place to prevent, recover from, and deal with potential threats and is therefore vulnerable to events which may disrupt business as usual.	- Each of the five places has a business continuity (BC) plan in place, supported by a business impact assessment -Place BC plans are being refreshed and an overarching ICB BC policy will be completed by July 2023 -WY ICB Incident Coordination Centre function in place - An ICB EPRR policy has been agreed which includes BC arrangements - ICB on call system is fully operational - Testing and exercising of BC plans is undertaken	- The WY ICB does not currently have an overarching Business Continuity (BC) Policy in place. -A common business impact analysis template will be completed as part of the WY policy by July 2023. - A multi-year testing and exercising plan has not yet been completed	- Regular cycle of Internal Audit review of BC arrangements - Annual assessment against EPRR (including BC) core standards reported to the Board - Annual statement of EPRR (including BC) compliance - Annual review of Business Impact Assessments to be undertaken by ICB teams	- Internal Audit review of BC arrangements with a view of Significant assurance following the audit in early 2023. - Successful continuity of services through prolonged period of industrial action in 2022 and 2023 - Evidence of successful BC exercises and tests	None identified	New - Open
2267	04/04/2023	Quality	Tackle inequalities in access, experience, outcomes	9	(I3xL3)	6	(I3xL2)	April Daniel	Beverley Geary	There is a risk in relation to the impact of economic pressures on patients across the LMNS. The impact of this risk may be that patients are unable to attend appointments, or make phone calls, or be able to provide their own self-care during pregnancy. This may impact on or lead to poorer birth outcomes.	Bradford have established some project work in relation to patient poverty in response to their stillbirth rates. This work was reported to the October LMNS SI Panel, and potential work across the LMNS was considered. This risk to be raised at LMNS Inequalities Group, where future planning will be discussed. LMNS have circulated advice to Trusts on voluntary sector support.	Bradford best practice work has been highlighted to ICB inequality group who will move forward with work on personalisation, and will try to embeed addressing this risk within that work. Further work with voluntary sector to improve on the mapping already undertaken. There will be a robust overview of where women can be suported to be shared with both women and staff groups. Proposal to LMNS Board April 23 that this is a high risk. Data on impact of econonmic pressures on women to be sought from Bradford and patient outcomes will be seen through LMNS SI and Safety Forums.	To be reported to LMNS Board and LMNS Inequalities Group. Cost of living risk across the maternity population is being managed though local health inequalities work streams at the ICB and linking with the LMNS health inequalities group where they have an equality action plan to report against. It is also managed through several of the workgroups ran by public health who sit on and report into the maternity population board at the ICB.	TBD	TBD	New - Open
2234	17/02/2023	Both FPC and QC	Improve healthcare outcomes for residents	9	(I3xL3)	9	(I3xL3)	Caroline Squires	Laura Ellis	There is a risk to key services of the ICB and commissioned services due to a successful cyber-attack, hack or data breach of a commissioned Provider or supplier to the ICB, resulting in disruption of ICB services, potential for damage and distress to individuals, reputational damage to the organisation and regulatory action under data protection legislation.	ICB in hours and oncall escalation arrangements Business continuity plans in place in the event of a prolonged IT system issue. Procurement including information security/cyber security due diligence, DTAC (Digital Technology Assessment Criteria) Contractual levers, NHS Standard Contract Terms and Conditions, Data Protection Protocol Terms and Conditions, contract monitoring arrangements Dedicated cyber security resource/expertise utilising national alerting and reporting. ICB EPRR expertise and resource.	1. Review of business continuity arrangements 2. Testing/simulation of business continuity arrangements specifically in relation to cyber-attack (including ransomware attacks) experienced by commissioned Providers or suppliers to the ICB.	Contract monitoring arrangements Due diligence checks on IT suppliers (requirement of the Data Security and Protection Toolkit)	Internal Audit of the ICB's Business Continuity arrangements	None identified	Static - 1 Archive(s)
2197	30/11/2022	Quality	Tackle inequalities in access, experience, outcomes	9	(I3xL3)	6	(I3xL2)	April Daniel	Beverley Geary	There is a risk to the continuous delivery of high quality intrapartum care at Birth Centre at Mid-Yorkshire and Huddersfield Hospital due to their temporary closure. This temporary closure limited the range of birth places provided by both Trusts which may lead to reduced patient experience and reputational damage. The closures are due to staffing deficits.	Each of the Trusts offer midwifery led care in attached units in Calderdale and Wakefield. Both services provide antenatal and postnatal care in the Kirkless footprint. As per national guidance pregnant people have access to three birth setting choices. Equality Impact Assessments have been undertaken by the individual Trusts. Place Care Partnerships are aware of the situation. Ongoing work with the Maternity Voices Partnerships (MVP) to ensure good communication with service users.	Without sufficient staffing the two units cannot re-open.	A Task and Finish Group is in place that includes CHFT and Mid-Yorks to discuss and plan future service provision. The T&FG will report into the LMNS Board.	The impact is on a small number of women. Each of the units offer midwifery led care in attached units.	LMS providers to be kept as this could impact on women's choice of place to have their care.	Static - 2 Archive(s)

2112	25/08/2022	Finance, Investment and Performance	Enhance productivity and value for money	9	(I3xL3)	6	(I3xL2)	Keir Shillaker	James Thomas	There is a service delivery risk that individual workstreams do not have the sufficient capacity within organisations or from project teams to deliver the intended transformation due to limitations on resourcing resulting in a lack of delivery.	MHLDA core programme team recurrently resourced by ICB. SRO workstream leadership and leadership for elements of work sourced from places and providers where possible. Maximising last remaining non-recurrent funding for the programme following previous carry forward	Requirement to manage upwards on demands and ability to access additional funding sources if needed to fund capacity on agreed priorities beyond current non-recurrent pots	Ability to deliver on workstreams and capacity/feedback from programme team regarding their working patterns and confidence in delivery	We have identified gaps in CYPMH and CMH and are resourcing using remaining non-recurrent funding pots	Need over time to maximise the benefit of capacity at both place and system level	Static - 3 Archive(s)
2188	25/11/2022	Finance, Investment and Performance	Improve healthcare outcomes for residents	8	(I4xL2)	6	(I3xL2)	Ian Holmes	Ian Holmes	There are risks associated with the delegation of primary care functions to the West Yorkshire ICB from April 2023, specifically: - The full transfer of NHS England capacity to carry out the functions for our ICB - due to uncertainty around the NHSE change programme - The full transfer of budgets to allow us to commission the service to a satisfactory standard - due to financial pressures in the system and underspends against existing contracts - Our ability to deliver service improvements in line with public expectations - due to significant issues around service access and inequalities Resulting in staffing and financial pressures and reputational damage to the ICB.	- West Yorkshire POD delegation task and finish group is overseeing the transition work - The Yorkshire and Humber Regional Delegation Delivery Group is overseeing the work from an NHSE perspective - We are providing regular updates to the Board - We are engaging with system partners, including scrutiny and HWBs to share plans and help mange expectations - We are working with NHS Confed and other ICBs to share thinking on the art of the possible and influence upwards	None identified	Minutes, action logs and risk registers from the WY T&F group and the regional delegation delivery group Board papers minutes and actions. Pre Delegation Assessment Framework (PDAF) agreed and approved my NHSE Currently completing a Safe Delegation checklist.	Report to Board in March led to agreement to taking on delegated functions while recognising some residual risks relating to staff transfer.	Confirmation on staffing model for supporting functions.	Decreasing
2177	17/10/2022	Both FPC and QC	Enhance productivity and value for money	8	(I4xL2)	6	(I3xL2)	Keir Shillaker	James Thomas	There is a relationship risk that the intended collaborative ways of working don't work due to unresolvable differences in opinion, resulting in a lack of decision making	Continue to use the forums established and roles of SROs to ensure transparency of workstreams. Further development of principles for LPC decisions	Further discussions needed as operating model developments regarding decision making at place and system level	MHLDA Partnership Board regular assessment with place leads regarding balance of decision making	Decision making regarding NightOWLS and Complex Rehab being taken through MHLDA Partnership board in August/September	Need to be able to share examples of where divergent views are at play - such as current discussions re Adult Eating Disorders and physical health monitoring with CONNECT/Primary Care	Static - 3 Archive(s)
2118	07/09/2022	Finance, Investment and Performance	Enhance productivity and value for money	8	(I4xL2)	6	(I3xL2)	Adrian North	Jonathan Webb	There is a risk that the ICS/ICB will not manage within the 2022/23 capital limits set by NHS England potential to exceed due to inflationary pressures and other demands, or undershoot due to lead times or delayed funding notifications leaving little time for procurement leading to non-delivery of one of the financial statutory targets and a reduction in the expected capital allocation for 2023/24. Underspend could result in increases in backlog maintenance requirements, detrimental impacts on NHS infrastructure, and lost funding as capital money cannot be carried into future years.	1. West Yorkshire wide capital plan with robust schemes which are designed to alleviate need fairly across the West Yorkshire service providers 2. Collective understanding and agreement across all WY providers that the over-commitment of 5% allowed in the planning process will need to be managed collectively by the end of the 2022/23 financial year. 3. Capital working group established which involves all WY NHS providers which meets monthly to oversee year-to-date expenditure, forecasts, risks ad opportunities 4. Oversight of capital position by WY ICS Finance Forum	1. Detailed plans which detail which elements of the 2022/23 capital plan can be reduced to live within capital allocation	1. NHS England oversight and management; 2. Review of capital plans in West Yorkshire Finance Forum between commissioner and providers; 3. ICB Finance, Investment and Performance Committee oversight; 4. ICB Board overview	1. System capital expenditure at month 10 is behind plan, with forecasts at planned level	None identified	Decreasing
2117	07/09/2022	Finance, Investment and Performance	Enhance productivity and value for money	8	(I4xL2)	8	(I4xL2)	Adrian North	Jonathan Webb	There is a risk that the ICS will not deliver the 2022/23 financial requirement of breakeven (with a requirement that the ICB delivers a planned surplus of £4.5m) which it has agreed with NHS England. This is due in part to several key elements listed below which bring a level of uncertainty to achievement of the statutory responsibility to deliver the target., resulting in reputational damage to the ICS/ICB , potential additional scrutiny from NHS England and a requirement to make good deficits incurred in future years. REASONS 1. Uncertainty around prescribing and IS costs in the ICB 2. Unforeseen issues or uncertain forecast assumptions made by any of the 11 statutory NHS bodies	1. Agreement of West Yorkshire ICS 2022/23 Financial Framework by all NHS organisations setting out arrangements in place to manage financial risk 2. Delegation of resource to five places supported by robust budget setting at place through planning process. 3. Review of financial position via the West Yorkshire ICS Finance Forum	1. Agreed the establishment of an efficiency management group at ICB level - still to finalise; 2. Consider additional controls to manage recruitment to ensure running costs targets are delivered; 3. Absence of a contingency in financial plans to mitigate against unplanned expenditure or efficiency delivery shortfall	1. Budget management at places; 2. Overview of financial performance and risk in place committees; 3. ICB Oversight and Assurance System Leadership Team and ICB Finance, Investment and Performance Committee oversight of financial position and risks; 4. ICB Audit Committee oversight of risks and capacity to instruct a deep-dive into areas of concern; 5. ICB Board statutory responsibility; 6. West Yorkshire System-wide management including provider target achievement 7. NHS England review of financial position on a monthly basis	1. Submission of a system financial plan which is an aggregation of NHS provider and ICB plans which were all approved via individual organisational governance following review and challenge; 2. At month 10, year-to-date system financial performance ahead of plan, with all organisations forecasting to deliver financial plans for the full-year 3. Financial planning assumptions have been moderated across the ICB core and 5 places , they have been subject to peer review and challenge across the WY ICS	1. Further review at month 11 of risks and mitigations leading to articulation via place committees, consolidated and considered via ICB Oversight and Assurance System Leadership Team and ICB Finance, Investment and Performance Committee.	Decreasing
2110	23/08/2022	Both FPC and QC	Improve healthcare outcomes for residents	8	(I2xL4)	1	(I1xL1)	Jason Pawluk	James Thomas	Living with and Beyond Cancer (Strategic Focus Risk): There is a risk that the strategic outcomes from the Living with and Beyond Cancer transformation programme will not be fully delivered due to the approach taken by providers to prioritise the NHS Constitutional Waiting Time standards for cancer (see other risk). This would impact on the quality of care, delivery of the national cancer strategy, and risk significant reputational damage for the ICS.	The Cancer Alliance has commissioned a report on options for a Digital Remote Monitoring System to deliver benefits for cancer follow up. Provider trusts are now responsible for delivering the recommendations arising and providing a timeline as discussed with WYAAT CIOs. Data collections on other areas such as holistic needs assessments, personalised care support plans, and opportunities for effective pre-habilitation and rehabilitation following cancer treatment. Dedicated Steering Group set up. Provision of Implementation Project Managers to oversee trust responses. National quality of life metric developed. Cancer Alliance Board level oversight of National Cancer Patient Experience Survey.	The development of a milestone tracker has been useful in collecting data, but it has been difficult to complete and is done manually. IT support to make this process easier is required.	Supported by national data collection. Implementation managers to support the delivery in local providers. A national quality of life metric has been launched. Covid-19 recovery plans are in place to restart LWBC agenda, both locally and Alliance wide. Cancer workforce and activity being protected as we encounter further waves of Covid.	None identified.	None identified.	Increasing
2107	23/08/2022	Both FPC and QC	Improve healthcare outcomes for residents	8	(I2xL4)	1	(I1xL1)	Jason Pawluk	James Thomas	Constitutional Access Standards - Cancer Performance Risk: There is a risk that patients in WY&H will not receive cancer care in accordance with the access standards set out in the national cancer strategy and NHS Constitution. Significant failure to deliver the access standards risks clinical harm, regulatory intervention, loss of funding, and significant reputational damage.	Provider trusts deliver pathway improvement work collaboratively through WYAAT forums. This includes work on mutual aid, effective capacity expansion measures, role of independent sectpr. Places have also developed proposals for community diagnostic centres which will support longer-term growth of capacity. Development of place-level workforce plans to support the delivery of the cancer standards. Oversight/support of Cancer Alliance - reviewing areas of best practice and also stimulating pathway improvement work in defined areas, based on operational priorities.	None identified.	Develop system wide plan, pathway analysis work, use of Transformation Funds and Diagnostic Capacity and Demand programme. Also ongoing and close planning with WYAAT Leadership.	22/23 - the number of patients waiting more than 62 days for cancer treatment has exceeded the national trajectory and is amongst the best in the country (as a percentage of the patient tracking list), however the proportion of patients being treated within 62 days remains significantly lower than the NHS Constitution standard access measure, so no change to risk score.	None identified.	Static - 3 Archive(s)

2199	01/12/2022	Both FPC and QC	Improve healthcare outcomes for residents	6	(I3xL2)	3	(I3xL1)	Caroline Squires	Laura Ellis	There is a risk of confidential personal data and commercially sensitive information being sent by email and by paper based correspondence (from areas such as e.g. CHC, complaints, IFR, HR) to an incorrect recipient or recipients, resulting in a breach of confidentiality and potential for damage and distress to individuals, reputational damage to the organisation and regulatory action under data protection legislation.	1. NHS Mail supportive features: employing organisation detailed when picking from Address Book, additional details in 'Contact Card' to verify identity, Address Book filter by organisation. 2. Guidance included within 'Effective Use of Emails' guidance, part of NHS Mail user guidance on computer desktops as part of NHSMail implementation. 3. Annual Data Security training of all West Yorkshire Integrated Care Board (WY ICB) staff. 4. Staff awareness of the risk via policy level messages (IG Policies Book), IG staff handbook, bespoke communication reminders to staff. 5. Data flow mapping and mitigation of any risks, by IAOs. 6. Return to Sender sticker or markings on outgoing confidential patient/staff correspondence from the relevant departmental areas of the ICB (may vary in extent across functions and places of the ICB) 7. Local departmental verbal and written reminders of good record keeping and administrative process and checks of personal details against source (may vary in extent across functions and places of the ICB)	1. Programme of ongoing awareness to ensure all staff remain sighted on the risk, including enhanced practical guidance on alternatives to email, controls to keep data in transit secure and awareness of checking emails and attachments before sent. 2. Audit of data quality processes (focused on admin and record keeping processes that produce high volumes of patient or staff confidential correspondence) in place and subsequent recommendations on findings of the audit.	1. Monitoring of incident patterns and trends via Incident and Near Miss Process Reviews. 2. Monitoring of incidents reported via the Information Governance Steering Group and Integrated Governance Report to Audit Committee. 3. Report on findings and recommendations of data quality audit and subsequent monitoring of completion of actions, via WY ICB IG Steering Group.	1. No serious incidents relating to confidential personal data and commercially sensitive information being sent by email to an incorrect recipient or recipients reported to the Information Commissioners Office. 2. Ongoing awareness to ensure all staff remain sighted on the risk, e.g via West Yorkshire Shareboard and bulletins such as Christmas IG good practice reminder messages. 3. Data Quality Audit is a mandated requirement of the Data Security and Protection Toolkit 22/23.	None identified at this time.	Static - 2 Archive(s)
2193	29/11/2022	Finance, Investment and Performance	Enhance productivity and value for money	6	(I2xL3)	4	(I2xL2)	Suzie Tilburn	Kate Sims	There is a potential risk of increased turnover or wellbeing concerns for staff within the West Yorkshire ICB following the recent transition from their previous organisations, (in most cases the local West Yorkshire CCGs). Whilst the ICB operating model and the necessary system to support the new organisation develop, some staff may experience a greater period of uncertainty which may result in matters of increased wellbeing concerns or possibly result in colleagues opting to leave for an alternative role.	• Results of local ICB level staff surveys and the national NHS Staff Survey 2022. • Turnover data including feedback through exit interviews. • Indication of increased absence relating to work-related matter and evidence of increased referrals / access to Occupational Health provision	None identified at this time, until results of the staff survey are available and an action plan developed.	• West Yorkshire Staff Briefings – focus on how colleagues are feeling • West Yorkshire ICB Staff Engagement Group – notes / actions from this group going forward • Corporate People Team work programme – the aspects which support staff engagement, wellbeing etc. • Staff Survey action planning (following outcome of nation survey) • Staff Engagement Group and Staff Equality Networks	• Staff Briefing – recordings of the briefing sessions are available • Corporate People Team work programme	• Staff survey action plan – currently in development in 2023 following survey results • Potential impact of current Operating Model review.	Static - 2 Archive(s)
2178	17/10/2022	Both FPC and QC	Improve healthcare outcomes for residents	6	(I2xL3)	3	(I1xL3)	Keir Shillaker	James Thomas	There is a service delivery risk that certain priorities (such as those relating to Children & Young People) either end up being duplicated in the MHLDA programme and other programmes (i.e. CYP programme) or they fall through the gaps due to confusion in leadership, resulting in non-delivery on key pieces of work	Strong relationships with key programmes such as CYPMH, LTCs and IPH to share joint work and communicate on cross programme areas	Capacity to 'know what we don't know' is tricky but ways of working through ADs meetings and directorate discussions are opportunities to maintain the links	Clarity of purpose across all functions/programmes of work and joint working evident in workplans and workstreams	Working with CYPMH and WYAAT on support for CYP in acute environment, joint CYP and MHLDA presentation to SLE. Joint role with LTCs on personalisation. IPH links with Suicide Prevention role and Consultant in Public Health. Cancer programme employing Psychological Therapies role	These sorts of relationships often fall outside of core priorities as priorities tend to 'come down' in silos, so they can be difficult to prioritise and often are first to go when capacity is a problem	Static - 3 Archive(s)
2104	23/08/2022	Quality	Improve healthcare outcomes for residents	6	(I3xL2)	6	(I3xL2)	April Daniel	Beverley Geary	There is a risk in relation to achieving the national ambition for Continuity of Carer, including financing and delivery continuity of care and maintaining the reputation of Trusts.	Each place has a Continuity of Carer plan and the LMS have an overarching plan to support Trusts, showing CoC as the default model Co-produced with staff and service users Financial modelling undertaken Focus on inequalities LMNS CoC lead and regional CoC Lead meeting with each Trust	While the timescale for delivery element of CoC has been removed, but the planning for this remains in place	This is reported to LMNS Board on a quarterly basis. LMNS receiving support from regional and national team, with support visits being undertaken jointly with LMNS.	Continuing to support Trusts who all have recently updated their plans, which are reviewed by the LMS Board	Trusts need to develop 'building block' of new modelling.	Closed - Reached tolerance
2100	23/08/2022	Finance, Investment and Performance	Tackle inequalities in access, experience, outcomes	4	(I2xL2)	4	(I2xL2)	Catherine Thompson	Ian Holmes	There is a risk that the costs of clinically agreed policies may not be affordable in all places due to lack of sufficient funding resulting in a requirement to limit access based on non-clinical criteria	Decision making on the policy thresholds will be done in two tranches to enable more accurate estimation of the impact. Decisions will not be made without an impact assessment being conducted and agreed as acceptable.	No established framework or methodology exists to assess the financial impact. An approach has been devised within the programme team which will be tested on a range of policies in December / January. Revisions to policy thresholds will be considered after impact assessment and governance processes. Initiate early discussion with WY clinical forum to consider how clinical decision making can guide the governance process.	Once the financial impact for a range of policies has been estimated using the proposed approach it will be reviewed by the Finance Director lead for planned care and with the WY finance forum to assess voracity of the approach.	None.	None.	Closed - Reached tolerance
2099	23/08/2022	Finance, Investment and Performance	Improve healthcare outcomes for residents	4	(I2xL2)	4	(I2xL2)	Catherine Thompson	Ian Holmes	There is a risk that it may not be possible to fully understand the potential costs of implementation of the harmonised policies or predict the financial and workforce impact over future years due to the absence of a proven methodology, resulting in future financial and workforce pressures.	None currently exist	Work with BI and finance leads to develop a framework for assessing the impact of policy harmonisation including full implementation costs. Thresholds for access policies will be agreed in two tranches to enable a better understanding of the cumulative impact of implementation.	WY Finance Forum will review the framework.	None.	None.	Closed - Reached tolerance

Mapping of risks – 1st risk cycle of 2023/24 (as at 4 May)

COMMON RISKS

System Flow / Capacity and Demand Risks

Place	Risk	I	L	Score	Common Risk
Kirklees (2055)	There is a risk of increasing pressure on specialist primary care medical services due to an anticipated increase in the numbers of asylum seekers to the region resulting in difficulty for primary care in meeting patient need and demand	3	3	9	Common risk re: impact from incoming refugees / asylum seekers
Kirklees (2054)	There is a risk of increasing pressure on general practice due to the number of people arriving on the refugees from Ukraine national schemes resulting in a deterioration in access to services	2	2	4	
Wakefield (2207)	There is a risk that public health and health and care providers will not be able to respond in a timely way to address health needs of asylum seekers due to not being given sufficient notice by the Home Office of people being moved into temporary accommodation in the district.	3	3	9	
Kirklees (2195)	There is a risk that the Kirklees Health & Social Care(H&SC) system organisations are unable to deliver comprehensive care. Due to multiple partners across the H&SC system declaring organisational OPEL 4 for sustained periods of time and pressure across the system partners continuing to escalate. Resulting in increased potential for patient care, safety and experience to be compromised.	3	3	9	Common risk re: impact across the system / OPEL 4
BDC (2222)	There is a risk of the entire urgent care system seeing an unprecedented demand which far exceeds capacity. This will drive demand towards ED resulting in overcrowding, increase in long waits to be seen and for admission resulting in poor performance e.g. ECS and 12 hour wait standards and it will negatively patient experience, safety and outcomes. There would be a further impact on general flow with side room availability being an issue. This would further negatively impact on ambulance handover times. The numbers of discharges and flow out of hospital would also be impacted. It would also be likely to impact workforce further reducing the system's ability to deal with the excess demand.	3	3	9	
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, acuity and length of stay of inpatients and the time spent by people in hospital beds with no reason to reside, resulting in poor patient quality and experience, failed constitutional targets and reputational risk.	4	5	20	
Wakefield (2135)	There is a risk of delays for children and young people requiring access to CAMHS, including admission for Tier 4 beds due to increased referrals and CYP presenting in crisis, resulting in more children and young people being admitted inappropriately to acute wards or adult mental health beds and additional demands on ED.	3	3	9	Common risk re: CAMHS

Leeds (2243)	There is a risk of delay in accessing MH treatment due to the significant increase in referrals over the past years and a lack of capacity within MindMate SPA to deal with referral numbers, resulting in young peoples mental health deteriorating whilst they are waiting to be triaged by MindMate SPA.	3	4	12	
Calderdale (1977)	There is a risk that Children and Young People's (CYP) will be unable to access timely therapy due to:- a) increase in demand, b) existing high waiting times and c) inability for provider to recruit to vacant posts In particular the risk relates to the waiting times for speech and language (SLT) and occupational health therapies, where we have received a significant increase in the number of referrals in 21/22 compared to previous year. For example SLT new appointments in September 2019 compared to September 21 was an increase of 245%. The same comparison period for follow up shows an increase of 98%. In September 21 there were 1314 CYP waiting for a new appointment, 296 waiting for a follow-up with an average wait of 157 days (however, this picture has increased). During Covid-19 lockdown, therapy staff at CHFT were redeployed (as this was a f2f service). Once services reopened, staff returned and virtual/telehealth appointments were offered Workforce remains a risk with vacancies across therapies which Provider are unable to recruit to (national picture)	3	3	9	
Kirklees (2196)	There is a risk that the Kirklees' Children & Young peoples (CYP) mental health service are unable to deliver timely, comprehensive care to those being referred or self referring when in crisis. Due to a significant increase in demand from pre pandemic levels & increased acuity. Resulting in patient care and safety to be compromised.	3	4	12	
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: mental health services capacity and demand
Leeds (2018)	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.	4	4	16	

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	3	12	
Calderdale (1493)	Risk that patients being discharged from hospital are subject to delays in their transfer of care due to health and social care systems and processes are not currently optimised, resulting in poor patient experiences, harm to patients, risk of hospital acquired infection, additional pressure on the acute bed base and pressure on elective recovery plans.	4	4	16	Common risk re: delayed transfers of care
Kirklees (2071)	There is a risk that we will not be able to meet the 2022/23 national Transforming Care trajectories due to 1. to lack of funding in the system to develop new models of care 2. lack of workforce capacity and capabilities 3. inadequate accommodation provision 4. potential risk of hospital closures impacting on additional discharges This will result in the delayed discharge of people currently in an inpatient bed due to there not being the right provision and the right support to put in place within a community setting.	2	2	4	

Covid Backlog / Risk of Harm / Performance/ Statutory Duties Risks

Place	Risk	I	L	Score	Proposed Action
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	Common risk re: emergency departments demand
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	
BDC (2222)	There is a risk of the entire urgent care system seeing an unprecedented demand which far exceeds capacity. This will drive demand towards ED resulting in overcrowding, increase in long waits to be seen and for admission resulting in poor performance e.g. ECS and 12 hour wait standards and it will negatively patient experience, safety and outcomes. There would be a further impact on general flow with side room availability being an issue. This would further negatively impact on ambulance handover times. The numbers of discharges and flow out of hospital would also be impacted. It would also be likely to impact workforce further reducing the system's ability to deal with the excess demand.	4	4	16	

Calderdale (62)	That the system will return to the pre-C19 levels of demand and will not deliver the NHS Constitution 4-hour A&E target for the next quarter, due to pressures associated with; avoidable demand, implications of social distancing measures and capacity and flow out - resulting in harm to patients and patient experience being compromised.	4	3	12	
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 (2182)	There is a risk that the WDHCP will not meet the national ambition of reducing gram negative blood stream infections by 50% by 2023/24 due to a significant number of the cases having no previous health or social care interventions, resulting in failure to meet the requirements of the single oversight framework (should this measure be included).	4	3	12	Common risk re: gram negative blood infections reduction target
Kirklees (2058)	There is a risk that the WY ICB Kirklees Place will not achieve the national ambition of reducing gram negative blood stream infections by 50% by 2024/25 due to the gaps identified in the key controls; resulting in a risk to population health and experience.	3	3	9	
Calderdale (1942)	There is a risk of harm to patients with LTC/frailty due to t 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: management of patients with long term conditions / frailty / link to health inequalities
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	
BDC (2221)	There is a risk of failure of the Reducing Inequalities Alliance (RIA) and other programmes to support and coordinate action by the BDC partnership to reduce health inequalities due to lack of influence of the RIA so that inequalities become a golden thread through all programmes, lack of identified action & evaluation of the impact of this work, reduction of specific inequalities funding streams (e.g Core20PLUs5, RIC, health inequalities practice premium) which could result in health inequalities getting wider. This has also been influenced by the COVID19 pandemic and continues to be influenced by wider socio-economic inequalities.	4	3	12	
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	Common risk re: failure to meet

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	3	4	12	Constitutional standards
Calderdale (62)	That the system will return to the pre-C19 levels of demand and will not deliver the NHS Constitution 4-hour A&E target for the next quarter, due to pressures associated with; avoidable demand, implications of social distancing measures and capacity and flow out - resulting in harm to patients and patient experience being compromised.	4	3	12	
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	3	12	
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	
Kirklees (2049)	There is a risk that Kirklees and Wakefield place will fail to meet the required cancer standards for 62 day cancer waiting time targets due to operational performance and increased referrals for 2ww at Mid Yorkshire Hospitals NHS Trust (MYHT), resulting in an adverse impact on the quality of care and patient experience, and a failure to meet key national targets potentially resulting in reputational damage to the system and having a negative reputational impact on Kirklees and Wakefield places.	3	4	12	
BDC (2168)	SYSTEM PERFORMANCE AGAINST NATIONAL REQUIREMENTS There is a risk that poor performance against national requirements (key constitutional standards, operational planning targets and recovery) will impact upon our place based contribution to the annual ICB performance assessment. This may lead to both financial and reputational impact alongside reduced patient care.	3	5	15	
Wakefield (2146)	There is a risk that demand for adult ADHD assessment exceeds capacity due to increased referrals, resulting in more people exercising Choice and seeking private assessment which presents a financial risk.	3	3	9	Common risk re: adult ADHD assessment
BDC (2227)	There is a risk of further deterioration for adults with ADHD waiting for assessment, diagnosis and immediate post-diagnostic support due to staffing levels, quality of referrals, excessive waiting times and a growing gap between capacity and demand for this service resulting in complaints from patients and referrers and scrutiny from council elected members. Inequitable access to services for those who do not exercise Right to Choose and request a referral to an independent sector provider.	3	4	12	

BDC (2266)	There is an increase across adult and children of an increase of Right to Choose requests for both ADHD and Autism assessments. This will lead to a significant unbudgeted cost to the ICB (GP's can refer to any provider that is on a NHS framework and the ICB get the invoice in retrospect. In children's the annual cost projected this year is over £200,000	4	4	16	
Kirklees (2180)	There is a risk of non-compliance with the Children & Families Act 2014 and the Health and Care Act 2022 relating to ICB responsibilities with regard to Children with Special Educational Needs and Disabilities (SEND). This is due to Education, Health and Care Plans not being completed within statutory timescales. A key factor is that Health information is not always provided by clinicians in a timely manner. Resulting in delayed assessment of needs and Health provision not being in place to support access to education. This can lead to complaints, appeals and tribunals.	3	4	12	Common risk re: SEND and Children & Families Act statutory duties
Leeds (2253)	There is a risk of not fulfilling the statutory duties to provide timely health advice into EHCPs for CYP with SEND within legislative timescales due to increasing pressures on the system, resulting in delayed support for CYP with SEND and that the EHP Plans do not accurately reflect the needs of CYP and could impact on outcomes and aspirations of CYP. *The consequence is that the contribution of health advice to the ECH Assessment process does not meet with the statutory duties.	3	4	12	

ICB Workforce Risks

Place	Risk	I	L	Score	Proposed Action
Kirklees (2078)	There is an ongoing risk of a continual increase in overdue CHC/joint funding/FNC reviews due initially to business continuity arrangements during Q4 21/22 (when "low risk" reviewing activity was paused), but since, vacancies, recruitment challenges and sickness absence in the CHC clinical team, resulting in a poorer patient experience and a negative impact on the CHC activity and delivery. The number of overdue reviews continues to increase.	3	4	12	
Kirklees (2074)	There is the risk of delays to Continuing Care administration processes and workflows due to a staff shortage in the business support team, resulting in an impact to clinical workflows, the wellbeing of the team, patient experience and a potential impact to organisational reputation. It also has an impact on the financial position of the CHC team, with delays to invoices being paid and potential impact to NHSE mandated activity.	3	4	12	Common risk re: continuing healthcare workforce challenges
Calderdale (2092)	The Continuing Healthcare team is currently significantly short staffed with eight (8) live vacancies. This is at a time where the team is experiencing high volumes of complex case management and increased scrutiny and requests for information coming from NHSE. There is a risk with regard to the	3	3	9	

	organisational effectiveness in the delivery and quality of the service provided, patient/carer dissatisfaction and increase in complaints leading to reputation damage to the organisation, non-compliance in meeting national assurance targets set by NHSE, and with regard to financial efficacy. Due to the reallocation of work over fewer staffing numbers, there is a risk of staff burnout, leading to increased sickness levels and difficulty in staff retention resulting in high staff turnover within the team. Staff have alerted Over the past 12 months five staff within the learning and disability and mental health fraction of the team only, have left the team citing excessive caseload as the reasons for leaving. Recruitment to these positions in particular and within Children's Continuing Care has proven to be challenging despite going out to recruitment for these positions on multiple occasions. There are also several projects relating to service improvement occurring across the Calderdale footprint that various staff within the team are contributing to. All these projects aim to provide a more joined up approach and economical delivery model for the people of Calderdale. The current level of staffing shortage within the team risks a delay to the progress of these projects as staff focus on ensuring statutory functions are prioritised.				

Infrastructure – digital / estates / non ICB workforce Risks

Place	Risk	I	L	Score	Proposed Action
Kirklees (2154)	There is a risk of a reduction of quality, safety and experience of women accessing maternity services, due to recruitment and retention challenges resulting in poor outcomes and experience	2	3	6	Common risk re: maternity services Also see corporate risk. A risk is also anticipated being added in Leeds
Calderdale (2156)	There is a risk of a reduction of quality, safety and experience of women accessing maternity services, due to recruitment and retention challenges resulting in poor outcomes and experience	2	3	6	
Wakefield (2128)	There is a risk of children and young people aged 0-19 year waiting up to 52 weeks for autism assessment due to availability of workforce to manage the volume of referrals	3	4	12	Common risk re: waits for CYP neurodiversity This has been flagged as potential area for a
Calderdale (1338)	There is a risk that children and young people (CYP) will be unable to access timely mental health services (in particular complex 'at risk' cases and Autism Spectrum Disorder/Attention Deficit Hypertension Disorder (ASD/DHD)). This is due to a) waiting times for ASD (approx. 14 months) b) lack of workforce locally and nationally to recruit into this service and c) appropriate services not being available for CYP as identified in SEND. Resulting in potential harm to patients and their families.	4	3	12	

Kirklees (2240)	There is a risk of children being unable to access a timely diagnostic service for neurodevelopmental conditions. This is due to increased demand for the service and the impact of the Covid 19 pandemic on provision of the service. At the end of Jan 23 the average waiting time for assessment was 68 weeks, with 1282 children waiting for assessment. resulting in delays to timely diagnosis, may also impact upon access to other support services across Health, Education and Social Care and reputational damage.	3	4	12	new risk on Corporate Risk Register
Leeds (2241)	There is a risk of increasing delay in accessing the neurodevelopmental pathway (CAMHS school age) due to a steady increase in the number of referrals and the backlog of referrals at MMSPA being cleared, resulting in deterioration of child social, emotional and mental health	3	4	12	
BDC (2039)	CHILD AUTISM and/or ADHD ASSESSMENT AND DIAGNOSIS There is a risk of further deterioration in the statutory duty service offer for children waiting for assessment, diagnosis and immediate post diagnostic support. This results in non-compliance with the NICS (non-mandatory) standard for first appointment by three months from referral which was highlighted as an area for a remedial Written Statement of Action in the Ofsted/CQC local area SEND inspection held in March 2022.	4	4	16	
Kirklees (2147)	There is a risk to the ability of care homes to be able to provide safe, high quality and person centred care due to staffing levels, high cost agency usage, increased costs of living and increased intensity of need of residents. This results on an increased requirement on the systems to provide intense responsive support to care homes, and risks care homes de-registering or closing due to financial unsustainability.	3	3	9	Common risk re: care homes staffing
Calderdale (2149)	There is a risk to the ability of care homes to be able to provide a safe, high quality, person centered quality lifestyle due to staffing capacity and gaps in knowledge resulting in poor quality care and experience.	3	3	9	
Wakefield (2138)	There is a risk to quality, safety and experience in the independent care sector due to the requirement to manage people with increased complexity, rising costs and workforce supply challenges, resulting in insufficient capacity and delayed discharges.	3	3	9	
Wakefield (2203)	There is a risk that the GP workforce challenges across some GP Practices are not effectively managed which means that leads to demand across system partners and poor patient experience.	3	2	6	Common risk re: general practice workforce
Leeds (2008)	There is a risk of an inability to attract, develop and retain people to work in general practice roles due to local and national workforce shortages resulting in the quality of and access to general practice services in Leeds is compromised.	3	3	9	
Calderdale (1434)	There is a risk that the quality of and access to commissioned primary medical services in Calderdale is compromised due to local and national workforce shortages, resulting in the inability to attract, develop and retain people to work in general practice roles.	4	2	8	

Calderdale (1629)	There is a risk that the additional roles being introduced within General Practice will not be utilised to their maximum benefit, will compromise the safe delivery of care and intervention for patients and be asked to practise outside of their scope of competency, due to limited professional and clinical experience in general practice of these roles resulting in the potential for harm to patients, poor retention and recruitment rates and a lost opportunity for general practice to maximise the roles and support the GP workforce effectively.	4	2	8	

Quality and Safety Risks

Place	Risk	I	L	Score	Proposed Action
Wakefield (2186)	There is a risk to patient safety and experience of care Due to specific concerns about quality of and access to care for patients Resulting in the Mid Yorkshire Hospitals Trust continuing to be rated by the CQC as 'requires improvement' overall (inspection March/April 2022)	4	3	12	Common risk re MYHT CQC assessment
Kirklees (2201)	There is a risk to patient safety and experience of care Due to specific concerns about quality of and access to care for patients Resulting in the Mid Yorkshire Hospitals Trust continuing to be rated by the CQC as 'requires improvement' overall (inspection March/April 2022)	4	3	12	
Kirklees (2179)	There is a risk of Looked After Children (LAC) not receiving an Initial Health Assessment (IHA) or Review Health Assessment (RHA) within statutory timescales. This is due to an increase in the complexity of individual cases and increasing numbers of LAC from outside the area living in private children's homes Kirklees. This includes an increase in Unaccompanied Asylum Seeking Children (USAC), resulting non achivement of mandatory timescales Resulting in performance targets not being met and assessments being carried out late. Health needs may not be identified early enough to ensure that support is put in place promptly.	3	3	9	Common risk re: Looked After Children health assessments
Leeds (2257)	There is a risk of not meeting target for Initial Health Needs Assessment completion for CLA, lack of capacity within service responsible for delivering IHNAs, resulting in health plans not being available for the first multidisciplinary Child Care Review meeting, delay in identification of health issues and subsequent support. There is also a risk of potential breach of statutory duty.	3	4	12	

Finance and Contracting Risks

Place	Risk	I	L	Score	Proposed Action
Kirklees (2204)	Capital Availability - There is a risk that capital spending limits will be set at a level that restricts our ability to progress our strategic capital developments	4	2	8	Common risk re: capital spending limits
BDC (2170)	CAPITAL AVAILABILITY There is a risk that NHS capital spending limits will be set at a level that restricts our ability to progress our strategic capital developments.	5	4	20	
Wakefield (2142)	There is a risk that the national capital regime and arrangements for the allocation of funding will mean there is insufficient resource within Wakefield place to support necessary service transformations.	4	3	12	
Kirklees (2116)	There is a risk that the transformational changes required to address the approved case for change programme (CHFT) will not be achieved within the required timescales, due to delays in allocating Business Case funding for Huddersfield Royal Infirmary (HRI) due to current political changes. Resulting in failure to deliver improved patient experience, better clinical outcomes and overall system sustainability.	3	3	9	Common risk re: CHFT business case funding
Kirklees (2064)	There is a risk that the allocated Full Business Case funding for Huddersfield Royal Infirmary (HRI) is not released by the secretary of state (Her Majesty's Treasury), due to current political changes, within the required timescales, resulting in an inability to fully implement the estate changes required to address the case for change and failure to deliver overall system financial sustainability.	4	2	8	
Calderdale (821)	There is a risk that the allocated funding is not secured due to the Full Business Case (FBC) not being approved by Her Majesty's Treasury, resulting in an inability to implement the transformational changes required to address the Financial and Quality and Safety case for change and failure to deliver improved patient experience, better clinical outcomes and overall system financial sustainability	4	2	8	

POSSIBLE RISKS FOR TRANSFERRING TO THE CORPORATE RISK REGISTER / RISKS CLOSED DUE TO TRANSFER TO CORPORATE RISK REGISTER THIS CYCLE

System Flow / Capacity and Demand Risks

Place	Risk	I	L	Score	Proposed Action
Wakefield (2145)	There is a risk of insufficient capacity in the Local Care Direct (LCD) - Out of Hours GP Services via the West Yorkshire Urgent Care (WYUC) contract due to increased referral activity and potential changes to referral pathways, resulting in poor outcomes and experience for patients and reduced quality of care.	4	3	12	This is under discussion as to whether should remain as 'common' risk, or be moved to corporate risk register.
Kirklees (2083)	There is a risk to patient safety, experience, the quality of care delivered by Local Care Direct (LCD) - Out of Hours GP Services via the West Yorkshire Urgent Care (WYUC) contract due to increased demand for the service.	3	3	9	
Calderdale (1361)	There is a risk to patient safety, experience, the quality of care delivered by Local Care Direct (LCD) - the provider of Out of Hours GP Services via the West Yorkshire Urgent Care (WYUC) contract due to increasing demand for the service.	4	3	12	
Kirklees (2246)	There is a risk to delivery of implementation of the Patient Safety Incident Response framework (PSIRF) due to capacity to train and release staff across the system to investigate patient safety incidents to fulfil the requirements of the framework, resulting in not meeting NHSE mandatory timeframes.	2	4	8	Possible corporate risk re PSIRF as not Place specific
Calderdale (2335)	There is a risk to delivery of implementation of the Patient Safety Incident Response framework (PSIRF) due to capacity to train and release staff across the system to investigate, review and fulfil the requirements of the framework.	2	4	8	

Finance and Contracting

Place	Risk	I	L	Score	Proposed Action
BDC (2220)	There is a risk of increased prescribing costs due to inflation and supply disruption resulting in financial strain on the primary care prescribing budget.	4	4	16	
Leeds (2158)	There is a risk of increased prescribing costs due to inflation and supply disruption resulting in financial strain on the primary care prescribing budget.	4	3	12	

Calderdale (2126)	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	Common risk re: prescribing costs

Appendix 3

Leeds Health and Care Partners - Top Risks – as at June 2023						
The ICB in Leeds	20 ⇔	There is a risk of harm to patients in the Leeds system due to people spending too long in Emergency Departments (ED) due to high demand for ED, the numbers, acuity, and length of stay of inpatients and the time spent by people in hospital beds with no reason to reside, resulting in poor patient quality and experience, failed constitutional targets and reputational risk.	20 ⇔	There is a risk that the financial position across the Leeds system will not achieve financial balance due to the combination of undelivered QIPP and cost pressures in 2023 – 24. This could result in the system not meeting the statutory duties.		
Leeds Teaching Hospital Trust	16	**High occupancy levels and insufficient capacity and flow across the health and social care system causing impact on patient safety, outcomes, and experience** There is a risk to maintaining sufficient capacity to meet the needs of patients attending hospital and being admitted for planned/elective care and unplanned (acute) care caused by demand being greater than the available hospital capacity. Efficiency of patient flow and placement due to high occupancy across the health and care	20	**Delivery of the financial plan and operational capital plan for 2023/24** There is a risk that the Trust does not achieve its planned control total and deliver the operational capital plan in 2023/24 due to a reduction in the capital allocation to address strategic capital risks across the ICB. This would have the following impact: Reducing the internal funding for the Trust's ambitious Five-Year Capital programme, including Building the Leeds Way. Cash shortfall and risk to supplier payment.	16	**Workforce risk** There is a risk in filling staff vacancies across all professional groups and support workers, caused by local and national shortages of qualified and unqualified staff, exacerbated by the coronavirus (COVID-19) pandemic, and internal financial controls impacting on decisions to recruit to vacant posts; resulting in a potential failure to provide safe care and treatment, protect staff from psychological and physical harm (burn-out), loss of

		system impacts on patient safety, outcomes, and experience. There is also a risk to the delivery of constitutional standards, impacting on the Trust's delivery and efficiency ratings and reputation.		Potential non-compliance with regulatory requirements, including new medical devices regulation (Regulation EU 2017/45). Limiting the capital programme / not replacing equipment. Increased clinical risk due to inability to replace capital assets within agreed replacement schedules. Greater reliance on external sources of funding. Potential to contribute to the Integrated Care System not meeting its overall control total. Reputational damage, as the Trust fails to deliver on a key statutory duty (financial plan) and the Trust fails to invest in equipment, estate, and digital infrastructure to support service development.		stakeholder confidence and/or material breach of regulatory conditions of registration.
Leeds Community Healthcare Trust	12	1. As a result of an imbalance in capacity and demand there is a risk of reduced quality of patient care in Neighbourhood Teams. It is anticipated that this may have an impact on the responsiveness to referrals, potential increase in patient safety incidents and complaints and a reduction in positive patient	12	2. As a result of the increasing number of referrals in the ICAN service for complex communication assessments there is a risk of not meeting the current service level agreement [breaching 18-week wait time] resulting in financial penalties for the Trust and associated delays for children and families for	12	3. Due to an increase in referrals to the speech and language therapy service, there is a risk that the current staff capacity may not be able to meet the 18-week waiting time for routine referrals. As a result, a patient's condition could deteriorate, and this may impact on hospital admissions

		experience and staff morale and health and wellbeing. This risk is increased in circumstances where this situation continues where capacity and demand are mis-matched and adequate mitigations are not achievable.		assessment, identification of needs and intervention, resulting in family pressures and leading to complaints and reputational damage.		and GP attendance. It could also impact on staff morale, potentially resulting in increased sickness and/or increased staff turnover.
	12	4. The number of children and young people taken into and remaining in care has increased with a greater complexity of issues, including those children who are placed beyond 20 miles of Leeds. Due to a lack of staff capacity within PHIN's SILC and the Specialist Children Looked After (CLA) Nursing team, there is a risk that staff will not be available to meet the health needs identified in health assessments, attend multi-agency childcare review meetings, or respond to requests for support from social care/foster carers. This could lead to a potential deterioration in the children's health, undiagnosed health problems and potential long term health issues. Service level agreements and National guidance may not be met, and the Trust reputation could be	12	5. Risk of increased waiting times in CAMHS service following initial assessment (urgent, prioritised or consultation clinic), because of reduced capacity, prioritisation of urgent work. The impact could be a delay in treatment for patients, which could lead to worsening symptoms or a continuation of treatable symptoms.		

		damaged.				
Leeds and York Partnership Foundation Trust		**System flow and Out of Area Placements** There is a risk to the quality of care of our service users as a result of ineffective patient flow within the system with an increasing use of Out of Area Placements, compounded by a lack of recurrent funding and a resulting financial cost to the system.		**Community Mental Health Services redesign** The Community Mental Health redesign and recovery plan will result in the need to do things differently across the city, and impact on the way partners provide their services. If this is not sufficiently addressed there is a risk to the overall quality of patient care and experience.		**Neurodiversity Waiting lists** There is a risk of harm to service users in Leeds due to the length of the waiting list for Neurodiverse Services impacted by the lack of sufficient funding to meet the increasing demand for these services.
Leeds GP Confederation	12	**Strategic**: There is a risk that both main aspects of the Confederation's purpose are compromised due to strategic decisions that are out with of our control. Voice & representation; if the funding for this is reduced or lost. Combined with PCNs taking Enhanced Access 'in-house' the combined affect will be a much-compromised Confederation infrastructure with limited ability to deliver purpose.	12	**Financial**: Currently forecasting a deficit for 2024/25. Aiming to increase income through winning tenders but there is a risk that these contracts do not yield the level of income required. Thus, a requirement to review expenditure which in turn may compromise purpose.		
Voluntary, Community and Social Enterprise		Currently unavailable.		Currently unavailable.		Currently unavailable.
Leeds City Council	New	**Increased demand and complexity** Increasing demand for services (health, care, children's, welfare and street support)	⟺	**Financial pressures** Ongoing impact of financial pressures on the local authority services leading to problems satisfying competing priorities	⟺	**Recruitment and retention, workforce pressures and market sustainability** Worsening workforce pressures and market

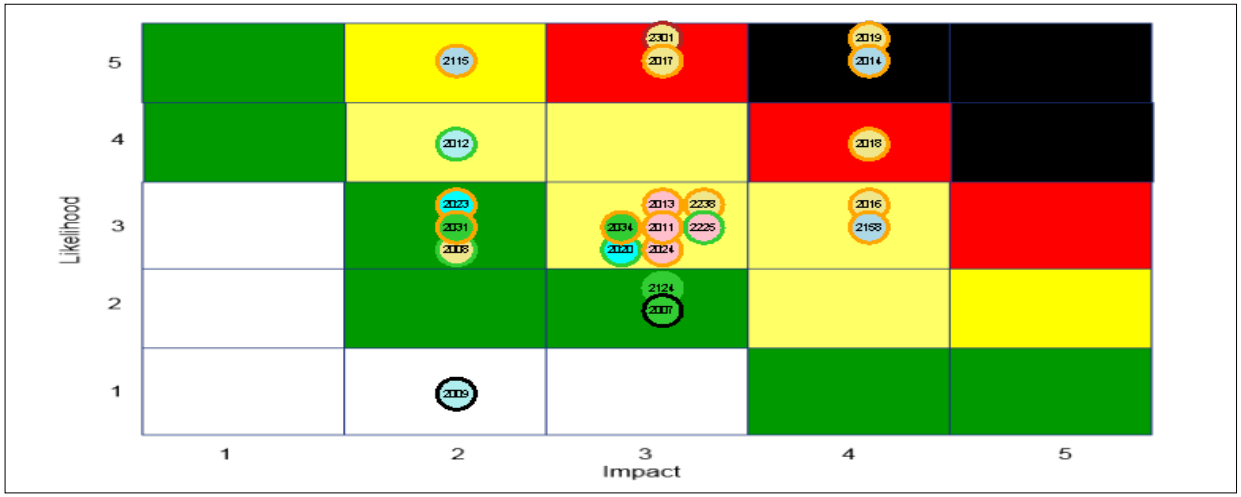
		coupled/reflected with increased complexity of the services required, resulting in significant, additional resource pressures (both in the short and longer terms). Example: school attendance levels being below pre-pandemic reflects a range of needs that will impact on service demand short term to address and potentially longer term if engagement in learning is lost. Pressure on families, on parents and on carers (both in Children and Families and Adults and Health Directorates) with wider pressure on family and community resilience. Sources: Increasing demand/requests for services. Slower progress in recovering to pre-pandemic performance levels.		and/or reduced levels of service delivery. The same amount of money buys fewer services now. Sources: Inflation and significant increases in the prices that local authorities pay for health and social care services. Ongoing impact of over a decade of public sector austerity measures.		sustainability position. Problems in both Adults and Health and Children and Families directorates in recruiting and retaining care staff (in particular: social workers, professionals, educational psychologists, schools) leading to increased resource pressures and adverse impact on our ability to deliver a wider range of services. Risk that the workforce capacity gap could worsen. Sources: High vacancy factors that are proving difficult to fill. Market sustainability and competition in the labour market (internal and external to the sector). Underinvestment in the labour market. Staff leaving the sector(s) for better paid and less stressful jobs in other industries. Long term problems from the pandemic and Brexit.

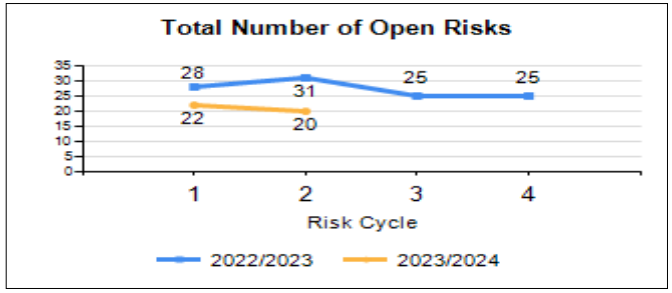
NHS West Yorkshire
Integrated Care Board

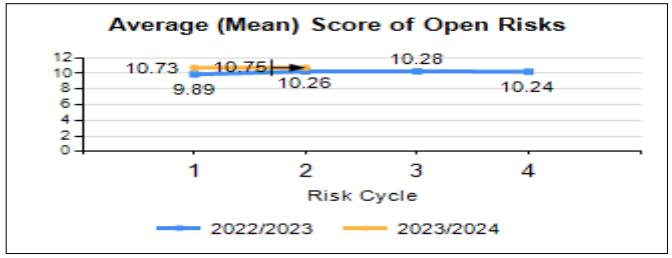
Total Risks	22
Delivery	2
QPEC	2
Delivery and QPEC	7
Finance Best Value	3
Leeds Committee	4
EMT	4

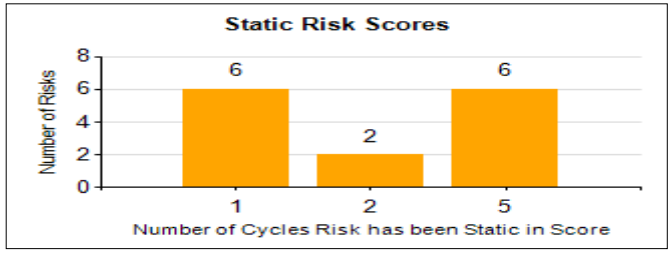
Movement of Risks	
New	0
Marked for Closure	2
Risk score increasing	1
Risk score static (1 cycle)	6
Risk score static (2+ cycles)	8
Risk score decreasing	5

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

Meeting name:	Leeds Committee of the West Yorkshire Integrated Care Board (WY ICB)
Agenda item no.	LC 14/23
Meeting date:	5th July 2023
Report title:	Finance Update at Month 2 (May) 2023-24
Report presented by:	Visseh Pejhan-Sykes, Finance Director Leeds Place of the WY ICB
Report approved by:	Visseh Pejhan-Sykes, Finance Director Leeds Place of the WY ICB
Report prepared by:	Visseh Pejhan-Sykes, Finance Director Leeds Place of the WY ICB and Gareth Winter, Head of Financial Resources, Leeds Place of WY ICB

Purpose and Action

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

Previous considerations:

The Leeds System has been undertaking a prolonged financial planning process since the start of this calendar year. After a number of submission s in March, April and May, the final plans were submitted and accepted by NHS England during May 2023.

This paper recaps on the earlier reported versions to the Committee and tracks the position to the final submission. It also updates the Committee of the financial position as at the end of month 2 (May 2023) against the final agreed plan for 2023-24

Executive summary and points for discussion:

The system finances and maintaining total commissioned spend within allocated resources are a statutory requirement of the West Yorkshire (WY) Integrated Care Board (ICB) and of the Leeds Place of that ICB in relation to the share of the WY budget delegated to it. Furthermore, the 4 NHS organisations in Leeds must also collectively remain financially sustainable as part of the wider WY system's financial duties.

The Leeds Place of the ICB has a recurrent underlying deficit gap of over £30m plus further risks of c£13m-£15m for which there are currently little or no mitigations in place.

The WY ICB has access to some non-recurrent financial support which means that the Leeds Place of the ICB needs to find between £16 and £24m of the gap this year – if its risks can be fully mitigated. The full gap must be found by the start of the 2024-25 financial year if we are to start the next financial year in financial balance. Until then, we will need to remain in financial recovery mode and we are also highly likely to experience NHS England interventions if our 2023-24 financial forecasts start to indicate a closing deficit position for the year, after month 6 this year.

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

☐ Improve healthcare outcomes for residents in their system

☐ Tackle inequalities in access, experience and outcomes

☒ Enhance productivity and value for money

☐ Support broader social and economic development

Recommendation(s)

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

1. **REVIEW** and **COMMENT** on the month 2 position
2. **REVIEW** and **COMMENT** on the QIPP delivery for 23-24
3. **DISCUSS** next steps across the Leeds System

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

Assurance around the establishment of a QIPP Steering Board and Executive Team oversight of the Leeds ICB financial recovery plan

Appendices

2. Appendix 1 – List of 2023-24 QIPP Schemes Risk Rated

Acronyms and Abbreviations explained

1. WY ICB – West Yorkshire Integrated Care Board
2. QIPP – Quality, Innovation, Productivity and Prevention (Commissioner terminology for efficiencies)
3. CIP – Cost Improvement Programme (Provider terminology for efficiencies)
4. NHSE – NHS England
5. LTHT – Leeds Teaching Hospitals NHS Trust
6. LCH – Leeds Community Healthcare NHS Trust
7. LYPFT – Leeds and York Partnership Foundation NHS Trust
8. EMT – Executive Management Team (Leeds Place of the ICB)

What are the implications for?

Residents and Communities	Restricted developments
Quality and Safety	None identified
Equality, Diversity and Inclusion	None identified
Finances and Use of Resources	Strict Financial Recovery Measures
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	Continued scrutiny on value for money
Citizen and Stakeholder Engagement	None identified

1 Summary of Financial Plan for 2023-24

1.1 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.

1.2 The WY ICB submitted a balanced plan but with the expectation that it would be posting a deficit outturn of £25m for the first 6 months of the year, but which point additional income or savings will need to have been identified if the ICB is to achieve a balanced position at the end of the 23-24 financial year.

1.3 The second iteration of the 2023 financial plan submission for West Yorkshire collectively (End of April) was not approved by NHSE with a requirement for the system to reduce its residual deficit gap. In summary the initial gap was closed in stages to nil as follows:

- £109m in March submission,
- £59m in April (reduced by NHSE support of £32m+) to £25m
- to a break-even position for the final submission.

	£m
Plan at 30 March 2023	(109.4)
Target improvement	50.0
Deficit	**(59.4)**
NHS England funding	32.0
LTHT improvement	2.8
LCH and LYPFT Support retained towards system risks	(0.5)
Plan at end of April	**(25.1)**
WY required improvement - split fair shares to Places	**25.1**
Final 2023-24 Plan	**Balanced Plan**

1.4 The position in Leeds changed as follows:

	2022/23	**2023/24 March**	**Additional QIPP/CIP to Earn NHSE Support**	NHSE Support	**2023/24 End of April**	**CIP/ QIPP**	**Final 23-24 Plan**
2023-24 Plans	£m	£m	£m	£m	£m	£m	£m
LTHT	7.6	(24.5)	8.8	Net NHSE support Shared out between the Providers £12.9 and additional CIP of £2.8m	0.0	119.3	0.0
LCH)	1.0	0.0	0.0		0.0	8.2	0.1

	2022/23	2023/24 March	Additional QIPP/CIP to Earn NHSE Support	NHSE Support	2023/24 End of April	CIP/ QIPP	Final 23-24 Plan
2023-24 Plans	£m	£m	£m	£m	£m	£m	£m
LYPFT (excludes further risks for out of area patient activity)	1.1	0.1	0.0		0.1	8.5	0.0
Leeds Place of the ICB	6.4	(24.6)	9.1	£8.5m WY redistribution of Core resources	(7.0)	£15.4m QIPP Plus System QIPP of £8.6m	1.6
Leeds Place TOTALS	16.1	(49.0)	18.0	21.4	(6.9)	160.0	1.7
WYICB TOTAL	0.0	(109.4)	50.0	32.0	(25.1)	362.8	0.0

1.5 The position above excludes any risks currently held across the West Yorkshire NHS system. In Leeds ICB we are currently holding a further £13m-£15m of risks some of which are already crystallising in month 2 and for which we have limited or no mitigations identified as yet.

1.6 Leeds ICB needed to ensure that it had a deliverable QIPP plan in place by early May 2023 to ensure that it would meet it initial QIPP target of £15.4m, make headway towards a further system QIPP of £8.6m and also able to develop mitigation towards a further £13m - £15m of risks, some of which were highly likely to crystallise.

1.7 It also needed to be in a position to have pulled back on its underlying deficit position of c£30m+ by the end of March 2024 to ensure that it could start the 2024-25 financial year in a balanced position.

1.8 Given the tight timescales a decision was made early in the process by the Executive Management Team to identify QIPP and progress with schemes for 23-24 using management action and a turnaround approach – e.g. vacancy freeze, contract renewal reviews, restricting system growth, slippage on new spend and systematic review of all discretionary spend lines.

1.9 In parallel, a QIPP Steering Group was set up to engage with Population Boards vis Pathway Leads to start early in 23-24 to identify and implement schemes for 24-25 in advance of the start of the next financial year. The turnaround process will also be maintained alongside the population board approach in case the latter does not deliver the full savings needed.

1.10 Ideally Leeds will not only meet its £30m+ challenge but will also create some headroom to invest in system priorities in lines with the Leeds Health Plan.

3. Month 2 Position

2.1 The Leeds wide position as at month 2 is as follows:

	Final 23-24 Plan	QIPP	Month 2 Variance	Forecast outturn
2023-24 Plans	£m	£m	£m	£m
LTHT	0.0	119.3	(2.0)	0.0
LCH	0.1	8.2	(0.2)	0.1
LYPFT (excludes further risks for out of area patient activity)	0.0	8.5	0.0	0.0
Leeds Place of the ICB	1.6	£15.4m ICB plus £8.6m System	(3.0)	(7.0)
Leeds Place TOTALS	1.7	160	(5.2)	1.7

2.2 From the perspective of the Leeds ICB we are already seeing pressures around risks emerging and challenges around ensuring that QIPP scheme delivery stays on track.

2.3 The ICB will be able to report a forecast deficit of £25.1m up to month 6. Thereafter if the position does not improve, there will be supportive measures introduced by NHS England as has already been provided to Trusts and systems with high risks (financial and performance related).

2.4 At month 2 the year to date and forecast outturn positions are as follows:

	YTD Spend	YTD variance		Annual Plan	Forecast Spend	Annual Variance (best case)	Likely Case Variance £000	Worst Case Variance £000
Expenditure								
Acute	138,062	4		828,346	828,346	(0)	(500)	(0)
Mental Health	36,982	987		215,974	217,209	1,236	3,736	8,136
Community	36,135	(42)		217,063	216,312	(751)	(751)	444
Continuing Care Services	12,214	623		69,545	68,982	(563)	437	2,437
Prescribing and Primary Care	27,006	(281)		163,726	163,744	17	3,417	6,417
Primary Care Co-Commissioning	25,922	0		155,528	155,528	0	750	1,500
Other	1,670	(29)		10,194	10,255	61	61	61
Programme Reserves	(1,683)	1,436		(59,647)	(51,091)	8,556	8,556	8,556
Sub Total Programme	**276,309**	2,698		**1,600,729**	**1,609,285**	**8,556**	**15,706**	**27,551**
Running Costs	1,853	(278)		12,787	12,787	0	0	0
Total	**278,162**	2,421		**1,613,516**	**1,622,072**	**8,556**	**15,706**	**27,551**

2.5 The position reported to NHS England by WY ICB corresponds to the best case scenario in the Leeds system. Given the emerging risks currently experienced in the first 2 months of the year, the more likely position is a deficit forecast of £15.7m - after assuming that our QIPP of £15.4m will be partly delivered in 23-24. Should all anticipated risks crystallise in year, the worst case scenario – despite a partial achievement £15.4m QIPP for 23-24 would be a deficit of £27m. This needs to be added to our 24-25 QIPP target if we are to return to a financially sustainable position.

2.6 A milestone stock take of the QIPP position will happen at the end of Q1 whereby the deliverability of 2023-24 schemes will be reviewed. 24-25 schemes long lists are also expected from the Population boards at the end of that month.

2.7 If the stock take leads to the conclusion that our financial forecast is likely to deteriorate further, then EMT will be asked to implement more interventions to redress the position. This will include a full review of all contracts coming up for renewal and potentially involving intervention form other parts of the system.

2.8 Leeds ICB is currently spending more than its fair share allocation. It therefore needs to plan to spend the equivalent of c2-3% less across all sectors to redress this balance by 1 April 2024.

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

1. **REVIEW** and **COMMENT** on the month 2 position
2. **REVIEW** and **COMMENT** on the QIPP delivery for 23-24
3. **DISCUSS** next steps across the Leeds System

Appendix 1 – 2023-24 QIPP Schemes Risk Rated

Scheme Detail	Scheme owner	Value £m	Contract / Spend Area	Population Boards	Transactional Change enacted - e.g. contract notice etc	Delivery of Saving has started	Forecast to Deliver in full	New Risks Emerging	Mitigation in place to manage risks	Overall Scheme Rating	Comments
ERF in Original Plan as Target	Visseh Pejhan-Sykes	4,000	Acute - Independent Sector	Acute Planned Activity							Risks inherent as waiting times and choice can work against QIPP delivery - protocols with LTHT being developed to ensure mitigation is in place
Prescribing	David Wardman	3,000	Prescribing	All							Schemes identified and being put in place - but pressures in year can also work against budgetary control
Community Cancer Review	Helen Lewis	200	LCH	Cancer							
Hospices uplift not in line with 'full offer'	Helen Smith	100	Hospices	End of Life							Hospices to be notified - needs EMT to be formally notified

Scheme Detail	Scheme owner	Value £m	Contract / Spend Area	Population Boards	Transactional Change enacted - e.g. contract notice etc	Delivery of Saving has started	Forecast to Deliver in full	New Risks Emerging	Mitigation in place to manage risks	Overall Scheme Rating	Comments
Cessation of all Spot purchase beds (25) from 1 June.	Nicola Nicholson		Intermediate Care	Frailty / LTC							Measure to kick in from Q2. LTHT bed closures can increase pressure on community bed demand
Uncommitted Discharge Funds	Helen Lewis	500	Intermediate Care	Frailty / LTC							Measure to kick in from Q2. LTHT bed closures can increase pressure on community bed demand
Virtual Ward	Helen Lewis	900	LCH	Frailty / LTC							
Leeds Community Equipment Store	Caroline Baria	150	Equipment Store (BCF?)	Frailty / LTC							
Transfer of Care - Hub Review	Nicola Nicholson	200	LCH	Frailty / LTC							LCH review of existing services to cover costs from within existing contract - ideally recurrently

Scheme Detail	Scheme owner	Value £m	Contract / Spend Area	Population Boards	Transactional Change enacted - e.g. contract notice etc	Delivery of Saving has started	Forecast to Deliver in full	New Risks Emerging	Mitigation in place to manage risks	Overall Scheme Rating	Comments
Newton Europe Fees	Jenny Cooke	-2,600	Consultancy Costs	Frailty / LTC							Implementation of changes still to happen as are identification and tracking of sustained system savings. No mitigations in place if savings are not delivered despite the committed spend
Health Inequalities Schemes	Jenny Cooke	3,100	Health Inequalities Cost Centre	Ind Schemes							
Home Oxygen VAT Review	Charlotte Coles	540	Oxygen	Long Term Conditions							Consultancy Contract now let – Consultants to Engage with HMRC for refund
Out of Areas Reduction 50% of savings on complex rehab patients as	Eddie Devine	1,500	LYPFT	Mental Health							Numbers are currently increasing in out of area placements

Scheme Detail	Scheme owner	Value £m	Contract / Spend Area	Population Boards	Transactional Change enacted - e.g. contract notice etc	Delivery of Saving has started	Forecast to Deliver in full	New Risks Emerging	Mitigation in place to manage risks	Overall Scheme Rating	Comments
cash releasing											
Reduction in high cost s117 and people no longer eligible for s117 (LCC reviewing team leading)	Eddie Devine	200	S117 LD Pool	Mental Health							Very expensive long standing cases coming through – staffing capacity issues to review cases quickly. Options to recruit being pursued
GP Confederation Support Post	Visseh Pejhan-Sykes	55	Programme Staffing	Primary Care Split							
LCD Rotational Paramedics	Gaynor Connor	80	Urgent Care	Urgent Care Split							Scheme ceased completely in 22-23 – difference to Full Year Effect as part year effect was already accounted for in 22-23 QIPP (£160k saving in total)

Scheme Detail	Scheme owner	Value £m	Contract / Spend Area	Population Boards	Transactional Change enacted - e.g. contract notice etc	Delivery of Saving has started	Forecast to Deliver in full	New Risks Emerging	Mitigation in place to manage risks	Overall Scheme Rating	Comments
Continuing Healthcare	Andrea Dobson	1,800	Continuing Healthcare								EMT supported launch of schemes in May 2023. Stepping up of review of care packages will provide mitigation in year but rising case complexity and numbers can work against budget containment measures
Running Costs flexibility target	Tim Ryley	500	Running Costs								New Operating Model and Capacity pressures as staff numbers fall may lead to the need for agency and temporary staffing costs

Meeting name:	Leeds Committee of the West Yorkshire Integrated Care Board (WY ICB)
Agenda item no.	LC 15/23
Meeting date:	5th July 2023
Report title:	Refresh of the Healthy Leeds Plan (Joint Forward Plan)
Report presented by:	Jenny Cooke, Director of Population Health Planning
Report approved by:	Jenny Cooke, Director of Population Health Planning
Report prepared by:	Joanna Howard, Population Health Outcomes Development Lead, and Catherine Sunter, Head of Population Health Planning

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

Previous considerations:

Partners from across the system have been invited to review and comment on the draft Healthy Leeds Plan, including the Partnership Executive Group (PEG), City Wide Planners, the Tackling Health Inequalities Group (THIG), the Population Health Planning Steering Group, the Leeds Carers Partnership, and the Person-Centred Care Advisory Group.

Executive summary and points for discussion:

The Healthy Leeds Plan outlines the health and care contribution towards delivering the Leeds Health and Wellbeing Strategy ambition that *Leeds will be a caring city for people of all ages, where people who are the poorest improve their health the fastest.*

The plan has been refreshed. The most significant changes are:

- A shift from a number of overarching strategic indicators to a much smaller number of system goals
- A requirement to be broader than the initial document since it will also act as our place Joint Forward Plan, a national requirement that was set out in the NHS Planning Guidance 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 ICB is asked to: 1. **NOTE** the revised and reduced number of system goals as described in the refreshed Healthy Leeds Plan document 2. **CONSIDER** and **ENDORSE** the Healthy Leeds Plan document 3. **CONSIDER** the role the committee can play in terms of overseeing delivery of the two system goals in addition to progress made in identifying and implementing the priority areas of focus
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:
No
Appendices
1. Feedback from Population and Care Delivery Board on revised system goals 2. Healthy Leeds Plan Document
Acronyms and Abbreviations explained
1. JFP – Joint Forward Plan 2. PEG – Partnership Executive Group

What are the implications for?

Residents and Communities	Highlighted throughout the report and refreshed plan.
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	

1. Healthy Leeds Plan Development

1.1 The original Healthy Leeds Plan (formerly the Left Shift Blueprint) was approved, by the Partnership Executive Group and Health and Wellbeing Board in early 2021. It is the plan that outlines the health and care contribution towards delivering the Leeds Health and Wellbeing Strategy ambition that *Leeds will be a caring city for people of all ages, where people who are the poorest improve their health the fastest.*

1.2 Following changes within the Leeds Health and Care Partnership, including the development of the West Yorkshire Integrated Care Board and the renewed system wide focus on population health planning, it was agreed that the Healthy Leeds Plan would be refreshed in 2023.

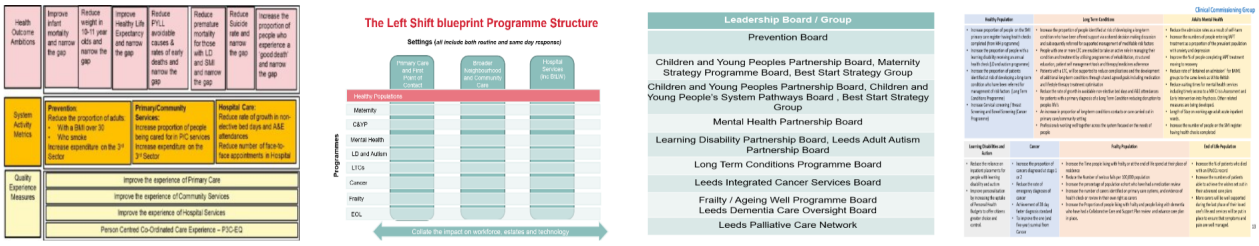
1.3 This timeline also aligned with the national ask through the NHS Planning Guidance 23/24 for each ICB to develop a Joint Forward Plan (JFP). Our Healthy Leeds Plan will also act as the Leeds contribution to the West Yorkshire Joint Forward Plan, capturing our system priorities for the next 12 - 18 months within a single document.

1.4 The overall aim of the refresh was to:

- Agree our ambition for how the health and care system in Leeds needs to change over the next five years and how this will be measured through refined strategic indicators;
- Create a plan that will drive the partnership's transformation programme over the next five years;
- Describe our partnerships approach to population health;
- Reflect the work of the Population and Care Delivery Boards, the outcomes they are aiming to achieve and the infrastructure that has been put in place to achieve this; and
- Meet the requirements of the Joint Forward Plan (NHS Planning Guidance 2023/4).

1.5 Over the last few years, significant progress has been made in developing our population health approach in Leeds which has informed the refresh of the Healthy Leeds Plan. The development and evolvement of the Healthy Leeds Plan can be seen in fig. 1 and 2

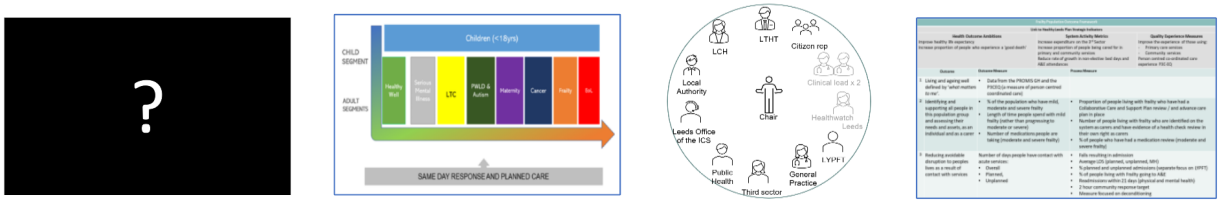
Fig 1 – Original Healthy Leeds Plan Construct



Strategic indicators – what we are collectively looking to achieve in Health and Care → **Programmes of work** – the areas of focus to divide the work into in order to deliver the strategic indicators → **Partnership Groups** – multi agency forums to drive the coordination of the work → **Programme Measures** – how success in the changes the programmes are looking to drive will be measured – ultimately link to the strategic indicators

This has gradually evolved to the below:

Fig 2 – How the Healthy Leeds Plan Structure has evolved



Strategic indicators – what we are collectively looking to achieve in Health and Care → **Population segmentation** – mutually exclusive segments with similar needs → **Population and Care Delivery Boards** – accountable for the outcomes, experience and use of resources for that population → **Population Outcome Frameworks** – Setting out what is important to that population from a health and care perspective and how it will be measured

2. System Goals

a. The previous iteration of the Healthy Leeds Plan had a considerable number of strategic indicators which signalled a positive step in terms of the system working together towards a collective goal, however, it felt that these could be improved to provide a more focussed and targeted approach for the partnership. Therefore the decision was made to revise these.

b. The revised system goals have been influenced by the refreshed Health and Wellbeing Strategy. A number of priorities are outlined

within this strategy but the Health and Care System have a particularly significant role to play in the following areas:

- A mentally Healthy City for everyone
- The best care in the right place at the right time
- Support for carers and enable people to maintain independent lives
- Promoting prevention and improving health outcomes through an integrated Health and Care System
- A child friendly city where people have the best start in life and age well

c. The emerging work with Staten Island where the system united behind a single goal ‘reducing avoidable hospital use by 25% over 5 years’ with a focus on improving population outcomes and reducing cost has also influenced the revised system wide goals. Their focus on this goal has to date has resulted in:

- 62% reduction in preventable ED visits
- 61% reduction in preventable BH ED visits (Mental Health)
- 51% reduction in preventable readmissions

d. It is not just the goal but the behaviours that focussing on the goal has led to which has contributed to its success:

- The annual selection of a small number of data-led priorities each year (utilising their linked data set).
- For each of these priorities working with people, communities and staff and using the latest evidence to understand the root cause of the problem. This involves understanding the needs of individuals, the most frequent users of specific services, their holistic needs and developing interventions based on this understanding.
- ‘starting somewhere and following it everywhere’, accepting that understanding the root cause may lead to a solution linked to the wider determinants of health, a health solution or most likely both.
- Being willing to fail – monitoring the impact of interventions carefully and being open to change if interventions are not having the anticipated impact.

e. The two system goals that have been identified through working with Partnership Executive Group (PEG) members are set out below:

1. **Reduce preventable unplanned care utilisation across health settings**
2. **Increase early identification and intervention (of both, risk factors and actual physical and mental illness**

These goals will be with a focused on the 26% of the population in Leeds who live in the 10% most deprived areas nationally.

f. In summary the refreshed approach to strategic indicators of the Healthy Leeds plan (now shared system goals) is:

- **Beneficial for people** – encouraging a focus on keeping people well rather than treating them when they get sick and minimising the disruption to people's lives through unplanned visits to hospital. It also links well to people receiving the best care in the right place at the right time. Engagement with people on the outcomes frameworks has told us that sometimes people need to access care in an unplanned way but if it could have been avoided through earlier intervention it is the preference.

- **Demonstrate a better use of the Leeds £** - unplanned utilisation consumes a disproportionate use of resource within Leeds. In a resource constrained system that has an aspiration of increasing the amount of resource that is focused on keeping people well rather than treating them when they get sick there needs to be a focus on reducing activity in the high-cost areas if this is to be achieved.

- **Aligns with our commitment to reducing health inequalities** – If you live in IMD1 you are far more likely to access care in an unplanned rather than a planned way. This is an example of the inverse care law, the principle that the availability of good medical or social care tends to vary inversely with the need of the population served.

g. These focussed goals will help the partnership to target resource, prioritise work and make tangible improvements in the health and wellbeing of people in Leeds, identifying and reducing areas of unmet need in a targeted and systematic way. Concentrating on areas of high cost will also support financial sustainability and allow us to invest further in the upstream, prevention areas that we want to as a system.

h. The system goals and the rationale for selecting these goals have been shared with the wider partnership including the Population and Care Delivery Boards and other system forums. The Population and Care Delivery Boards will have a significant role to play in supporting delivery of the system goals. The wording of goal 1 has evolved thanks to feedback from these boards from '*reduce avoidable unplanned care utilisation across health settings through a focus on keeping people well'* to the current wording of *'reduce preventable unplanned care utilisation across health settings*'.

i. An engagement session was held with Population and Care Delivery Board chairs and Pathway Integrators to talk through the system goals and the current financial position. Those chairs who were there suggested how they would like to see these two goals influence how they lead their boards. They suggested the following principles:

- Every board will have a role to play in delivering the system goals (even if they are not connected to the chosen priorities).
- Every board should agree what their key contribution could be to this goal.
- Boards will by necessity focus on other things (for example linked to national planning priorities) but transformational capacity and resource will be focused on pieces of work with a demonstrable impact on this goal and / or any schemes the boards identify that are cash releasing (ideally the work on this priority will also reduce overall costs and where there is limited capacity would we choose those areas which do both)

A list of engagement undertaken with Population and Care Delivery Boards on the refreshed Healthy Leeds Plan goals and themes from this engagement can be found in appendix 1 of this report.

3. Measuring Goal 1

a. As a Partnership it is critical to monitor progression and understand if we are achieving our system goal. In partnership with stakeholders, four measures have been identified which will be used to measure goal 1. These include:

Reduce preventable unplanned care utilisation across health settings		
Unplanned acute admissions	All ages	Bed days

A&E attendances including Walk in Centre and Urgent Treatment Centre	All ages	Number of attendances
Mental health inpatient admissions	All ages	Bed days
Access to specialist mental health crisis services	All ages	Number of attendances

b. This goal will require a contribution from all Health and Care partners to deliver it. Those partners not reflected in the 'measure' are likely to form part of the 'solution'. For example, although the third sector doesn't feature explicitly in the measure, they are likely to feature in the interventions to address the challenges highlighted by this goal. There is an appetite from Primary Care colleagues to have Primary Care reflected in the measure. Work will be undertaken with the Primary Care Board over the coming months to try and establish a clearer understanding of the role of Primary Care in terms of planned vs unplanned utilisation which will help to inform this.

4. Areas of Focus

a. Using the Leeds data model, our linked health and care data set, a number of potential options for system priorities linked to achievement of goal 1 have been identified by considering areas where there appears to be disproportionate utilisation of preventable unplanned care.

b. The purpose of selecting a small number of priority areas is not only to drive change in these areas but develop and test a population focused methodology and to learn from this to shape future work.

c. The intention is that work in progressing these priorities will be driven through existing governance, either a population or care delivery board working with at least one Local Care Partnership (LCP).

d. Further work is being undertaken to qualify these potential priority areas that can be shared at the Leeds Committee of the ICB meeting on the 5th of July. Areas being considered can be found in the Healthy Leeds Plan document.

5. Development of the Healthy Leeds Plan Document

a. Our Healthy Leeds Plan Document will be submitted to the West Yorkshire ICB at the end of June as the Leeds Place contribution to the Joint Forward Plan to find. To find out more about the role and purpose of joint forward plan please click here. There will still be scope for small amendments following engagement with the Leeds Committee of the ICB on July 5th and the Health and Wellbeing Board on the 20th of July. The final draft version of the plan is be circulated with this report.

b. One implication of our Healthy Leeds Plan also being our JFP is that it has to also include our plan as a system to meet national and regional requirements. In this way the aspiration is for the Healthy Leeds Plan to be the one place where our local, regional and national priorities are documented along with what we plan to do to deliver on them over the next 12 - 18 months.

c. Guidance sets out that the JFP is required to:

- Demonstrate delivery of the integrated care strategy and local joint health and wellbeing strategies
- Be fully aligned with the wider system partnership's ambitions
- Support subsidiarity by building on existing local strategies and plans as well as reflecting the universal NHS commitments
- Be delivery focused, including having specific objectives, trajectories and milestones as appropriate

d. Partners from across the system were invited to review and comment on the draft Healthy Leeds Plan including the Partnership Executive Group (PEG), City Wide Planners, the Tackling Health Inequalities Group (THIG), the Population Health Planning Steering Group, the Leeds Carers Partnership, and the Person-Centred Care Advisory Group.

e. Through this process the team received in excess of 180 comments. Wherever possible these comments have been acted upon. Those that were not reflected in the document were generally around next steps in implementation of the plan, for example the need to further refine our methodology for identifying priority areas to meet system goals.

6. Next Steps

a. As referred to above, whilst achievement of this goal will require a broad contribution from all Health and Care system partners the intention is for the system to be continually working and focused on a small number of data led priorities to reduce unplanned utilisation. A key next step is the confirmation of these initial areas. The intention is that these will be identified and agreed with PEG by the end of July.

b. Identifying a realistic system-wide 5-year target for goal one, taking into consideration population growth and trends. The intention is that an initial suggestion and rationale will developed and ready for testing with system partners by the end of July.

c. Communicating the plan across Team Leeds. Whilst key elements of the plan have been shared with many system-wide boards and groups the intention is to work with communications colleagues to develop a broader communications plan, particularly focused on sharing the system goals.

d. Work to date on the shared system goals had been focused on goal one. The intention is to undertake some more focused work on goal 2 ‘increase early identification and intervention’ from September this year. Most Population and Care Delivery Boards raised the fact that they are particularly supportive of having goal 2 in addition to goal 1. They felt that maintaining a focus on early identification and support was important and that they would welcome further work being undertaken on this goal to identify where the particular areas of focus should be.

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

1. **NOTE** the revised and reduced number of system goals as described in the refreshed Healthy Leeds Plan document
2. **CONSIDER** and **ENDORSE** the Healthy Leeds Plan document
3. **CONSIDER** the role the committee can play in terms of overseeing delivery of the two system goals in addition to progress made in identifying and implementing the priority areas of focus

8. Appendices

Appendix 1 - Feedback from Population and Care Delivery Board on revised system goals

Appendix 2 – Healthy Leeds Plan document

Appendix A – Feedback from Population and Care Delivery Board on revised system goals

Board	Date of meeting	Feedback
Learning Disability and Neurodiversity	4-Apr	• The Board was supportive of the refined goals and have used the approach to consider and refine their outcome framework accordingly
Mental Health (SMI)	26-Apr	• The board were supportive of the goals due to clarity of focus • They wanted to further understand how this approach has worked in mental health • The board would like to further understand further the reasons for attendance at ED by people within the SMI population
Frailty	27-Apr	• Felt both goals provided a positive and clear direction of travel • Consider positive language around the measures – e.g. an increase in admission avoidance rather than a decrease in admissions • Was not yet clear how to deliver on the goals and priority areas within the current financial position as investment may be required
Primary care	4-May	• It was requested that a working group be set up to get to the point of understanding the impact of Primary Care on unplanned utilisation to then potentially reflect in the measure
End of Life	4-May	• Request to amend wording within Goal 1 '….keeping people well' to reflect those with an illness '…keeping people as well as can'. • Suggest consideration of a specific quality or patient experience measure • Wasn't sure they could see the role of the End-of-Life Board in goal 1 but was supportive of goal 2
Planned care	4-May	• Suggested the plan needs to reflect the role of primary care • Requested consideration of other methodologies which are better aligned to our system than Staten Island.

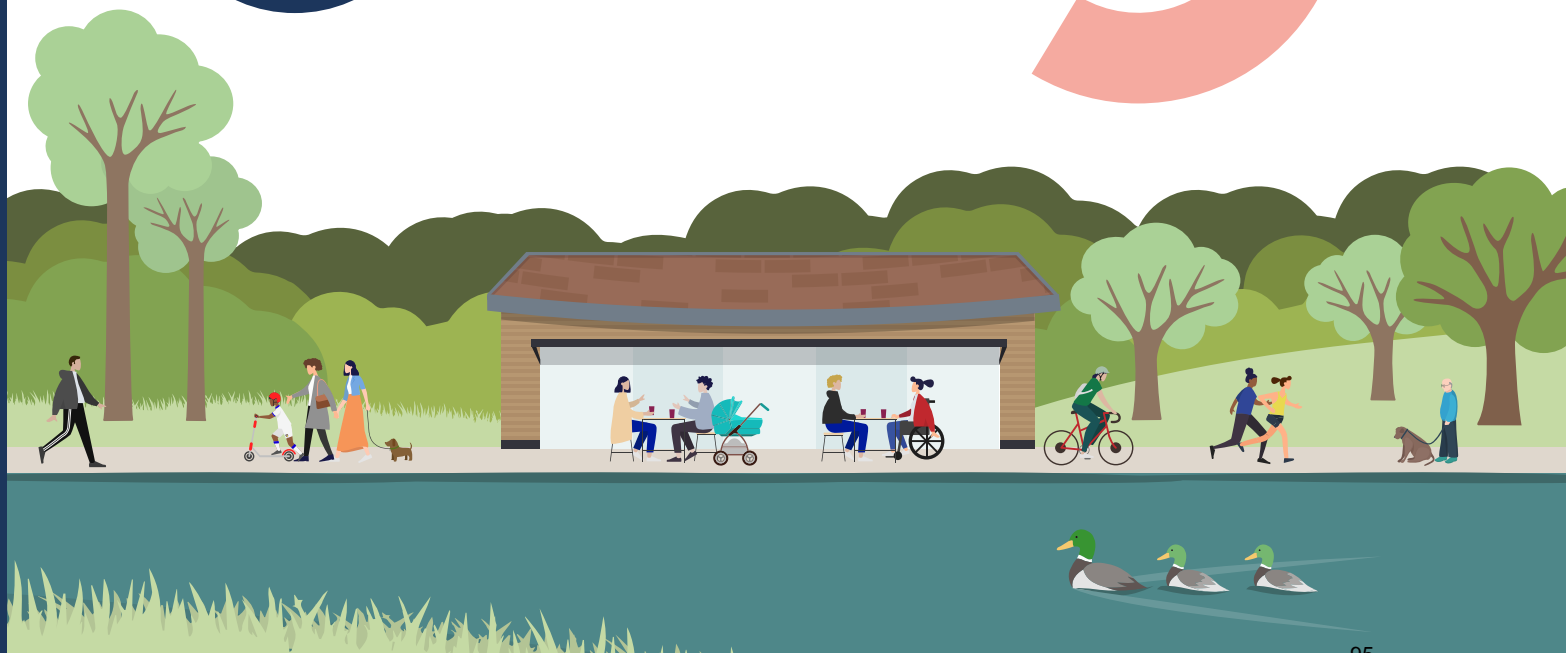
		• Further detail on the impacts of the financial situation needed:
		  ○ How do we consider reductions across populations and care delivery boards?
		  ○ Need to ensure efficiencies are not already included within provider plans?
		  ○ Must understand wider impacts of stopping things across the system?
		  ○ Need to understand value.
		  ○ Who makes the decision and is held responsible/accountable for ending contracts?

Maternity Board	17-May	• Supportive of the goals • A reduction in unplanned utilisation with no additional resources to support the 'left shift' could cause challenges
Cancer	18-May	• Felt the goals are very interdependent but were supportive of both • Supported the reduction in goals and a more focussed approach to the plan. • Concern regarding the financial challenges as a system and how we move resource to focus on prevention and the wider determinants (within the remit of health and care).
LTC Board	18-May	• Overall supportive of the goals • How will we understand real impact when demand is rising so quickly? • Would like to know what the overall system target would be • Given the financial challenges we need to consider the role and what is within the remit of the Board to support achievement of the system goals
Children and Young People's Board	6-June	N/A
Healthy Adults Board	7-June	N/A

Leeds Health & Care Partnership

The Healthy Leeds Plan

2023 - 2028



Contents

Leeds Health & Care Partnership

The Healthy Leeds Plan

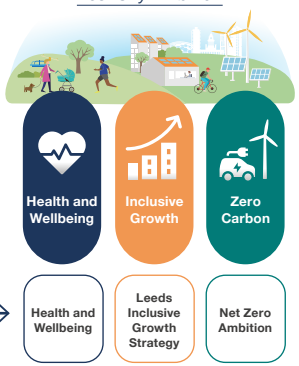
This document, **The Healthy Leeds Plan**, sets out the contribution of health and care partners toward achieving the vision of the Leeds Health and Wellbeing Strategy. It is intended as an iterative plan and will adapt as our population changes and our city's capabilities evolve and grow. Our summary on a page provides a visual summary of the key components that make up the plan and provides links to key sections within it.

See ***Introduction*** and ***Our City and Vision*** for more

Our vision **(Health and Wellbeing Strategy)**: Leeds will be a healthy and caring City for all ages where people who are the poorest improve their health the fastest

What health and care partners will do to meet this vision (Healthy Leeds Plan) –

Three pillars of our *Best City Ambition*



See ***Our goals*** to understand why we are focusing on these two areas

Our Goals:

1. Reduce preventable unplanned care utilisation across health settings
2. Increase early identification and intervention (of both, risk factors and actual physical and mental illness)

Focused on: **26%** of population in Leeds who live in the **10%** most deprived areas nationally.

See ***Identifying Our Priority Areas of Focus*** for more detail on why and how these were identified as possible priority areas for making an impact on our goals

Drawing on analysis from the Leeds Data Model, there are five clear areas of need where we feel we can make an impact on Goal 1 and 2.

- Children and Young People: Diseases of the respiratory system respiratory failure
- People with three or more Long Term Conditions and Mental Health
- Frailty Population: Injury / Fracture
- People with a Learning Disability and / or Neurodiversity
- HomeFirst Programme

See ***Population Health Infrastructure*** for info on the Population boards. Also see ***Our Plans*** and ***Appendix One and Two*** to understand the work underway in Leeds (guided by these boards) and how this delivers on national requirements.

Our city's population health Infrastructure will enable us to drive change in the areas above, alongside delivery of national priorities and improvement work underway within individual organisations

See ***enablers*** section

All of this is supported by a set of enabling skills and capabilities

Workforce | **Research & Academia** | **Leadership & Culture** | **Data & Intelligence** | **Digital** | **Estates** | **Quality Improvement** | **Financial Stewardship** | **Communications & Involvement**

Introduction

Our vision is for Leeds to be a healthy and caring city for all ages where people who are the poorest improve their health the fastest *(Leeds Health and Wellbeing Strategy)*. The Healthy Leeds Plan sets out the health and care contribution towards achieving this vision. It describes the outcomes we want to achieve for the people of Leeds and our plans for doing so. It also outlines our five-year strategic vision, as well as setting out a detailed one-year operational plan to achieve local, regional and national priorities. In delivering our plan we will focus on equitable access, excellent experience, optimal outcomes and ensuring we get the best value from the Leeds pound *(NHS Triple Aim)*.

The principles of our *Health and Care Partnership* underpin how we work together to deliver on our ambition and vision as set out in the Leeds Health and Wellbeing 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' people, communities, unpaid 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.
>
> **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 pound.

Starting with people means listening to their experiences of health and care services and acting on what matters to them. We will ensure that service changes and improvements across the city are undertaken with people at the centre and in line with what matters to them: better **communication** with people; effective **co-ordination** of health and care services; and **compassion** in the delivery of services.

To ensure the Healthy Leeds Plan addresses local needs alongside regional and national priorities, this document also represents our contribution to the West Yorkshire Integrated Care Board (ICB) Joint Forward Plan (JFP), the *West Yorkshire Integrated Care Strategy* and the *NHS Long Term Plan*.

Our City and Vision

Leeds Health and Care Partnership

Leeds is a great, forward looking, northern city with strong innovation, creativity, and commitment from partners to work together to improve our population's health and wellbeing outcomes and to address health inequalities. It is a richly diverse city with people of different ages, backgrounds, cultures and beliefs working alongside each other. The Leeds Health and Care Partnership (see Fig. 1) exists to improve the health and wellbeing of the 880,000 people in our city. It operates in a city with a unique combination of assets and ways of working, which gives us a firm foundation for continuous improvement and innovation. We strive to be inclusive in our partnership, starting with people and bringing together a network of statutory and non-statutory third sector, health, local government, academic and industry partners. We also have a role beyond the boundaries of the city, by delivering services regionally and as a key partner within the West Yorkshire Health and Care Partnership (WYHCP) alongside the four other places in West Yorkshire (Bradford District and Craven, Calderdale, Kirklees and Wakefield District). Following the principle of subsidiarity, we work together at West Yorkshire level where it makes sense to do so, where there is a challenge or concern and to share good practice.

The third sector is the collective term for the Voluntary, Community and Social Enterprise (VCSE) organisations and networks which add so much value to the lives of the people in Leeds, particularly in deprived areas and communities of interest (groups of people who have a shared identity or experiences). Leeds has a challenged but comparatively thriving *third sector* and inspiring community assets, which is a fundamental part of our integrated health and social care system. *Forum Central* represents this diverse sector in Leeds, as part of the Health and Care Partnership – connecting third sector organisations with decision makers across health and social care. This strong third sector voice helps influence our strategy, policy and ways of working across our *Population and Care Delivery Boards*, *Local Care Partnerships (LCPs)* and the executive meetings of the West Yorkshire ICB.

Fig 1: The Health and Care Partnership in Leeds

In addition to our thriving third sector, Leeds has many anchor organisations within the city. These anchor organisations are an important presence as either large employers, purchasers of goods and services locally or as owners of important buildings, parks and similar assets in local communities. They include the national organisations that allow us to influence and engage national decision-making and policy for health and wellbeing. Also included are the three leading universities who, as part of the *Leeds Academic Health Partnership*, can help us solve some of the city's hardest health and care challenges and work with industry partners to accelerate the adoption of innovation.

Our health and care providers are equally important anchor organisations, and Leeds' *anchor organisations* are committed to providing good-quality employment, training, skills and careers for the diverse population of Leeds and the region, positively impacting some of the critical determinants of health and wellbeing.

Our City vision

The Leeds Health and Wellbeing Strategy has set the vision for the city:

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

We know that health and wellbeing is affected by social, economic and environmental factors beyond good healthcare. These are often referred to as the wider determinants of health and include factors such as income, education, access to green spaces and healthy food, type of employment, and housing. Inequalities in the wider determinants of health can lead to heath inequalities between different populations, and therefore addressing these wider socio-economic inequalities is a crucial part of reducing health inequalities for the people of Leeds *(The Kings Fund)*.

As such, whilst The Healthy Leeds Plan represents the critical contribution health and care organisations can make towards realising the vision of the Health and *Wellbeing Strategy*, it also sits alongside other important strategies that will help improve the lives and wellbeing of the people of Leeds.

Our Best City Ambition describes the three core pillars of our city's future ambition - Health and Wellbeing, Inclusive Growth and Zero Carbon

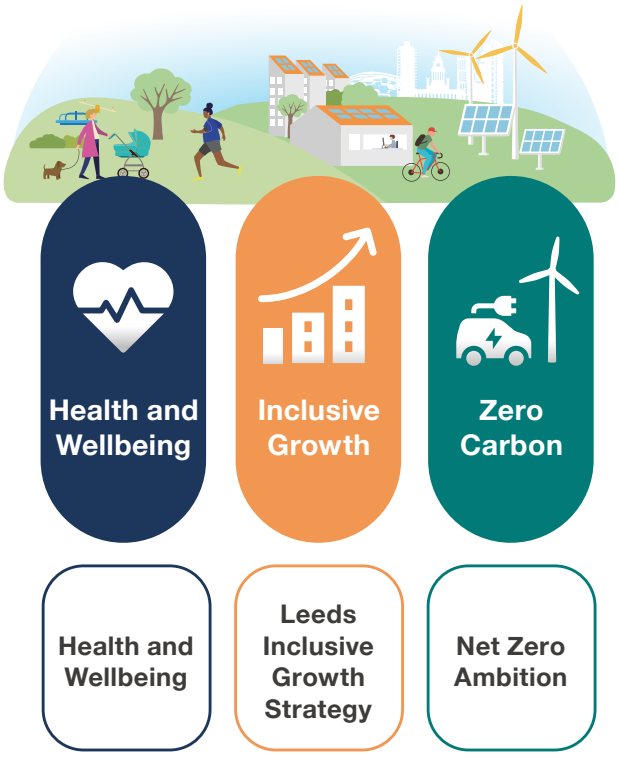
The Leeds Inclusive Growth Strategy sets out how we can make Leeds a healthier, greener and more inclusive economy that works for everyone

The Net Zero Ambition sets out our commitment to be carbon neutral

Leeds has also committed to become a Marmot City and is working in partnership with the Institute of Health Equity to take a strategic, whole-system approach to improving health equity.

Achieving our local vision and ambition will support work taking place across West Yorkshire, and will contribute to delivering the region's *10 Big Ambitions*.

Three pillars of our *Best City Ambition*



Overview of our population trends

Notwithstanding our strong vision and ambition, not everyone in our city experiences good health and prosperity, and we are seeing increasing and unsustainable levels of demand for health and care services. Within Leeds 26% of the population (an estimated 226,000 people) and 34% of children and young people (estimated 60,000 people aged 0-18 years) live within the 10% most deprived areas nationally (or IMD1, the lowest decile in the national Index of Multiple Deprivation). Our Joint Strategic *Assessment (JSA)* provided strong evidence that some inequalities are widening and will worsen following the COVID-19 pandemic. An overview of some of our changing population needs and characteristics as identified through our JSA can be found below.

Growing population in our areas of highest deprivation

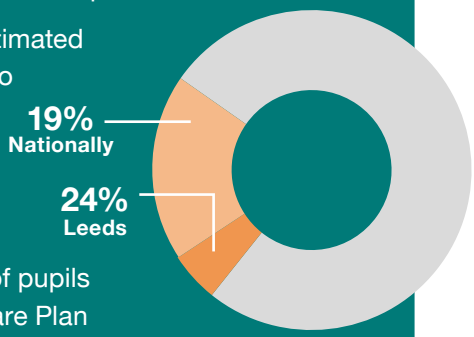
- Our population has been expanding, specifically within our inner-city areas which are often our most deprived communities. These communities experience our city's worse health outcomes.
- There is a 14-year life expectancy gap for women and a 12-year life expectancy gap for men between some of our most and least affluent areas of the city.
- Whilst people are living longer this is often in poorer health and with multiple long-term conditions. There has been progress in treating cancer, respiratory and heart disease but the premature mortality gap for these three areas have widened in our most deprived areas.
- Almost 175,000 people in Leeds are living in relative poverty.
- There has been a growth in in-work poverty with an estimated 74,000 working age adults across the city being from working households and living in poverty.

Ageing Population

- The population aged over 50 has grown by around 30,000 over the last 20 years. This demonstrates a 12% to 17% increase in each of the 50 plus age bands.
- Future population growth is predicted to be fastest amongst the 80+ age group which is expected to see a 50% increase over the next 20 years.
- The largest concentration of older communities is found within the inner-city areas. The proportion of people living with frailty within the most deprived communities is almost three times higher than those who live in the least deprived.
- At age 65 people in Leeds can expect to live half of the rest of their life free of disability or in good health, and half of it with a disability or in poor health.

Population of Children and Young People growing in our most deprived areas

- The child population is growing at a faster rate than the population of Leeds as a whole, but the growth is now concentrated within secondary school-age groups. This population is growing faster in our communities most likely to experience deprivation.
- In 2021, almost 24% children were estimated to live in poverty in Leeds compared to 19% nationally. We also know that 34% of children and young people in Leeds live in the 10% most deprived areas nationally.



- Between 2016 and 2021 the number of pupils who have an Education Health and Care Plan (EHCP) has more than tripled.

Our city is increasingly diverse

- According to the latest 2021 census, the population in Leeds is predominantly white (79%), with non-white minorities representing the remaining 21% of the population. Asian people were the largest minority group in Leeds accounting for 9.7% of the population.
- Nearly 200 languages are spoken by children studying in Leeds schools.
- 63% of Black, 40% of Mixed and 36% of Asian background people living in Leeds live within IMD1 areas, making IMD1 more ethnically diverse than the Leeds average.

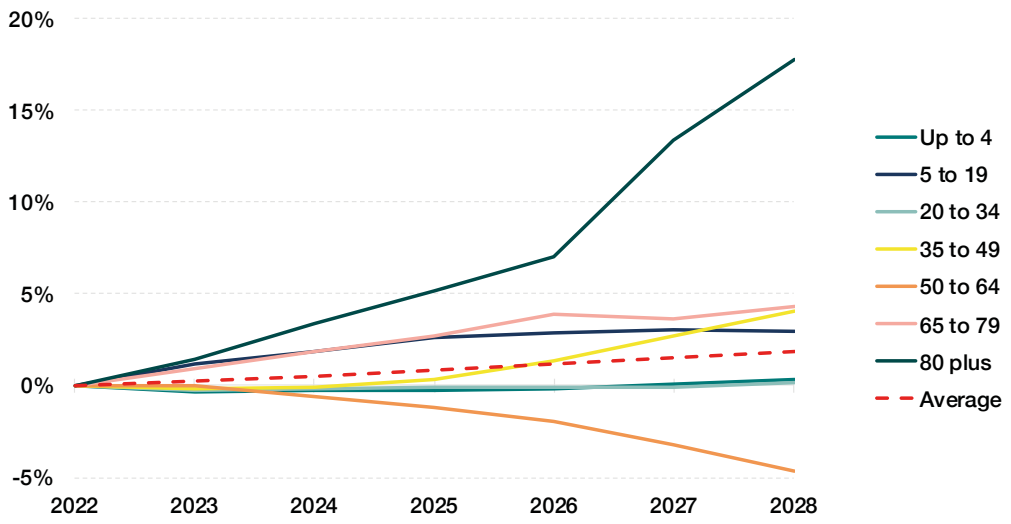
An increase in people experiencing mental health issues

- The proportion of adults reporting mental health issues increased during the pandemic, with some groups particularly affected including young adults and women; shielding older adults; adults with pre-existing mental health conditions, and Black, Asian and ethnic minority adults
- These mental health impacts are likely to continue due to the cost-of-living crisis, with concerns about job security and debt levels likely to increase.
- People with severe mental illness (SMI) in England are around 5 times more likely to die prematurely than those that do not have SMI, of which Leeds has been identified as an outlier (UKSHA report).

All these factors, and more, have implications for service provision and Leeds faces a number of significant challenges. The pandemic has driven up demand for health services in most areas above that which we saw before COVID-19 along with significant backlogs. An increase in more complex conditions as well as worsening health inequalities have resulted in an unsustainable growth in demand, further exacerbated by the challenges of recruiting and retaining workforce across the health and care sector. In addition, our health and care system is under significant financial pressure which has been intensified by the current financial climate and cost-of-living-crisis.

Looking at the overall population size and age-distribution (excluding deprivation effects) provides an indication of the likely future health and care demand expected in Leeds. The Office for National Statistics (ONS) provides a forecast of the population changes from 2022 to 2028, shown in figure 2 below.

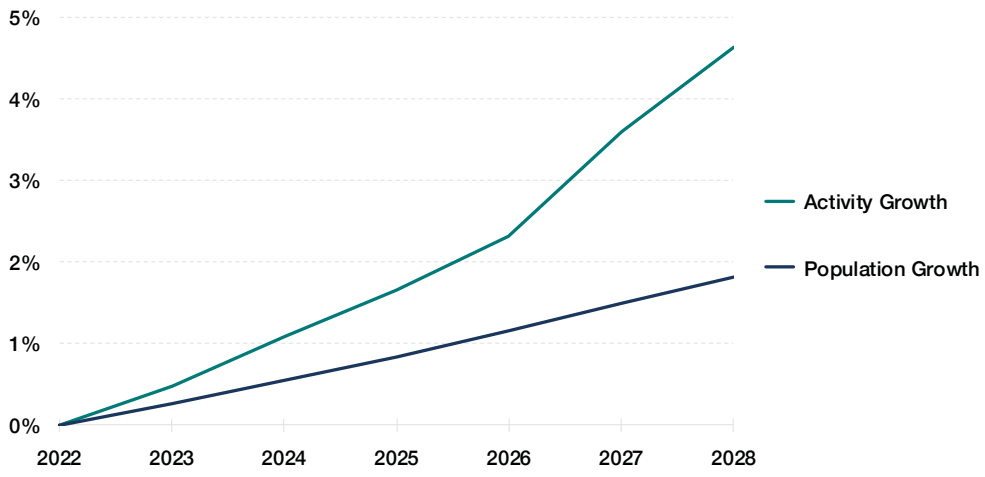
Fig 2: ONS Projected population changes by age-group from 2022



These forecasts can be combined with our existing data and insight on how much each age group currently uses health and care services and is used to create an age-weighted forecast of the average increase in healthcare demand. This is provided in figure 3 below, which shows likely changes in unplanned care utilisation (using acute admissions data).

Fig 3: A&E Admissions and Population Growth Projected 2022-28

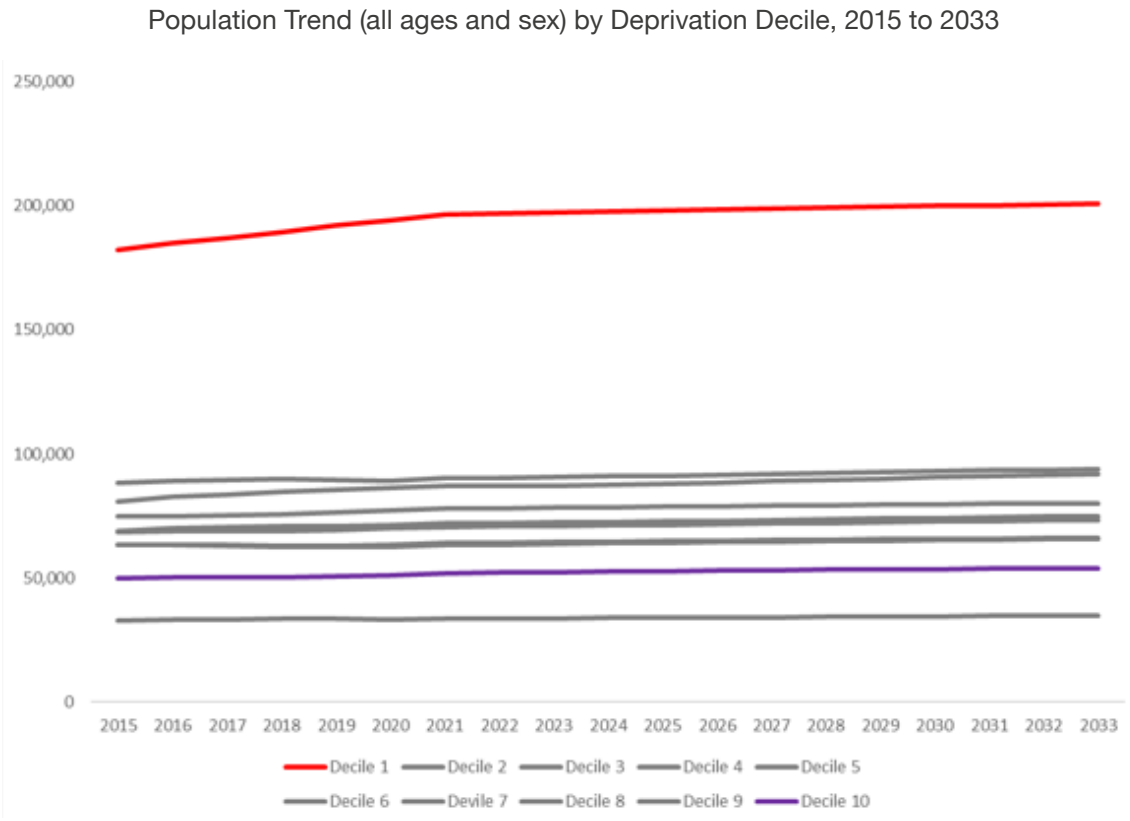
Activity Growth vs. Population Growth



To meet our citywide vision, given these challenges, we must start to understand and respond to future population need now. In delivering our Healthy Leeds Plan, we will apply an evidence-based, population health approach to drive innovation and deliver person-centred, integrated health and care for the people of Leeds, targeting those who need our support the most. We have also agreed as a Health and Care Partnership to focus our collective efforts toward a few specific goals to really drive change for the people of Leeds.

Forecasting data also indicates that the population within each deprivation decile is expected to grow but that IMD 1 is expected to grow the highest (see figure 4), and this is more significant within the younger age populations.

Fig 4: Population trends by deprivation decile



Our Goals

As individual organisations within the partnership, we have priorities that we need to achieve. However, we know that only by working together will we accomplish our individual goals and deliver better outcomes for the people of Leeds. At the centre of our approach is working with people and our Team Leeds health and care workforce to support the partnership. Together we can identify ways to achieve our goals, working better together to identify areas of improvement, and ensuring people and staff feel empowered to make a difference. In developing our collective goals, we believe that…

1. People will be equal partners in their care, ensuring high quality, personalised care services are delivered focusing on what matter to people – we will need to define outcome frameworks based on 'what matters to me'.
2. The population's health overall will move from being sicker and more dependent on services, to living, ageing, and dying well. To do this our Health and Care Partnership will need a much clearer focus on specific goals.
3. For the population's health to improve equitably and for us to reduce health inequalities, our partnership will need to ensure services are more inclusive and better targeted for those who are socially and economically disadvantaged or at higher risk of poor health – our goals must include a focus on reducing inequalities.
4. To achieve our ambition, we will need to shift more resources into prevention and personalised, proactive care – often meaning more activity and care taking place in community settings and people's homes* – we will develop measures of how activity levels will change.

*(*for some people with a complex physical or mental health condition, the most proactive approach is to have access to specialist care as quickly as possible, which may be delivered from hospital.)*

Given this, the Leeds Health and Care Partnership has agreed to focus on two collective system goals:

1. Reduce preventable unplanned care utilisation across health settings
2. Increase early identification and intervention (of both, risk factors and actual physical and mental illness)

Focussing on the 26% of the population in Leeds who live in the 10% most deprived areas nationally

Taking a person centred preventative and proactive approach - working with people and staff to co-design solutions.

The indicator to measure a reduction in preventable unplanned utilisation within Leeds consists of four parts:

Unplanned acute admissions (bed days)

A&E attendances including Walk in and Urgent Treatment Centres (number of attendances)

Access to specialist mental health crisis services (number of attendances)

Mental Health inpatient admissions (bed days)

Preventable unplanned utilisation refers to access or admissions to services where there was scope for earlier or different action to prevent an individual's health or wellbeing deteriorate to an extent where unplanned care services are required. Accessing the right care at the right time, in the right place is what patients, carers (paid and unpaid), families and staff have told us is important to them.

A focus on two goals will help us drive improvements that include:

Better outcomes for people: Patient insight has indicated that people would prefer to access care in a planned rather than an unplanned way. Our data shows that people admitted to hospital in an unplanned way have a longer length of stay compared to those admitted in a planned way. Episodes of unplanned care can also be disruptive for other areas of life such as caring arrangements, work and education.

Better use of resources: Within Leeds we know that a considerable amount of financial and operational resource is utilised by unplanned care. Given the current financial challenges faced by Leeds and other health systems, resources spent on prevention and early intervention are also likely to reduce costs and increase efficiency.

Addressing health inequalities: Those living in the most deprived neighbourhoods are more likely to utilise healthcare in an unplanned way and less likely to access care in a planned way. We also know from our JSA that the number of people living in IMD1 is expected to grow the fastest in the future.

National and international evidence supports this focussed approach. For example, Staten Island adopted a similar methodology:

Case Study

Staten Island Performing Provider System (PPS)

In 2014, *Staten Island PPS* (SI PPS) created an integrated network of providers to improve population health outcomes, reduce costs and reduce avoidable hospital use by 25% over five years. It is comprised of more than 75 provider organisations covering mental health, social care and community services; 22 population health practices; 20+ community organisations and 3600 primary care practitioners.

Approach

SI PPS model utilised a data-driven approach that focussed on a 'System of Care' methodology. The SI PPS created an advanced population health management ecosystem that monitored outcomes of care at an individual, practice and population level. The platform's geo-mapping and hot spotting capability made it possible to correlate geographic areas with services, health outcomes and social determinants of health. The analysis was used to understand risk factors, target interventions and measure success of various projects.

Priority work programmes

The data and insight from the analysis informs the potential programmes of work. Staten Island PPS, on an annual basis, work with people, local communities, and professionals to review the information and narrow down the potential programmes to a number of focus areas for that year, identifying and co-producing the solutions together. One area of focus was children with asthma. The data indicated that within specific geographic areas there were high numbers of children attending the Emergency Department, longer inpatient stays and much less planned activity compared to children in other areas.

The programme worked with these communities to understand the root causes linked to the higher numbers of children attending unplanned services for asthma. Several solutions were identified which included home visits and working with families and children at higher risk (risk stratification of the population), family hubs within local communities and a focus on eliminating triggers such as pest and mould, including the purchasing of vacuums and mattress covers. The programme resulted in a reduction in the number of Emergency Department attendances and inpatient stays as well as a reduction in the number of lost school days.

Overall achievements of the Staten Island PPS Model

The approach used by SI PPS has delivered significant improvements including, but not limited to:

62%
reduction in preventable Emergency Department visits, **saving $15m**

61%
reduction in preventable mental health Emergency Department visits, **saving $6.2m**

51%
reduction in preventable readmissions, **saving $6.5m**

The Staten Island Case Study shows how starting with a health based goal has led to numerous examples of improving outcomes and quality of life for people. The success of their paediatric asthma programme resulted in children and their families lives being less disrupted by not having to frequently attend hospital in an unplanned way.

These focussed goals will help the partnership to target resource, prioritise work and make tangible improvements in the health and wellbeing of people in Leeds, identifying and reducing areas of unmet need in a targeted and systematic way. Concentrating on areas of high cost will also support financial sustainability and allow us to invest further in the upstream, preventative areas that we want to as a system.

Analysis of preventable unplanned utilisation will help inform and understand where, as a system we need to increase early identification and intervention. Therefore, goal two and its supporting measures will be developed at a later stage during 2023/24.

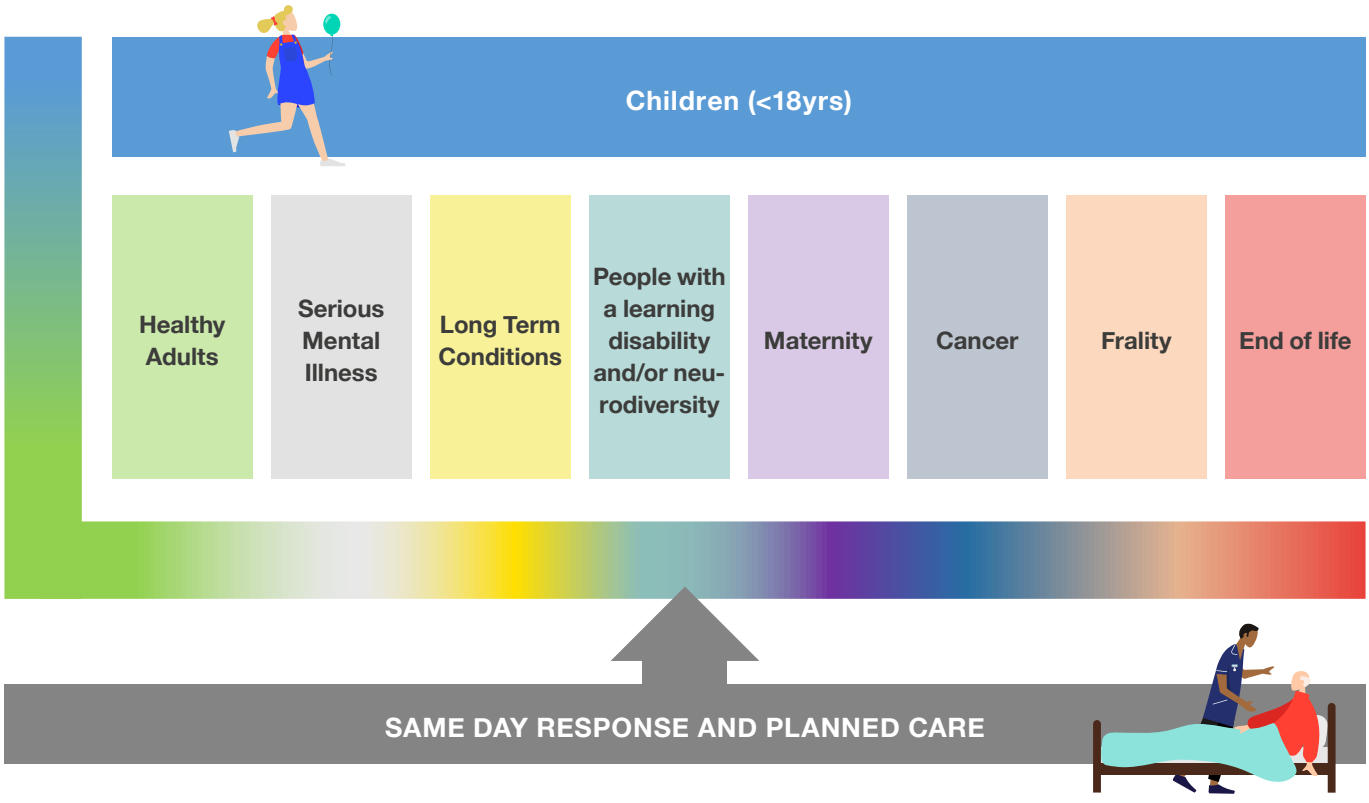
Population Health Infrastructure
(to support delivery of our goals)

The Leeds Segmentation Model

As a system we are developing robust population health infrastructure, designed to put the diverse needs of our population at the heart of everything we do and move decision-making closer to the people using our services. This infrastructure will help the Leeds Health and Care Partnership to achieve its goals.

- Within Leeds we have described the different needs of the Leeds Population using nine mutually exclusive population segments.
- Grouping people into segments of similar needs allows us to look at how we use our resources to best meet these needs.
- Everyone in Leeds fits in to only one segment at one time reducing the risk of double counting or misrepresenting changes in health outcomes over time
- This does not mean we cannot consider population needs across segments, but it does help us to understand the value and impact the partnership has on each segment.

Fig. 5: Leeds population segments

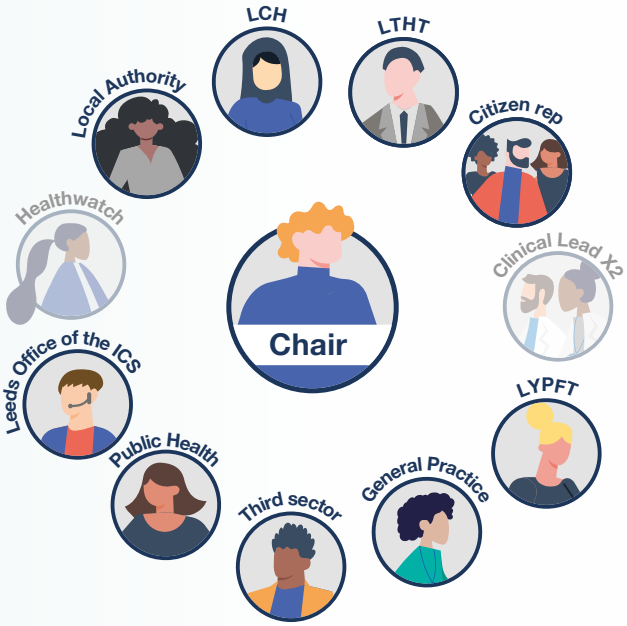


The Leeds Data Model

- The Leeds Data Model (LDM) is our pseudonymised, person level, linked dataset bringing together data from a range of partner organisations delivering health and care to the people of Leeds.
- The model enables us to identify specific cohorts through our population segmentation model to which we can compare service utilisation, prioritise services and help to plan existing or new services.
- The Leeds Data Model provides the system with the capability to cross reference utilisation with demographic and geographic information enabling the partnership to plan and deliver initiatives in a targeted and systematic way.
- Outputs from the Leeds data model was instrumental in the selection of our nine mutually exclusive segments.

Population and Care Delivery Boards

- A key element of the Leeds Health and Care Partnership governance structure are the nine population boards that mirror our segmentation approach.
- These boards have the responsibility for advising and guiding the Partnership on the best way to allocate NHS resources to improve value and reduce health inequalities for its defined population. They have an important role in identifying how to meet local priorities, national priorities and contribute towards narrowing the financial gap.
- In addition, two Care Delivery Boards work across all population segments to understand needs and effectiveness in two critical city-wide areas: Planned Care (elective secondary and community activity); and Same Day Response (same-day urgent and emergency services).
- Population and Care Delivery Boards are clinically led and consist of members from each organisation in our partnership. We are also establishing an approach to involving the people of Leeds in the decisions of the boards.
- Understanding the needs, health outcomes, spend, activity and contracting associated with each population is fundamental to a Boards capability to make recommendations.



Population Outcomes Frameworks

- Each of the Population and Care Delivery Boards have developed an Outcomes Framework, which clearly sets out what they are working to achieve for their population and how this achievement will be measured.
- Outcomes have been developed based on insight from people in Leeds as well as wider stakeholder and people engagement. Each Board has an *insight report* that summarises what people have told us about their experiences of care, and have been jointly produced with our partners through a series of *public involvement workshops*.
- Outcome frameworks continue to be reviewed and revised as further insight is received and the work of the boards evolves.
- Having clear and measurable outcomes, at a population level, enables us to track outcomes over time and develop an increasing, collective focus on how efficiently or effectively public resources are consumed across all organisations to improve health outcomes.

Local Care Partnerships

- *Local Care Partnerships (LCPs)* bring together a range of partners within Leeds to champion co-ordinated holistic person-centred care and address community priorities within the context of a wider health and wellbeing partnership.
- LCPs are central in understanding people-voice, insight and data to help inform decisions and delivery of person-centred care and have a vital role in supporting the wider partnership to achieve our system goals.
- The 15 LCPs focus on their local communities and implementing solutions to meet the needs of the local community.
- LCPs support the Population and Care Delivery Boards, as well as the Primary Care Board, in achieving the outcomes for their population at a local level.
- The work Forum Central has undertaken with the LCP team has ensured that there is a strong Third Sector presence in all LCPs, connecting communities (both geographical and communities of interest) to local health and care partners.

Health Inequalities – Tackling Health Inequalities Group and Communities of Interest Network

- The Tackling Health Inequalities Group (THIG) is an expert advisory group that was established to demonstrate our commitment to achieving our Health and Wellbeing Strategy ambition that the poorest improve their health the fastest.
- THIG acts as an expert advisory group to the system providing advice, expertise and challenge to ensure we are taking effective action to reduce health inequalities ensuring a consistent approach and sharing best practice. They have helped Leeds to develop its *Tackling Health inequalities Toolkit* that provides an evidence based and community informed framework for partners to use when addressing health inequalities.
- THIG has oversight of delivering the requirements of the national *Core20PLUS5 (adults)* and the *Core20pLUS5 (Children and Young People)* programmes which are in place to inform action to reduce health inequalities at both a national and system level.
- Whilst the Population and Care Delivery Boards are accountable for addressing health in equalities for their populations, THIG has a role to ensure that the system remains focussed on the 26% most deprived population within Leeds as well as the wider communities that are seldom heard / underrepresented
- In addition, the *Communities of Interest Network (COIN)* helps to highlight and address the needs and challenges faced by groups and communities which experience the greatest inequalities. A key focus of the network is to understand and raise awareness of the importance of intersectionality, where people's overlapping social identities may mean they experience multiple disadvantages or discrimination.

Fig. 6: Leeds and the areas of the most deprived 10% nationally

English decile	Leeds pop.	% of Leeds
English top 10%	**226,013**	**26%**
2	82,285	9%
3	78,288	9%
4	35,384	4%
5	91,191	10%
6	72,545	8%
7	93,652	11%
8	66,848	8%
9	68,490	8%
10	56,036	6%

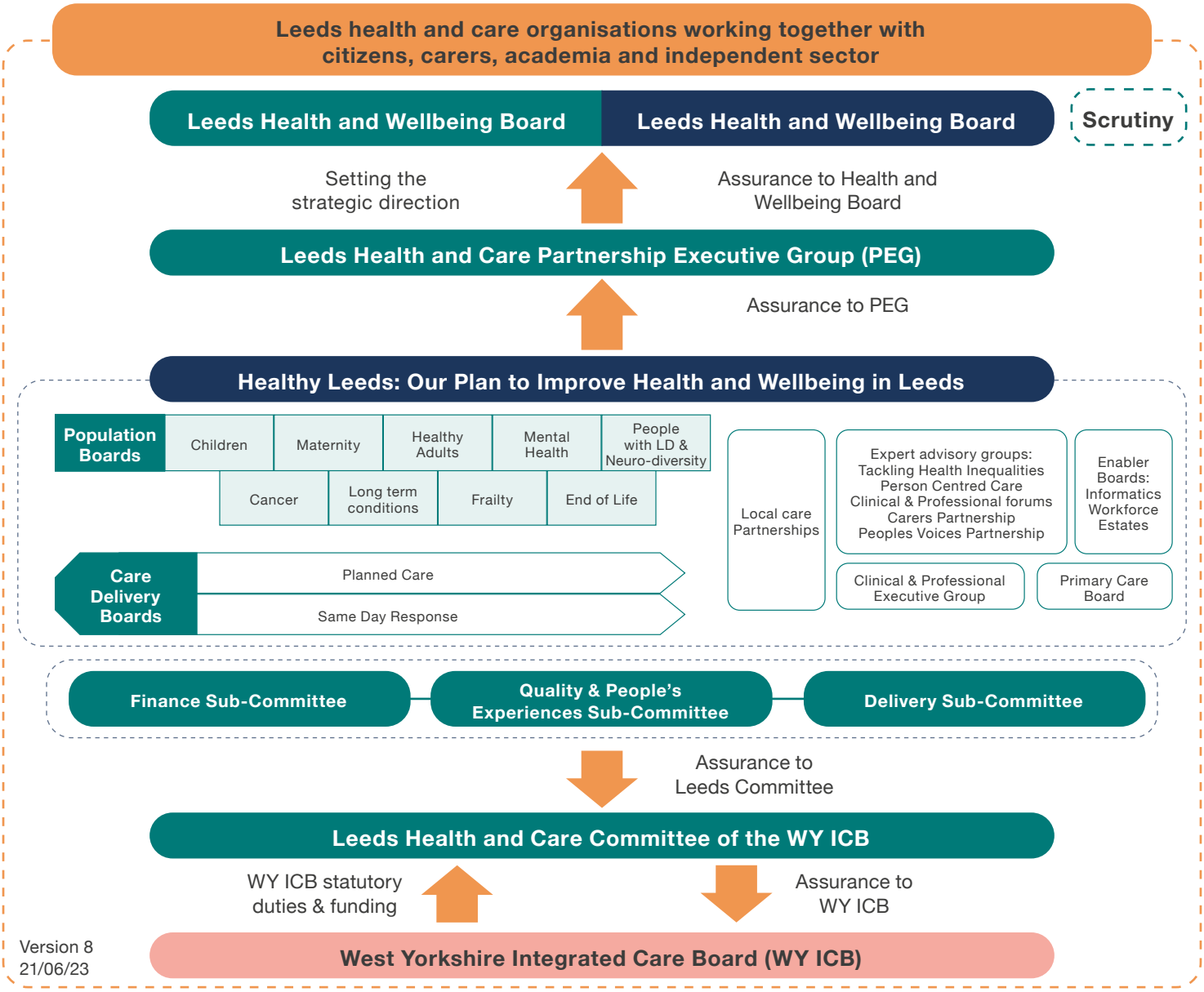
IMD2019 and October 2020 Leeds 2020 Leeds registered populations.

Collectively, the Population Health Infrastructure forms a central part of the Leeds Health and Care Partnership Governance Structure. The Population and Care Delivery Boards bring key partners in Leeds together so that they can work collaboratively to improve the outcomes, experience and value derived from NHS spend for their defined population. They are supported by the cities expert advisory groups and enablers. Population and Care Delivery Boards provide assurance to the three sub-committees in Leeds that the city is delivering the triple aim of healthcare; improving outcomes, improving experience for people; and ensuring effective use of resource and reporting on performance against the system priorities. These three sub-committees in turn provide assurance to the Leeds Committee of the West Yorkshire Integrated Care Board and subsequently the West Yorkshire Integrated Care Board.

The Partnership Executive Group in Leeds will have oversight of the delivery of our two system goals, with support from the Delivery Sub-Committee, which will have responsibility for monitoring implementation and delivery. The Partnership Executive Group is accountable to the Health and Wellbeing Board and members include the CEOs from the NHS in Leeds, Leeds City Council and Public Health, and advocates from the 3rd sector, General Practice and Clinical Senate.

Our governance structure is illustrated below.

Leeds Health & Care Partnership Governance Structure



Expert Advisory Groups provide high support high challenge to the Boards in areas that are a particular priority for the system:

The Person-Centred Care Expert Advisory Group was established through a collective and system commitment to implementing the "Leeds Person Centred Principles". The role of the group is to advise, influence and support implementation of best practice for services which communicate effectively, are compassionate and are coordinated (the Leeds 3 Cs). Within Leeds we support the West Yorkshire vision for everyone to be able to access high-quality health and care services that have been codesigned to take account of lived experiences and personalised through shared decision-making. The care will be responsive to health inequalities, trauma informed, and respectfully delivered, resonating with what matters most to the individual, their family and unpaid carers, and in support of the community connecting them.

The Leeds Carers Partnership champions the needs of the estimated 61,500 unpaid carers in Leeds and aims to influence service design and delivery in response to the needs of carers. Unpaid carers are crucial both to our communities and to the sustainability of health and social care in Leeds. Without unpaid carers individuals and communities would be worse off and the NHS, social care and community services would be overwhelmed. To achieve our ambition to be the best city for health and wellbeing we need to ensure we can identify and support our unpaid carers, recognise, and value the contribution that unpaid carers make. Alongside this we need to promote unpaid carers' own health and wellbeing, putting unpaid carers at the heart of everything we do, as described within *The Leeds Carers Partnership Strategy.*

The Tackling Health Inequalities Group (THIG), as described above, provides advice and expertise as well as challenge to the system to ensure we are focussing and taking actions to reduce health inequalities across Leeds. See Health Inequalities section of this plan for more detail.

The People's Voices Partnership (PVP) brings engagement and involvement leads from partner organisations together to share their work. Their common aim is to improve the way we hear the voices of local people, particularly those living with the highest health inequalities. The PVP are working together to understand what matters to people in Leeds. Projects like the Big Leeds Chat have helped senior leaders to listen directly to local people and staff from across the city. The PVP is an expert advisory panel and was instrumental in pulling together the insight reports that our Population and Care Delivery Boards use to understand what matters to the people of Leeds.

We have a number of public groups and involvement activities across the city that will help us work together with local people and staff. These groups and activities will enable us to continue listening to people and to use their feedback to shape our services. We are also committed to feeding back to people about how their stories and experiences help us to improve services in Leeds. You can read more about our work to involve people and find out how we are using feedback to shape our services on our *LHCP website*.

Identifying Our Priority Areas of Focus

Measurable improvement toward our goals will be driven by the people of Leeds, clinicians, professionals and the third sector. We will use population health management approaches and local insight (at a Local Care Partnership and city level) to identify, design and implement interventions and service changes that will have the biggest impact on people's health and wellbeing. In line with the Health and Wellbeing Strategy ethos of starting with people and communities, coproduction will run through all aspects of change.

Following identification of our system goals to reduce unplanned utilisation and increase early identification, the Office of Data Analytics (ODA) has developed an initial methodology to identify areas of opportunity to improve health and wellbeing, drawing on the capability of our Leeds Data Model (LDM).

Using data from the most recent financial year (2022/2023) and focusing on unplanned emergency admission to acute and mental health services (in Leeds or nearby) for those in IMD1, the ODA identified the presenting conditions that resulted in the highest rate of unplanned care activity per capita. The age, gender, ethnicity and location profiles of these groups were then investigated in further detail to identify themes and potential relationships to population segments. For example, identifying a high rate of unplanned care due to injury and falls (as a presenting condition) led to the identification of a cluster of need within the population segment. This initial methodology (and the assumptions made) were tested within an iterative process, with assurance, validation and challenge from clinicians and Subject Matter Experts at each step.

This methodology will be improved and refined over the next year, including a broader range of metrics from Goal 1 and drawing on more powerful analytical techniques to identify further areas of opportunity. However, the data analysis has indicated several areas for Leeds to consider during 2023/24 as potential areas of focus where we can make a difference and improve outcomes for our population. These are summarised in the next section.

Areas for consideration

Children and Young People: Diseases of the respiratory system respiratory failure, influenza and bronchitis

Data analysis identified that a significant number of children and young people and their families were impacted by respiratory disease, specifically within the following IMD1 areas of the city Burmantofts, Harehills and Richmond Hill; Morley and District; and Middleton and Hunslet. For these geographical areas the average length of stay is 2.5 days longer compared to the Leeds average. Through the work of the Children and Young People's Population Board and in developing our health economic approach in Leeds we know that the people aged under 18 are the fastest growing population in IMD1 and that investment in prevention for this population is important to support them in leading healthy lives in the future.

This priority sits well within the Children and Young People's Core20PLUS5 framework, which identifies Asthma as one of the five clinical areas of focus that requires accelerated improvements.

People with three or more Long Term Conditions and Mental Health

Data analysis indicated that this cohort of people utilise a high number of non-elective bed-days, coupled with a a high prevalence of known risk factors. For example we know, through the data, that 60% of this cohort are obese and 32% are smokers. We also know, through evidence based methodologies that these conditions are likely to be amenable to improvement via person-centred, proactive care.

For this priority the specific geographical of focus under consideration are Seacroft; West Leeds; and Burmantofts, Harehills and Richmond Hill. In addition, Serious Mental Illness and multiple Long Term Conditions are plus groups within the Core20PLUS5 national programme. In addition, three of the five clinical areas identified within the Core20PLUS5 programme that require accelerated improvements, are also workstreams within the Serious Mental Illness Population Board and the Long Term Conditions Population Board.

Frailty Population: Injury / Fracture

Despite significant focus and investment in this area as a city data demonstrates that injuries and fractures remain a challenge for the older population in Leeds even though improvements have been seen. Analysis indicated that a large proportion of unplanned bed days were occupied by older people with an estimated average length of stay at nine days. The geographical areas within IMD 1, which are being analysed further, include Burmantofts, Harehills and Richmond Hill; York Road; and Armley. The data indicates that people living within these areas, when admitted following an injury/fall are, on average, likely to stay in hospital 5.5 days longer than people in other areas.

People with a Learning Disability and/or Neurodiversity

Nationally, across West Yorkshire and within Leeds, improving outcomes for people with a learning disability and / or neurodiversity is a key priority. Nationally five out of 10 people with a learning disability die before they are 65 years old compared to one in 10 of the general population and autistic people die on average 16 years earlier than the general population. The data also indicates that people of Black, Black British, African or Caribbean, mixed ethnic group and Asian or Asian British ethnicity died at a younger age in comparison to people of White ethnicity. The national LeDeR data (2021) also highlights that 49% of deaths were classified as avoidable compared to 22% for the general population. Epilepsy was the most common Long Term Condition associated with an earlier death and we know that within Leeds 88% of the learning disability and neurodivergent population have two or more health conditions and 31% have five or more health conditions.

This evidences that people in this population experience significantly worse health outcomes than other segments. For this reason, reducing premature mortality for people with a learning disability and/or who are neurodivergent is a priority for the Population Board, is one of the West Yorkshire Big 10 Ambitions, and is to be considered a system priority for Leeds.

HomeFirst Programme

Alongside these priority areas the Partnership has agreed an additional focus on improving system flow overall - which directly links to achieving goal one. Every day in Leeds thousands of people receive great care and support from dedicated health and care staff, volunteers and unpaid carers. However, there are opportunities for us to improve people's outcomes:

- Too many people spend more time in hospital than they need to
- Our short-term care in the community is provided across many different services
- Outcomes for people can vary depending on where, when and how they are supported
- We have a high use of bed-based care
- Many older people could reduce or avoid deconditioning that has an impact on their independence and long term care needs

The HomeFirst programme (formally the Intermediate Care Programme) represents our fifth priority area for the partnership. This programme is developing and implementing a new model of intermediate care services to address the challenges described above, achieving more independent and safe outcomes for people, helping more people to stay at home, whilst improving the experience for people, unpaid carers and staff. By delivering improvements in five project areas (active recovery at home, enhanced care at home, rehab and recovery beds, transfers of care and system visibility and active leadership) it is expected to create real change for the people of Leeds, with improvement in the following areas:

- 1,700 fewer adults admitted to hospital
- 800 fewer people spending days in hospital
- 400 more people going directly home after their stay in hospital
- 1,200 people benefitting from a more rehabilitative offer in their own home
- 400 people able to get home sooner from a short-term bed
- 100 more people able to go home after their time in intermediate care

(all per year vs. a 2022 baseline)

Through the initial work of the HomeFirst Programme we know that 30% of the most deprived areas within Leeds account for 42% of intermediate care patients. On average, those patients living in IMD 1 are typically more frail and younger than the users from other deprivation deciles. People living with dementia are at least twice as likely to access intermediate care as the average person over 80 or the frailty population. Patients living with dementia have a higher re-admittance rate to hospital following discharge from Neighbourhood Teams or Community Care Beds. We also know that in Leeds people living with dementia have a disproportionate use of unplanned utilisation, particularly non-elective bed days and this is higher for those people living within IMD1.

Financial Sustainability

Leeds health and care partners will be unable to achieve its goals and deliver on the Health and Wellbeing vision if it doesn't also maintain financial stability during uncertainty post COVID-19. Our financial plans for 2023/24 are built on the premise that the city can achieve substantial in-year savings. The Leeds ICB budget has grown over recent years (by 34.5%), however spending on provision has grown even more - between 42% and 58% with our three main NHS providers in Leeds. Much of this spending has been on a recurrent basis and as such this has created an underlying deficit to the system that needs addressing. This change has three root causes:

- Through COVID-19 the NHS rightly received a lot of additional funding and this has now been withdrawn at a faster pace than the services (and staff) that were put in place;
- The pandemic has driven up demand for health services in most areas above that which we saw before COVID-19 along with significant backlogs; and
- Finally, the cost of living whether in the cost of utilities or indeed well-deserved staff pay rises has also impacted as these have not been fully covered nationally.

Therefore, a focus on our priorities as described above must not only improve outcomes and experience for people but it must also lead to a better use of resources and contribute towards closing the financial gap within the NHS, as well as considering the considerable pressures within our wider partnership such as social care and other non-statutory providers. Responsibility for closing the financial gap is owned by the Leeds Health and Care Partnership. It is important that financial decisions are made in line with our system strategy and that a collective feeling of financial stewardship is fostered within the system, particularly within our Population and Care Delivery Boards, to support Leeds in reaching financial sustainability.

With this aim our Population and Care Boards will play an important role in identifying, evaluating, and overseeing the implementation of the savings that need to be made. The people on these boards and their colleagues are the people closest to the services and their population. These boards have the knowledge and insight to drive better value for our Leeds pound.

Annual Priority Cycle

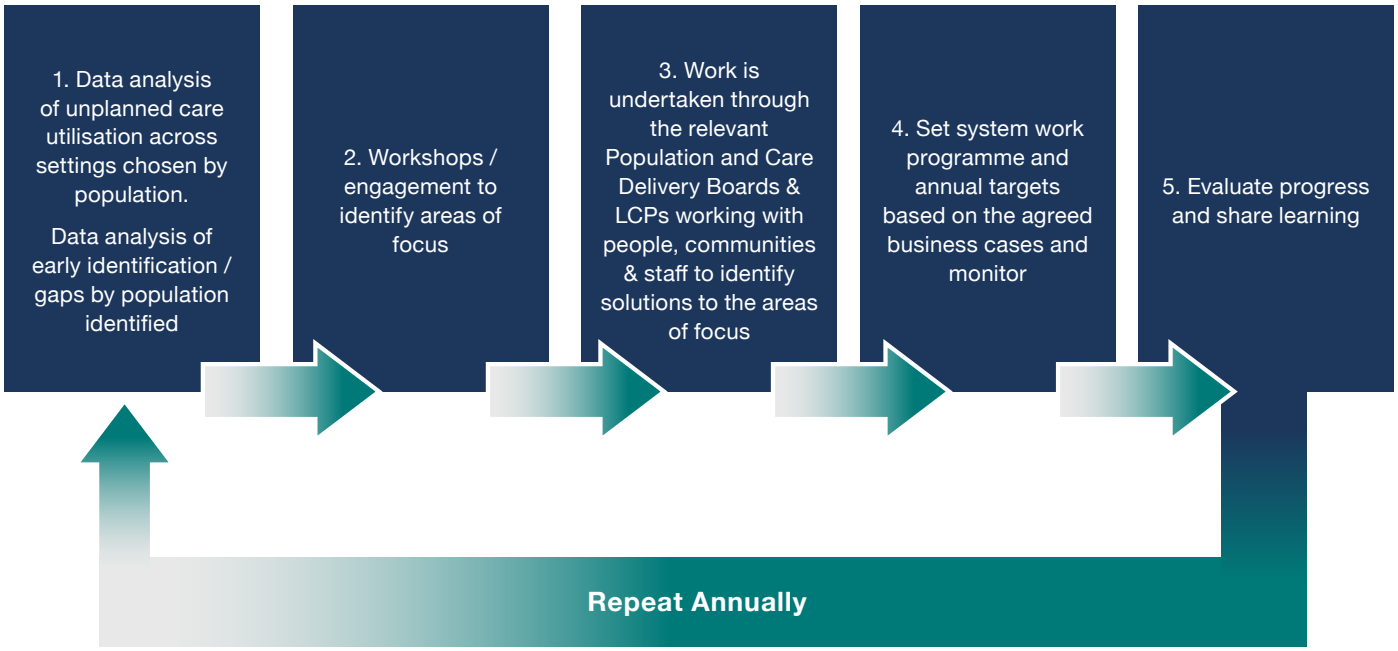
Ensuring success of a focussed approach, as demonstrated by Staten Island model, is not just about the goals themselves but the behaviours that focussing on a goal has led to. Within Leeds we have developed a partnership approach to an annual cycle (see fig. 7), based on the Staten Island model.

A small number of data-informed priorities, which link to our system goals, will be identified and reviewed each year by our partnership and will be informed by data, insight and evidence. For each priority area identified we will collaborate with people, communities and staff to really understand the root cause of the problem and work together to identify the solutions, whether these are health based or linked to the wider determinants. Solutions may be at a system level, population level or within our local communities. We will work together to monitor the impact of interventions and actively respond if the anticipated impacts are not being realised.

In undertaking this planning approach, we will always:

1. Plan care by understanding the clinical and financial risk profile of specific population groups to inform interventions and investment priorities, particularly in prevention.
2. Improve equity of access and reduce unwarranted variations in health and care services.
3. Target interventions to those who need it most by identifying people at risk of poor outcomes earlier.
4. Design and deliver how and where people receive health and care services, ensuring care is closer to their home, their family or community and that people remain in Leeds, by embedding a 'home first' approach and ensuring people have the tools, knowledge and skills to self-care.
5. Connect and integrate care and information across pathways, services and teams, where it makes sense, through new hospitals, redesigned intermediate care offer and improved community and primary care offer.

Fig 7: Annual cycle



Our Plans

Our Population and Care Delivery Boards are the focal point for delivery of the priorities identified above. They are also responsible for supporting the local delivery of West Yorkshire and Long Term Plan priorities. These come together within the individual board plans, included in the following pages. Each plan describes the vision, outcomes, and priority work programmes for each board (e.g. by population segment), and how these will drive improvements in our city's goals, support West Yorkshire ambitions and ensure delivery of Long Term Plan priorities, including COVID-19 recovery plans across Urgent and Emergency Care Recovery; Elective Recovery; and Primary Care Recovery.

There are two programmes of work that link to the West Yorkshire 10 Big Ambitions but are not aligned to a specific Population or Care Delivery Board and these are Suicide Reduction and Anti-microbial Resistance, and are described first.

The appendices (link) provide the detailed operational plan for how the partnership will meet the 31 national objectives and locally defined population through a wide range of individual projects.

Suicide Reduction

Our Suicide Prevention Action Plan, led by our citywide suicide prevention strategic group, supports suicide prevention work underway across West Yorkshire. It is a working document, used as framework to guide local action and activity, and is informed by local and national policy and evidence for suicide prevention, including the *Leeds Suicide Audit (2011-2013)* and *Preventing Suicide in England* reports. The Suicide Prevention Action Plan sits within the context of our wider public mental health programme. Other priorities in this programme include mental health promotion and wellbeing; reducing stigma and discrimination; and effective, equitable mental healthcare services. It brings strategic partners across healthcare and wider settings to ensure the best use of limited resources, and is being delivered through six workstreams:

1. Citywide leadership for suicide prevention;
2. Reduce the risk of suicide in high-risk groups;
3. Develop and support effective suicide prevention activity in local primary care services;
4. Provide better information and support to those bereaved or affected by suicide;
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour; and
6. Improve local intelligence on suicide in Leeds to inform suicide prevention activity.

The Leeds Suicide Audit (due for completion summer 2023) will provide details on demographics and risk factors of all suicides between 2019 and 2021 to help further target interventions to reduce risk, and will be used to update our local Suicide Prevention Action Plan.

Antimicrobial Resistance

Leeds is part of the wider West Yorkshire Health and Care Partnership Integrated Care System Antimicrobial Resistance Steering Group, with a place-based stewardship group. The Leeds Antimicrobial Stewardship Group was developed in 2016 with a range of partners from across the Leeds Health and Care System. We have also developed a local, place based, collaborative and system wide approach to address antimicrobial resistance in Leeds with a clear action plan which is monitored through the Leeds Antimicrobial Stewardship Group. The plan has three key priorities and aligns to the National Action Plan on Antimicrobial Resistance and the West Yorkshire Antimicrobial Strategy:

- Reducing the need for and unintentional exposure to antimicrobials
- Optimising use of antimicrobials
- Investing in innovation supply and access

Population	**Population definition**	**Population size**
Children and Young People	All Leeds residents under the age of 18	177,712*

Outcomes	Children are safe from harm	Children do well at all levels of learning and have skills for life	Children in Leeds are healthy	Children are happy and have fun	Children and young people in Leeds are active citizens who feel they have a voice and influence
Key workstreams	**Keeping children safe from harm** Compassionate Leeds supports the most vulnerable and addresses impact of trauma and adverse life experiences	**Children with Complex Needs** Neurodiversity identification, assessment and support review	**Addressing Health inequalities in children and young people** Core20PLUS5 action plan	**Children's Mental Health** Crisis offer for CYP from prevention to inpatient stays. Prevention and timely access to services	**Children's System Flow** Develop proactive and reactive model to ensure children are seen at the right time in the right place
NHS national priorities	Improve access to mental health support for children and young people (0-25 years)				
Core20PLUS5	Focus on the most deprived communities and plus groups Asthma, Diabetes, Epilepsy, Oral health and Mental health				

WYICS 10 Big Ambitions:

- Address the health inequality gap for children living in households with the lowest income, including halting the trend in childhood obesity
- Reduce the gap in life expectancy between people with mental health conditions, learning disabilities and/or autism and the rest of the population. In doing this we will focus on early support for children and young people

WY programmes

- Supporting our children, young people and families

Health and Wellbeing Strategy (2023-2030):

- A Child Friendly and Age Friendly City where people have the best start and age well.
- Safe and sustainable places that protect and promote health and wellbeing
- A mentally healthy city for everyone

Local strategies and plans

- The Future In Mind Strategy
- Compassionate Leeds Strategy
- Child Friendly Leeds
- Leeds Children and Young People's Plan
- Best Start Strategy
- Early Help Strategy
- Nesta partnership
- Attainment Achievement and Attendance strategy
- Thriving strategy
- Leeds Play Strategy
- Leeds Food Strategy

**from the LDM and based on the population definition criteria*

Population	**Population definition**	**Population size**
Maternity	People over 18 and pregnant or within 2 years of a pregnancy	12,777*

Outcomes	Families and babies are supported to achieve optimal physical health	Families and babies are supported to achieve optimal emotional health	People receive personalised maternity care safely	People feel prepared for parenthood	
Key workstreams	**Maternity dashboard quality surveillance** Review utilisation, safety and risks Monitor workforce and retention Bookings before 10 weeks	**Maternity and Neonatal Voices Partnership (MNVP)** Accessible and close to home care service user engagement Staff satisfaction / feedback	**Gestational diabetes & maternal healthy weight** Targeted healthy eating and physical activity interventions Infant feeding support Future pregnancy planning education Community based peer support sessions for diabetes and unhealthy weight	**Health Inequalities** Review of interpreter service within maternity including digital access accessible and closer to home care Young parents and doula service offer and support	**Perinatal and maternal mental health** Service offer to combine maternity, reproductive health and psychological therapy Increase access to perinatal and maternal mental health services	**People feel prepared for parenthood** Perinatal parenting programmes Breastfeeding Baby Steps Infant mental Health

NHS national priorities

- Make progress towards the national safety ambition to reduce still birth rate, neonatal mortality, maternal morality and serious intrapartum injury
- The NHS will continue to contribute towards levelling-up, through its work to tackle health inequalities showing a continued reduction in the difference in the stillbirth and neonatal mortality rate between that for Black, Asian and Minority Ethnic women and the national average.
- Listening to and working with women and families with compassion
- Growing, retaining, and supporting our workforce
- Developing and sustaining a culture of safety, learning and support
- Standards and structures that underpin safer, more personalised, and more equitable care

Core20PLUS5

- Focus on the most deprived communities and plus groups
- Maternity: Ensuring continuity of care for women from Black, Asian and minority ethnic communities and from the most deprived groups. This model of care requires appropriate staffing levels to be implemented safely.

WYICS 10 Big Ambitions:

- Reduction in stillbirths, neonatal deaths, brain injuries

WY programmes

- Maternity services

Health and Wellbeing Strategy (2023-2030):

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

Local strategies and plans

- Leeds Maternity Strategy
- Child Friendly Leeds
- Ockenden Review
- Maternity Transformation Programme

**from the LDM and based on the population definition criteria*

Population	**Population definition**	**Population size**
Healthy Adults	People 18+ with no diagnosed long-term conditions and not pregnant	343,243*

Outcomes	People in Leeds are mentally healthier for longer	People in Leeds are physically healthier for longer	People in Leeds are supported to live well, and have a standard of living which supports their health and wellbeing

Key workstreams	**Healthy Mind**	**Healthy Body**	**System Flow**	**People supported to live well**	**Tackling Health Inequalities (Core20PLUS5)**	**Health Inclusion**
	Data led approach to targeted interventions for those at greatest risk of developing anxiety. depression and risk of suicide	Data led approach to targeted interventions for those at greatest risk of developing hypertension, diabetes, liver disease and osteoarthritis	Out of Hospital Project for those with no fixed abode/ multiple complex disadvantages Social Prescribing in A&E Home Plus Service	Social Prescribing for non-clinical health and wellbeing needs Social Prescribing in A&E Digital Health Hubs	Community Grant schemes via LCPs Development of Core20PLUS5 data lenses for all boards Development of models best practice to design and implement interventions to tackle inequalities	Outreach, advocacy and access – focussed support and intervention for the most vulnerable and at risk cohorts (sex workers, gypsy and travellers, refugee and asylum seekers, homelessness, offenders) Development and synthesis of qualitative data for health inclusion group access, experience and outcomes of care.

NHS national priorities	• Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals (specifically weight management for this population) • The NHS will invest in prevention to improve health outcomes
Core20PLUS5	Focus on the most deprived communities and plus groups

Local strategies and plans:

- *Leeds Drug & Alcohol strategy*
- *Leeds Best City ambition*
- Inclusive Growth strategy
- Marmot City Ambition

Health & Wellbeing strategy:

- A city where everyone can be more active, more often
- Improving housing for better health
- A mentally healthy city for everyone
- Promoting prevention and improving health outcomes through an integrated health and care system

WYICS 10 Big ambitions:

- We will increase the years of life that people live in good health
- Address the health inequality gap for children in poverty, including halting the trend of childhood obesity
- Increased early cancer diagnosis rates
- Reduce suicide by 10%

**from the LDM and based on the population definition criteria*

Population	**Population definition**	**Population size**
Learning Disabilities and Neurodiversity	Diagnosis of a learning disability and/or Autism	5,180*

Outcomes	Appropriate early identification of a Learning Disability and/or Neurodiversity	Prevention of LTC within this population through a focus on keeping Healthy	Early detection and proactive support around the management of LTCs within this population	Learning disability, Autism and ADHD acceptance in Leeds with a focus on services making reasonable adjustments and better meeting the needs of this population	
Key workstreams	Reducing reliance on inpatient care for people with a learning disability and/ or autism	Step Up Crisis Alternative review and redesign to provide an alternative to hospital assessment and treatment and a proactive means of preventing placement breakdown	Review and improve integrated pathways for diagnosis, treatment and support for autistic people and people with ADHD	Improve access to and uptake of mainstream health services responding to the Health Facilitation Team evaluation, Autism access project outputs	Accuracy of GP registers and increase uptake of annual health checks

NHS national priorities

- Reduce reliance on inpatient care, while improving the quality of inpatient care, for adults and children with a learning disability and/or who are autistic
- Continue to increase the number of people aged over 14 on the GP learning disability register receiving an annual health check and health action plan
- Improve access to and uptake of mainstream health services:
  - The LEDER programme
  - Digital Reasonable Adjustment Flag

Core20PLUS5

- Focus on the most deprived communities and plus groups
- Increase access to epilepsy specialist nurses and ensure access in the first year of care for those with a learning disability or autism.

WYICS 10 Big Ambitions:

- 10% reduction in the gap in life expectancy between people with mental health conditions, learning disabilities and/or autism

WY programmes

- Mental Health, Learning Disabilities and Autism

Health and Wellbeing Strategy (2023-2030):

- A mentally healthy city for everyone
- The best care in the right place at the right time
- Promoting prevention and improving health outcomes through an integrated health and care system

Local strategies and plans

- Being Me strategy
- Leeds Autism strategy

**from the LDM and based on the population definition criteria*

Population	**Population definition**	**Population size**
Serious Mental Illness (SMI)	Over 18 and with a diagnosis of Serious Mental Illness	12,452*

Outcomes	People in Leeds with a serious mental illness receive care at the right time and in the right place	People in Leeds are proactively supported within the community	People in Leeds have timely access to crisis support	People in Leeds are discharged in an appropriate, timely and supported way

Key workstreams

Community Mental Health Transformation

Design and implement a new model of care with PCNs and LCPs that responds to local needs and removed barriers to access so people can access care, treatment and support as early as possible and be supported to live as well as possible in their community.

Further develop outreach and pathways to improve access to **Physical Health** checks and interventions for those with SMI

Further improve and develop the early Intervention in psychosis pathway, providing access to evidence based interventions for those with at risk mental states (ARMS)

Reducing inappropriate Out of Area mental health bed days

Mental health discharge challenge event with focus on peer support discharge workers and Acute Care Excellence (reducing unnecessary clinical variation, improving quality of acute impatient provision)

Mental Health Crisis

Crisis Pathway Redesign implementation

Redesign of simplified access to MH crisis

Embedding **NHS 111** into this local crisis redesign

Optimising value of MH spend through review of outcomes, experience and value of current MH crisis pathway, including responding to the evaluation of the community bases crisis house 2 year pilot with LYPFT crisis team to reduce admissions for people with acute MH crisis support needs.

Implementation and evaluation of new delivery model for **street triage**.

NHS national priorities

- Increase the number of adults and older adults accessing IAPT treatment
- 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
- Improve access to perinatal mental health services

Core20PLUS5

- Focus on the most deprived communities and plus groups
- Ensuring annual health checks for 60% of those living with SMI (bringing SMI in line with the success seen in learning disabilities).

WYICS 10 Big Ambitions:

- Achieve a 10% reduction in the gap in life expectancy between people with mental health conditions, learning disabilities and/or autism
- Achieve a 10% reduction in suicide rates

WY programmes

- Mental Health, Learning Disabilities and Autism

Health and Wellbeing Strategy (2023-2030):

- A mentally healthy city for everyone
- Strong, engaged, and well-connected communities
- The best care in the right place at the right time

Local strategies and plans

Leeds Mental Health strategy

**from the LDM and based on the population definition criteria*

Population	**Population definition**	**Population size**
Cancer	Diagnosis of cancer	27,806*

Outcomes	People living with cancer will receive person centred care	More cancers will be prevented	People with cancer in Leeds will be diagnosed earlier when evidence shows this to be beneficial	People will receive the safest and most effective cancer treatments that are available

Key workstreams	**Person Centred Care** 2ww frailty assessment clinics	**Screening, Prevention and awareness** • **Leeds Health Awareness Services** with a focus on deprived and culturally diverse communities • **Primary Care Screening Champions** within 45 most deprived practices • **Lung Fit Health Checks**	**Earlier diagnosis** • **Open access chest x-ray** for people concerned about lung cancer symptoms • Implement **FIT testing** within the lower GI pathway • **Primary care DES** to reduce DNAs and improve 2ww pathway • Pinpoint blood test evaluation • New camera equipment within community tele-dermatology • Increase training for PNs to request chest x-ray • Increase non-specific symptoms pathway • Develop new oral lesions pathway	**Living with and Beyond** • **Risk stratified pathways** and development of digital remote monitoring systems • **End of treatment summaries** to support people and recognise any signs to be aware of • Community cancer support services demobilisation plans

NHS national priorities	• Increase rate of cancer cases diagnosed at stage 1 or 2 • Reduce the number of people waiting longer than 31 and 62 days for treatment • Meet the 28 day Faster Diagnosis Standard	• Cancer screening targets (bowel, breast, lung and cervical) • Improve one year cancer survival rates

Core20PLUS5	• Early Cancer Diagnosis

WYICS 10 Big Ambitions:	**Health and Wellbeing Strategy (2023-2030):**	**Local strategies and plans**
• Increase the years of life that people live in good health • Increased early diagnosis rates for cancer, ensuring at least 1,000 more people will have the chance of curative treatment by 2024.	• The best care in the right place at the right time • Promoting prevention and improving health outcomes through an integrated health and care system	• Leeds Cancer Programme • LTHT Cancer work • WY cancer alliance

**from the LDM and based on the population definition criteria*

Population	**Population definition**	**Population size**
Long Term Conditions	Over 18 with a diagnosis of qualifying long-term condition (e.g. diabetes, asthma) and not in any other segment	242,528*

Outcomes	People living with an LTC get the support and tools they need to be as healthy and well as they can be	People with a LTC return to and maintain their normal activities and lifestyle in ways that matter to them	People with a LTC take an active role in managing their condition

Key workstreams	**Integrated Weight Management**	**Multi-morbidity (3 LTCs Plus MH)**	**CVD**	**Respiratory**	**Neurology**	**Diabetes**
	Integrated weight management model development Nutrition and Dietetics / Enteral feeds / Oral Nutritional Supplements	• Develop secondary prevention MDT / multimorbidity hub ambition • Long covid review and • Rehabilitation model development • Self-management • Cardio-renal-metabolic (CaReMe) • Digital remote monitoring	• Lipids Maintenance Hypertension • Remote monitoring/self-management • Anticoagulation and thrombosis • Integrated Heart Failure model next Steps	• Home Oxygen delivery across Yorkshire and Humber • CIVAS • Diagnosis and prescribing • Asthma prescribing • Spirometry and contribution to diagnostic hubs	• Stroke • Community Neurological Rehab Service • (CNRS) redesign • MS, Epilepsy, FND and MND	• National Diabetes Prevention Programme (NDPP) • Diabetes Remission • NHS Treatment and Care performance • Chronic Kidney Disease (CKD) • Continuous Glucose Monitoring (CGM)

NHS national priorities	• Increase percentage of patients with hypertension treated to NICE guidance • Increase the percentage of patients aged 25-84 years with a CVD risk score greater than 20 percent on lipid lowering therapies	• Increase the number of people supported via the NHS diabetes prevention programme – reflecting the NHS's contribution to wider government action to reduce obesity prevalence.

Core20PLUS5	• Focus on the most deprived communities and plus groups • To allow for interventions to optimise blood pressure and minimise the risk of myocardial infarction and stroke. • Address over reliance on reliever medications; and decrease the number of asthma attacks. • Increase access to real-time continuous glucose monitors and insulin pumps across the most deprived quintiles and from ethnic minority backgrounds; and Increase proportion of those with Type 2 diabetes receiving recommended NICE care processes.

WYICS 10 Big Ambitions:	**Health and Wellbeing Strategy (2023-2030):**	**Local strategies and plans**
We will increase the years of life that people live in good health **WY programmes** Supporting Long Term Health Conditions	• A city where everybody can be more active, more often • Promoting prevention and improving health outcomes through an integrated health and care system • Support for carers and enable people to maintain independent lives • A mentally healthy city for everyone	• *Leeds Diabetes Strategy* • *Leeds Stroke Priority Report*

**from the LDM and based on the population definition criteria*

Population	**Population definition**	**Population size**
Frailty	Over 60 AND eFI score >= 5	62,381*

Outcomes	Living and ageing well defined by 'what matters to me'.	Identifying and supporting all people in this population group and assessing their needs and assets, as an individual and as a carer	Reducing avoidable disruption to peoples lives as a result of contact with services

Key workstreams	**Home First Programme** Review of intermediate care services and pathways / processes to reduce delays	**Dementia needs** Coordinated dementia action plan to identify, support and manage more complex need	**Virtual Ward** • Hospital at Home • Remote Monitoring	**Reactive care** • Urgent community response • Falls response • Falls prevention	**Proactive care** Anticipatory care, falls strength and balance

NHS national priorities	• 2-hour Urgent Community Response (UCR) • Virtual ward capacity • Reduce general and acute bed occupancy	• Reduce the number of medically fit to discharge patients in our hospitals (and community provision) • Recover the dementia diagnosis rate
Core20PLUS5	Focus on the most deprived communities and plus groups	

WYICS 10 Big Ambitions:	**Health and Wellbeing Strategy (2023-2030):**	**Local strategies and plans**
We will increase the years of life that people live in good health **WY programmes** Supporting people leaving hospitals and developing integrated step-up and step-down intermediate care services	• Promoting prevention and improving health outcomes through an integrated health and care system • Support for carers and enable people to maintain independent lives • The best care in the right place at the right time • A mentally healthy city for everyone	• Age Friendly Leeds

**from the LDM and based on the population definition criteria*

Population	Population definition	Population size
End of Life	Over 18 and on palliative care register	3,095*

Outcomes	People approaching the end of their life are recognised and supported on time	People approaching the end of life live and die well according to what matters to them	All people approaching the end of life receive high quality, well-coordinated care at the right place at the right time and with the right people	People approaching the end of life and their carers are able to talk about death with those close to them and in their communities. They feel their loved ones are well supported during and after their care.	
Key workstreams	Enhance initiatives and capacity to raise community awareness and address barriers to care and support including linkage and analysis of routinely collected data, alongside targeted inquiry, to inform strategic action.	Enhance earlier identification and recognition of people approaching the end of their life in Leeds, utilising digital needs identification, to enable timely and effective support to patients, families, carers and communities.	Improve the uptake and quality of digital Advanced Care Plans (Planning Ahead), including the interoperability of digital ACPs across providers, to facilitate high quality coordinated care.	Continue to improve pathways and integration for end of life care across and within all providers with particular focus on out of hospital provision and effective use of acute hospital services.	Maintain and enhance 24/7 access to care, support, advice and guidance across all settings in Leeds.	Maintain the coordinated education and training provision for end of life care professionals in Leeds targeting areas of identified need.
Core20PLUS5	Focus on the most deprived communities and plus groups					

WYICS 10 Big Ambitions:

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

WY programmes

Palliative and end of life care

Health and Wellbeing Strategy (2023-2030):

- The best care in the right place at the right time
- Support for carers and enable people to maintain independent lives

Local strategies and plans

- *Leeds Adult Palliative and End of Life Care Strategy 2021-2026*

**from the LDM and based on the population definition criteria*

Population
Same-Day Response

Population definition
Those accessing 'on the day' urgent services

Outcomes	People are easily able to access the service that can provide the most responsive and appropriate care to meet their unplanned same day needs	People's same day care needs are met wherever they present (if possible), and where they need to be cared for elsewhere, this feels seamless and integrated.	Care is high quality, person-centred and appropriate to people's same day care needs now, whilst considering how these might change in the future.

Key workstreams	**PCAL+ Creating a new single gateway** Working with YAS to identity and 'push' referrals to UCR via PSUR as clinically triaged from ambulance stack and assessing impact of primary/community clinicians 'pulling' from the stack and providing UCR response	**Children Urgent Care** Paediatric ARI hub – CAPS service for Children requiring physical examination for respiratory symptoms	**24/7 Integrated Primary Care Services** • Same Day Primary Care Services • Integration between services across the 24hr period • Digital access to support same day	**Maximise PCAL and develop SDEC** Avoid unnecessary ED attendances by facilitating healthcare providers to get people to the right place for their care	**Urgent community response** • 2 hour crisis response offer • Telecare Rapid Falls response • Virtual wards (hospital at home and remote monitoring)

NHS national priorities	• Improve A&E waiting times to align with 4-hour target, reduce 12-hour waits • Improve category 2 ambulance response times to an average of 30 minutes • Reduce adult general and acute (G&A) bed occupancy levels • Step up out of hospital capacity including Virtual Ward Capacity
Core20PLUS5	Focus on the most deprived communities and plus groups

WYICS 10 Big Ambitions: We will increase the years of life that people live in good health **WY programmes** Same Day emergency care	**Health and Wellbeing Strategy (2023-2030):** The best care at the right place at the right time	**Local strategies and plans** NHS planning submission for planned care, diagnostics and outpatients

Population
Planned Care

Population definition
anyone being referred for, or awaiting a planned care procedure, treatment or appointment either in a community or hospital setting

Outcomes	Planned Care services are accessible to all regardless of who they are	People are supported whilst waiting for all planned care services	People agree appropriate and realistic shared health goals, and actively participate in their achievement

Key workstreams	**Managing capacity and elective recovery** • Community Gynae re-design • Procurement Community Ophthalmology Services • Procurement ENT & Adult Hearing Loss Services • Covid Urgent Eyecare Service (CUES) • Procurement of Community Gastro/ Endoscopy services • MSK Service Review	**Earlier Diagnosis** Implementation of Leeds Community Diagnostic Centres - Direct access to diagnostics understanding uptake and variation across Leeds	**Waiting Support** **Waiting Well for Planned Care –** support provided by Care navigator/support workers targeting people in the most deprived areas and working with PCNs that have highest utilisers of A&E whilst waiting for planned care **Shape up for Surgery** care navigator/support worker expansion to ensure patients are optimised for surgery/treatment with a focus on the most deprived areas	**Outpatients Redesign** Expansion of Advice and Guidance Increase use of Patient Initiated Follow up (PIFU) Reduction in outpatient follow up

NHS national priorities	• Eliminate waits of over 65 weeks for elective care (except where patients choose to wait longer or in specific specialties) • Deliver the system specific activity target • Increase the percentage of patients that receive a diagnostic test within six weeks • Deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostic waiting time ambition • Performance against 18-week Referral to Treatment waiting time standard
Core20PLUS5	Focus on the most deprived communities and plus groups across core clinical areas

WYICS 10 Big Ambitions: We will increase the years of life that people live in good health **WY programmes** Recover and transform planned care services	**Health and Wellbeing Strategy (2023-2030):** • The best care in the right place at the right time • An inclusive, valued, and well-trained workforce • Promoting prevention and improving health outcomes through an integrated health and care system	**Local strategies and plans** NHS planning submission for planned care, diagnostics and outpatients

Population
Primary Care

Outcomes	Improved care experience for patients with patients receiving appropriate and timely access, advice and care	Improved Health Outcomes	Reduced Health Inequalities	An improved work experience for staff, volunteers and carers

Key workstreams	**Optimising access to primary care** Implementation of the Primary Care Access Recovery Plan with a focus on cloud-based telephony, review capacity and demand models of care and new online consultation system and expanding the role of community pharmacy	**CVD prevention and diagnosis** Quality improvement across the PCN to address: • identification of hypertension • detection and management of atrial fibrillation (AF); • addressing cholesterol in the context of CVD risk, including detection and management of familial hypercholesterolaemia (FH); • earlier diagnosis of heart failure	**Annual health checks for people with LD** With a focus on those patients that have not received an AHC in previous 18 months	**Tackling neighbourhood health inequalities** Focussing on meeting unmet need at a local community level (PCN/LCP)	**Dementia Diagnosis** Practices to review dementia prevalence rate and identity patients at clinical risk of dementia and offer assessment and referral	**Personalised care** Targeted programme of social prescribing to an identified cohort with unmet need

NHS national priorities	• 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 the trajectory to deliver more appointments in general practice • Increase the workforce (recruit 26,000 (515wte for Leeds) Additional Roles Reimbursement Scheme by March 2024	• Support the Health and Wellbeing of the Workforce through supporting the QOF QI module • By 30 June 2023, PCNs to develop an access improvement plan which will improve patient experience of contacting their practices and being assessed and/or seen within the appropriate timeframe (for example same day or within 2 weeks where appropriate).

Core20PLUS5	Focus on the most deprived communities and plus groups

WYICS 10 Big Ambitions:
- We will increase the years of life that people live in good health
- Address the health inequality gap for children living in households with the lowest incomes
- 10% reduction in the gap in life expectancy between people with mental health conditions, learning disabilities and/or autism

WY programmes
Primary care transformation

Health and Wellbeing Strategy (2023-2030):
- The best care in the right place at the right time
- Support for carers and enable people to maintain independent lives
- Promoting prevention and improving health outcomes through an integrated health and care system

Local strategies and plans
- Core GP Contract
- Fuller Stocktake
- Access Recovery Plan
- PCN Directed Enhanced Service

Enablers

For Leeds to achieve the goals of the Healthy Leeds Plan and the vision of the Health and Wellbeing Strategy, it will need to harness the power of our city-wide enablers – building blocks for a transformative health and care system. These include our capabilities around digital, engagement and involvement, communications, estates, finance, quality improvement and workforce.

Our Workforce

The Leeds One Workforce Strategic Board (LOWSB) brings partners together to understand and prioritise the strategic actions required to strengthen and support our health and care workforce. There are seven strategic priorities of the LOWSB, including; 1. Integrated Workforce Design, 2. Growing & Developing Registrants, 3. Working Across Organisations 4. Preventing ill-health 5. Narrowing Inequalities and 6. Learning Together and Improving Health and Wellbeing. These priorities will help empower Leeds health and care staff to support the delivery the city's vision.

Within each strategic workforce priority there are a series of collaborative initiatives that together form the Leeds One Workforce programme, coordinated by the Leeds Health and Care Academy.

The approach taken to workforce issues in Leeds enables all partners in the health and care system to drive forward shared strategic workforce priorities in an integrated way, with the ambition of optimising investment and resource, focusing expertise, coordinating activity and ensuring benefits are realised for the whole health and care system.

Research and academia

The Leeds Academic Health Partnership (LAHP) is one of the largest and most diverse academic partnerships in the UK. It is a collaboration between three of the city's universities, our local NHS organisations, Leeds City Council, Leeds City College, the regional health and care partnership, the regional economic enterprise partnership, industry and third sector organisations. The LAHP draws on this collection of world-class expertise to discover transformative, sustainable solutions that can help solve some of the city's hardest healthcare challenges.

Communication and Involvement

The Leeds People's Voices Partnership (PVP) brings engagement and involvement leads from across the partnership together to share their work. Their common aim is 'to improve the way we hear the voices of local people, particularly those living with the greatest health inequalities'.

The aspiration is that insight (collected from people living in Leeds) is used alongside data to give our decision makers the tools they need to really put peoples voices at the centre of decision making.

The Strategic Communications Group (SCG), and its supporting Operations group (OCG), brings together communications professionals from across the partnership. Their aim is to focus Communications teams across the city on supporting the key strategic priority areas, to create insight driven behaviour change campaigns and to promote the work of the partnership to internal and external audiences.

Leadership and culture

A focus for our health and care partnership is to deliver system leadership, culture and change focussed on developing skills and behaviours underpinning integrated care. Working as 'Team Leeds' our leaders have a one city voice with a shared understanding and ownership of unified positions and messages that improves the health and wellbeing of our population. Using a common narrative, we will clearly describe why we work together, what we aim to achieve, and how we will do it together. We will consistently reflect our shared vision and ambition in the plans and individual contributions of all partners.

The Health and Wellbeing Board provides leadership and direction to help influence partners and stakeholders within Leeds to achieve the five Health and Wellbeing Strategy outcomes for all people and communities in the city. The Board also uses its influence to support organisations across sectors and key partnerships to drive personalisation in health and care, transform the use of information and analytics and create a culture of innovation in the city which will improve outcomes for people. Furthermore, helping to build a strong research culture in the city, which empowers our workforce to use evidence to make a difference to tackling health inequalities and improving health and wellbeing outcomes for all ages.

Data and intelligence

The Office of Data Analytics (ODA) is a citywide partnership between Leeds City Council and the ICB in Leeds, which aims to provide one central source of data and information to all partners, including the city's Population and Care Delivery Boards. The ODA works closely with clinicians and professionals and supports wider training and skills to make use of the data, insight and information it produces. Leeds benefits from an advanced linked data set, called the Leeds Data Model (LDM), which is maintained by the ODA. The LDM brings together primary, secondary, and community care data in pseudonymised form to create a picture of the health of the Leeds-registered population. The LDM contains information on population needs and disease prevalence, socio-demographics, service utilisation and (through combining these sets of information), population health inequalities This data is further enhanced by the intelligence and insight we received from communities and people's voices supporting the boards to meet the needs and outcomes for their population. This data and insight is used to enable and improve decision making and support delivery of the city strategies and plans. The insight from the LDM and communities are integral to enabling Boards to develop a good understanding of their population.

The Local Care Partnerships, with support from the ODA, is implementing a community-based model to increase digital health participation. As services increase their digital solution offer to improve access and responsiveness for patients this can often negatively impact our most vulnerable communities and we know that people who are digitally excluded are also more likely to be heavier users of face-to-face services. The city's digital health hubs work closely with specific demographics with poorer health outcomes to support our city ambition of improving the health of the poorest the fastest. Increasing digital inclusion and health literacy provides people with the skills and knowledge to access support information and self-management tools to improve their health and wellbeing as well as supporting them in other areas such as education, skills and employment. This, in turn, reduces the demand for unnecessary appointments and leads to fewer hospital appointments, supporting achievement of our system goals.

In addition, the development of the shared care record in Leeds will further open-up healthcare records, through appropriate access controls, to those who need to see them, including citizens. Our aim is to provide one version and central source of data and information accessible by all partners to enable the identification and reduction of variation, short and long-term planning, continual quality improvement as well as effective operational management. Staff have training and skills to use data, insight and information as intelligence to drive change; and citizens can access data about themselves and their community to help them take ownership for their health and wellbeing. Through the ODA, we:

- Drive efficiency and build capacity through appropriate use of technology and automation, with the aim of delivering outcome-focussed intelligence
- Enable data-driven health and care service improvement, demonstrating the positive impact of health and care interventions through appropriate, accessible data visualisation and presentation.
- Work with partners across the city to ensure access to data and insights; and to drive improvement in data literacy, encouraging curiosity and confidence.
- Promote a person-centred approach to intelligence.
- Innovate with leading edge technology and accessible products, with a “cloud first” and “do it once, share many” approach.
- Influence, advise and advocate best practice in use of data and insights.
- Apply robust information governance around our data assets and data sharing protocols and processes to keep our information assets safe and secure.
- Apply transparency by openly publishing central standards, our processes and methodologies.

Digital

By making better use of data and technology, and by taking a person-centred approach to service design and delivery, we will improve the way we can support people in their daily lives, helping them achieve their ambitions and overcoming any challenges they may face.

The Digital Strategy for Leeds has been written to underpin Leeds’ Best City Ambition and describes the key underpinning initiatives that we will put into place to ensure people are not left behind as we move towards our digital-first approach to delivering services. Each of these foundations underpin everything we do and provides the basis of how we intend to use existing and emerging technologies to serve the people of Leeds.

Data management, access and use: Better collection, management, and use of data that facilitates the delivery of improved, personalised services.

Connectivity and infrastructure: Delivery of 21st century connectivity and infrastructure that provides the backbone for world-class service delivery.

Digital inclusion: Continuing work with people to ensure equal opportunity to develop skills and access digital tools, technology and services that are the right for them.

Digital skills: Lifelong learning that ensures people continually have the right skills to get online, access digital services, and do their job effectively.

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

Our Digital Strategy mirrors the 'life course approach' to clearly articulate the impact of our plans for digital at every stage of a person's life from early years to older age – Starting well, Living well, Working well and Ageing well.

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

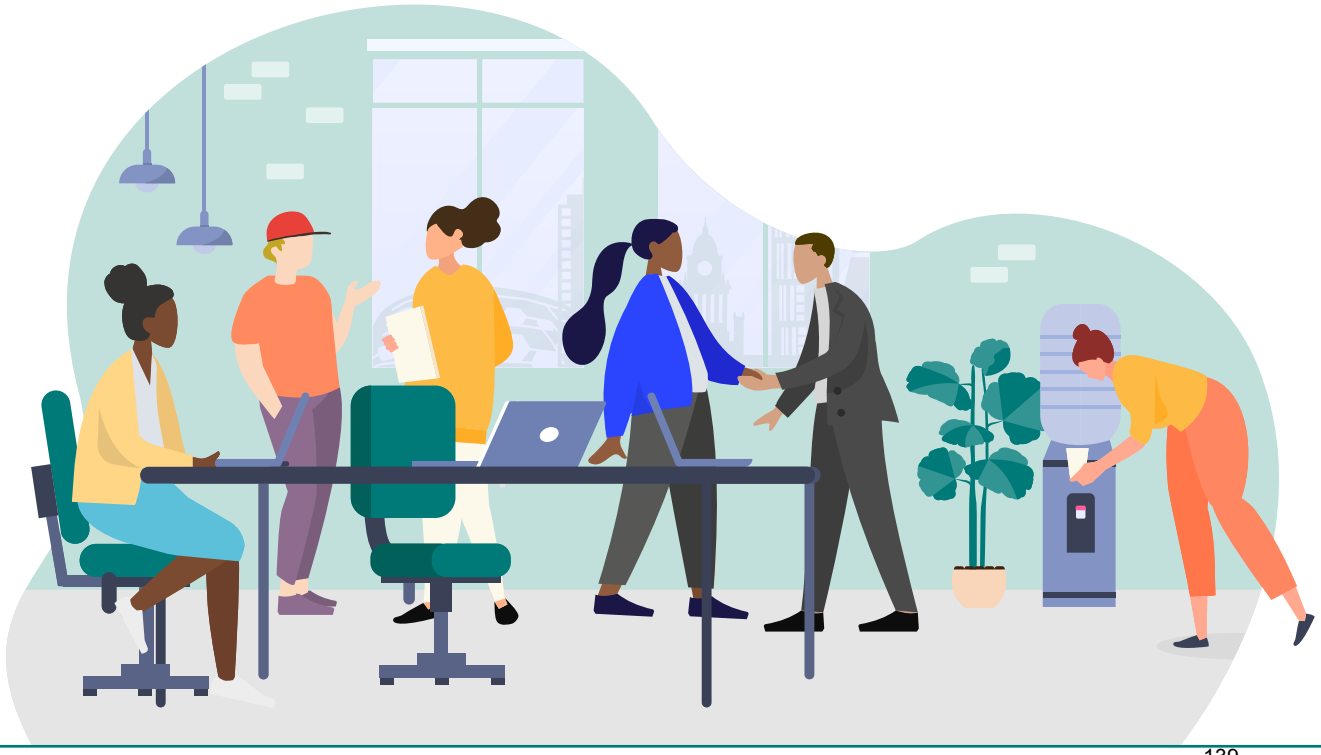
- using data (disaggregated by deprivation and key demographic variables) to identify and eliminate inequities;
- introduce new ways to stay healthy including education and services; and
- ensuring that all children can access and use technology.

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

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

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

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



Estates

Our vision is that Leeds will have a world class health and care estate that has great places to access services and to work, creating and supporting patient and staff wellbeing. Spaces will be flexible and fit for purpose, enabling services to be delivered in the communities where they are needed most, tackling health inequalities, and achieving a healthy population. Our estate is an enabler to support reducing health inequalities, effective system integration, digital transformation, workforce wellbeing, future growth and service redesign and importantly achieving our system goals.

Quality improvement

Quality improvement is about establishing a culture of continual improvement and theory of change philosophy that is embedded at all levels of the system and can be articulated by leaders at every level and in every profession. Each organisation will continue to use their established ongoing quality improvement methodology. However, where partners come together, we will increasingly adopt a common quality improvement language, core skills and set of tools. We will create the conditions that enable staff to identify, lead and deliver improvement and change and ensure all staff understand that they have two facets to their role: their core job (doctor, nurse, social worker, administrator etc); and the job to continually improve the quality, efficiency and effectiveness of the way they deliver work.

A model has been developed to highlight the potential architecture for the QI capability at system level and this is aligned to our organisational objectives. The Leeds Quality Improvement Collaborative has been established and continues to explore opportunities for collaborative QI work and are planning to develop a quality improvement framework during 2023, based around the people, processes and structures required from a system level perspective.

Financial Stewardship

As a partnership we will undertake financial planning in an open and transparent way, ensuring all partners can individually and collectively articulate how the system acts as a steward of all resources to drive the greatest health gain for the population and the financial sustainability of all partners.

Plenary and Next Steps

Our Healthy Leeds Plan sets out the contribution of the Health and Care System towards achieving the vision of our Health and Wellbeing Strategy. This work will be driven through our Leeds Health and Care Partnership, which will work to improve outcomes for the people of Leeds, experience of health and care services and the use of the Leeds pound through our two shared system goals and a focus on the 26% of the population who live in the 10% most deprived areas nationally. These goals are:

1. Reduce preventable unplanned care utilisation across health settings
2. Increase early identification and intervention (of both, risk factors and actual physical and mental illness)

To meet these we will apply an evidence-based, population health approach to drive innovation and deliver person-centred, integrated health and care for the people of Leeds. This will be supported by our city's capabilities – including digital, estates, workforce, quality improvement and research. Our initial five areas of focus will evolve over time, as the Leeds Health and Care Partnership draws on these capabilities and in doing so develops increasingly sophisticated methods for identifying need and intervening early to prevent poor outcomes. These will be used to identify future priorities, but for now, our next steps over the first few years of this plan are to bring about positive change within the priority areas identified. The trajectories and plans in the following appendices summarise our ongoing and continued work to improve the effectiveness, efficiency and impact of health and care services in Leeds, and summarise the work already in train to ensure Leeds continues to make progress on national requirements and indicators.

NB: Glossary to be included

Appendix One:
Leeds Operational Plan - Anticipated trajectories for National Indicators

Appendix Two:
Leeds Operational Plan Implementation

Appendix One: Leeds Operational Plan - Anticipated trajectories for National Indicators

This appendix summarises the Plan against the 31 National Objectives for Leeds. It summarises current performance, anticipated performance by March 2024, the board overseeing the work and interventions that will be made over the next 12 months to support the system in meeting the target.

Please note – the code next to each intervention sets out where in the document you can find more detail on that intervention in appendix 2. For example – CAN1 is the first intervention listed in the Cancer implementation plan that can be found in appendix 2.

No	National Planning Objective	Baseline position	Anticipated Position March 2024	Interventions to support achievement	Board Overseeing Progress
1	**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	76.5% (April 23)	76%	• Enhanced Community Response - deliver urgent community response services aiming to reduce disruption to people's lives via alternatives to ED attendance/admissions to hospital (SDR1) • Covid Urgent Eyecare Service (CUES) (PC3) • Social prescribing in A&E (HA4) • PCAL+ Creating a new single gateway that brings together the Primary Care Access Line (PCAL) and the Single Point Urgent Referral (SPUR) & Yorkshire Ambulance Service (YAS) push model (SDR1) • Enhanced Care at Home - Improving our urgent community offer to support people at home and reduce unplanned admissions (HF1) • Active Recovery at Home - Increasing the number of people who are able to be supported at home following hospital discharge (HF2) • Rehab and Recovery Beds - optimising and recommissioning intermediate care beds in Leeds (HF3) • Transfers of Care - streamlining our transfers of care between acute and intermediate care services to reduce the non-value-added time (HF4) • Community Ambulatory Paediatric Service (CAPS) – (SDR2)	Same Day Response Board and System Flow Steering Group

No	National Planning Objective	Baseline position	Anticipated Position March 2024	Interventions to support achievement	Board Overseeing Progress
2	**Urgent and Emergency Care -** 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	34 minutes – YAS footprint wider than Leeds area (March 23)	Not reported at place level	• Many of the above areas will contribute towards this • Yorkshire Ambulance Service (YAS) regional transformational work which includes expanding capacity, transforming services and improving efficiencies.	Same Day Response Board
3	**Urgent and Emergency Care -** Reduce adult general and acute (G&A) bed occupancy to 92% or below	98.1% (April 23)	98% (Occupancy of 92% not possible given level of demand, with any further reduction used to support elective recovery)	• Out of Hospital Project for those with no fixed abode / multiple complex disadvantages (HA1) • PCAL+ Creating a new single gateway that brings together PCAL and SPUR & Yorkshire Ambulance Service (YAS) push model (SDR1) • Community Ambulatory Paediatric Service (CAPS) – (SDR2) • Enhanced Community Response - deliver urgent community response services aiming to reduce disruption to people's lives via alternatives to ED attendance/admissions to hospital (SDR4) • Active Recovery at Home - Increasing the number of people who are able to be supported at home following hospital discharge (HF2) • Rehab and Recovery Beds - optimising and recommissioning intermediate care beds in Leeds (HF3) • Transfers of Care - streamlining our transfers of care between acute and intermediate care services to reduce the non-value-added time (HF4)	System Flow Steering Group
4	**Community Health Services** - Consistently meet or exceed the 70% 2-hour urgent community response (UCR) standard	56% (March 23)	70%	• Enhanced Community Response (SDR1) • Enhanced Care at Home - Improving our urgent community offer to support people at home and reduce unplanned admissions (HF1)	Same Day Response Board / Frailty Board

No	National Planning Objective	Baseline position	Anticipated Position March 2024	Interventions to support achievement	Board Overseeing Progress
5	**Primary Care -** Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals	No measure	No measure	• Children's system flow (CYP2) • Digital - remote monitoring implementation for 3 plus LTCs and mental health (LTC1) • Long Covid review and rehabilitation model development (LTC2) • A number of respiratory initiatives including MART (maintenance and reliver therapies), Expansion of pulmonary rehab, Spirometry next steps (LTC3) • CUES (Covid Urgent Eyecare Service) (PC3) • Advice and Guidance (PC10) • Ophthalmology re-procurement (PC8) • Social Prescribing (HA4) • Community digital health hubs (HA3) • Integrated Weight Management (LTC10) • Multimorbidity (3 LTCs Plus MH) - delivery of Diabetes Steering Group Work (LTC4)	Primary Care Board
6	**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	81.4% (February 23)	Anticipated target to be established	• Enhanced Access service (PRI2)	Primary Care Board
7	**Primary Care -** Continue on the trajectory to deliver 50 million more appointments in general practice by the end of March 2024	4,980k (March 23)	5,019k	• Implementation of the access recovery plan (PRI1) • Delivery of the Primary Care Workforce Action plan (PRI5)	Primary Care Board
8	**Primary Care -** Continue to recruit 26,000 Additional Roles	295 WTE (April 23)	515 WTE by December	• Delivery of the Primary Care Workforce Action plan (PRI5)	Primary Care Board

No	National Planning Objective	Baseline position	Anticipated Position March 2024	Interventions to support achievement	Board Overseeing Progress
	Reimbursement Scheme (ARRS) roles by the end of March 2024				
9	**Primary Care -** Recover dental activity, improving units of dental activity (UDAs) towards pre-pandemic levels	To be reported on at a West Yorkshire Level			
10	**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)	715 (March 23) – was not a requirement for 22/23	0	• Ophthalmology re-procurement (PC8) • ENT and Adult Hearing Loss re-procurement (PC4) • Gastro re-procurement (PC5) • Reduction in outpatient follow up (PC11) • Advice and Guidance (PC10) • Waiting well for Planned Care (PC13)	Planned Care Board
11	**Elective Care** - Elective activity levels as a proportion of 19/20 activity reaching 108%	N/A	106.5%	• Increased use of Patient Initiated Follow Up (PIFU) (PC9) • ENT and Adult Hearing Loss re-procurement (PC4) • Reduction in outpatient follow up (PC11)	Planned Care Board
12	**Cancer** - Continue to reduce the number of patients waiting over 62 days	329 (February 23)	288 people	• 2 week wait (2ww) frailty assessment clinics (CAN10) • Optimal Pathways: Head and Neck, Gynae, Prostrate, Bladder, Lung, Skin, Colorectal, Upper GI, Pancreas (CAN11) • MDT Streamlining (CAN11)	Cancer Board
13	**Cancer** - 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	75.5% (March 23)	75%	• Implement faecal immunochemical test (FIT) (CAN1) • 2ww frailty assessment clinics (CAN10) • Open Access Chest X-ray (CAN4) • Practice Nurse Training enable to request chest x-rays (CAN5) • Brain and central nervous pathway – developing a straight to test pathway (CAN6) • Teledermatology (CAN3) • Optimal Pathways: Head and Neck, Gynae, Prostrate, Bladder, Lung, Skin, Colorectal, Upper GI, Pancreas (CAN11)	Cancer Board
14	**Cancer** - Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the	56% (December 22) – WY footprint wider than Leeds area	Place data not available	• Pinpoint blood test (CAN2) • Teledermatology (CAN3) • Implementation of breast pain clinic (CAN8)	Cancer Board

No	National Planning Objective	Baseline position	Anticipated Position March 2024	Interventions to support achievement	Board Overseeing Progress
	75% early diagnosis ambition by 2028			• Implement FIT (CAN1) • Open Access Chest X-ray (CAN4) • Practice Nurse Training enable to request chest x-rays (CAN5) • Brain and central nervous pathway – developing a straight to test pathway (CAN6)Lung screening (CAN11)	
15	**Diagnostics -** Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%	90.4% (February 23)	95%	• Community diagnostic centres in Seacroft Hospital, Armley and Beeston Medical Centres (PC2) • LTHT Transformation Program – Diagnostics (PC12) • Gastro re-procurement (PC5)	Planned Care Board
16	**Diagnostics -** Deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostic waiting time ambition	No specific target	No specific target	• Community diagnostic centres in Seacroft Hospital, Armley and Beeston Medical Centres (PC2) • LTHT Transformation Program -Diagnostics (PC12)	Planned Care Board
17	**Maternity** - Make progress towards the national safety ambition to reduce stillbirth, neonatal mortality, maternal mortality and serious intrapartum brain injury	Still birth rate 3.9 per 1000 births (February 23)	Still birth rate <3.5 per 1000 births Neonatal mortality </= 3.55 per 1000 births Maternal mortality (direct causes) 0 Serious intrapartum brain injury </=10 p/a	Single delivery plan includes: • MNVP (Maternity and Neonatal Voices Partnership) Deep dive into engagement with service users to ensure care is accessible and close to home (M1). • Gestational Diabetes – targeted healthy eating and physical activity interventions (M2) • Doulas (M3) • Maternity Mental Health (M4)	Maternity Board

No	National Planning Objective	Baseline position	Anticipated Position March 2024	Interventions to support achievement	Board Overseeing Progress
18	**Maternity** - Increase fill rates against funded establishment for maternity staff	Q3 2022 data: Midwifery workforce 342.21 WTE Obstetric workforce 87.82 WTE Neonatal nurses 128.32 WTE Neonatal consultants 11.5 WTE Aesthetic workforce 9 sessions per week	Midwifery workforce – 363.36 WTE Obstetric workforce - 91.62 WTE Neonatal nurses - 151.97 WTE Neonatal consultants – 13 WTE Aesthetic workforce – 12 sessions per week	As a system we are focused on implementing the recommendations through the single delivery plan including the workforce element	Maternity Board
19	**Use of Resources** - Deliver a balanced net system financial position for 2023/24	Description of plan can be found in the main HLP			
20	**Workforce** - Improve retention and staff attendance through a systematic focus on all elements of the NHS People Promise	Description of plan can be found in the main HLP – coordinated by Strategic One Workforce Board			
21	**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)	8990 rolling 12 months	8800 rolling 12 months	• Compassionate Leeds - identifies areas where our current systems are failing to provide the intervention and support that children and families need which align to the themes of improvement identified through the national Early Help Review. (CYP1) • Prevention/timely access to services (CYP3)	Children and Young People's Board

No	National Planning Objective	Baseline position	Anticipated Position March 2024	Interventions to support achievement	Board Overseeing Progress
22	**Mental Health –** Increase the number of adults and older adults accessing IAPT treatment	7212 (22/23 – Q4)	7202	• Working to reduce waiting times to access NHS Talking Therapies (MH4)	Severe Mental Illness board
23	**Mental Health –** Achieve a 5% year on year increase in the number of adults and older adults supported by community mental health services	10,275 (February 23)	11,693	• Community Mental Health Transformation - Mobilisation of new integrated model of care for community mental health with Local Care Partnerships and PCNs (MH1) • Community Mental Health Transformation - Developing and increasing capacity in psychological therapies for people with SMI and more complex needs (MH2) • Community Mental Health Transformation – Developing and testing new workforce roles (MH3) • Early intervention in psychosis pathway - Further develop EIP to incorporate identification and intervention for those with at-risk mental states (MH7)	Severe Mental Illness board
24	**Mental Health –** Work towards eliminating inappropriate adult acute out of area placements	663 bed days (Q2 22/23)	450 bed days	• Community Mental Health Transformation - Mobilisation of new integrated model of care for community mental health with Local Care Partnerships and PCNs (MH1) • Community Mental Health Transformation - Developing and increasing capacity in psychological therapies for people with SMI and more complex needs (MH2) • Community Mental Health Transformation – Developing and testing new workforce roles (MH3) • Review and evaluation of MH crisis provision and models of crisis alternatives & crisis pathway redesign (MH5)	Severe Mental Illness board
25	**Mental Health –** Recover the dementia diagnosis rate to 66.7%	68.7% (March 23)	68.5%	• Practices to review their dementia prevalence rate and identify patients at clinical risk of dementia and offer assessment and referral (QIS) (PRI4)	Severe Mental Illness board and Frailty board
26	**Mental Health –** Improve access to perinatal mental health services	770 (March 23)	863	• Maternity Mental Health Service (M4)	Maternity Board and Mental Health Board

No	National Planning Objective	Baseline position	Anticipated Position March 2024	Interventions to support achievement	Board Overseeing Progress
27	**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	83% (March 23)	75 %	• Annual health checks for people with LD - Focus on those patients who have not received an annual health check in previous 18 months (QIS) (PRI3)	Primary Care Board
28	**People with a learning disability and autistic people** - 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	31 across ICB and NHSE commissioned beds (22/23 Q3)	26 (15 commissioned by the ICB and 11 NHSE / Provider collaborative)	• No new initiatives planned for the next 12 months although an initiative focused on LD/Autism step-up crisis alternative is in the process of being scoped	People with a Learning Disability and Neurodiversity board
29	**Prevention and Health Inequalities -** Increase percentage of patients with hypertension treated to NICE guidance to 77% by March 2024	65.9% (22/23 Q4)	77%	• Multimorbidity (3 LTCs Plus MH) - delivery of CVD Steering Group Work (LTC5)	Long Term Conditions Board

No	National Planning Objective	Baseline position	Anticipated Position March 2024	Interventions to support achievement	Board Overseeing Progress
30	**Prevention and Health Inequalities -** 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%	63.9% (22/23 Q4)	60%	• InHIP project delivery - WY/AHSN funded Health Inequalities project (LTC7) • STF Project Lipids - Project delivery on behalf of WY and Leeds (LTC8)	Long Term Conditions Board
31	**Prevention and Health Inequalities -** Continue to address health inequalities and deliver on the Core20PLUS5 approach	Current performance not available	No specific target yet	• Waiting well for Planned Care (PC13) • LCP community grants, Social Prescribing, SP community of practice, digital health hubs (HA3). • Social Prescribing in A&E; home plus; unplanned care for healthy adults (HA4) • Compassionate Leeds (CYP1) • Prevention/timely access to services for children and young people (CYP3) • Out of Hospital Project for those with no fixed abode / multiple complex disadvantages (HA1) • Women's health programme (HA2)	Within the scope of all boards

Leeds Health & Care Partnership

Appendix Two - Leeds Operational Plan implementation

The following pages describe initiatives that our population and care delivery boards will be overseeing implementation or continued implementation of over the next year to impact on either our place goals, West Yorkshire 10 Ambitions or NHS National Objectives.

Implementation Plan 23/24 Cancer

No	Workstream / Project	Description	Related Population Outcome	Impact on Place Goals	Impact on West Yorkshire 10 Ambitions	Impact on NHS National Objective	Timescales for Implementation
CAN1	Earlier Diagnosis - Implement FIT	Agreeing and implementing a pathway change to incorporate faecal immunochemical test (FIT) testing within the Lower GI 2 Week Wait (2WW) pathway	People with cancer in Leeds will be diagnosed earlier when evidence shows this to be beneficial	Goal 2 – Increase early identification and intervention	Early Diagnosis Rates for Cancer	Meet the cancer faster diagnosis standard by March 2024 Increase the percentage of cancers diagnosed at stages 1 and 2	**Start date:** July 2023
CAN2	Earlier Diagnosis - Pinpoint	Evaluation of the Pinpoint blood test which aims to use biomarkers, patient history and demographic to create a cancer risk score for patients attending primary care with symptoms.	People with cancer in Leeds will be diagnosed earlier when evidence shows this to be beneficial	Goal 2 – Increase early identification and intervention	Early Diagnosis Rates for Cancer	Increase the percentage of cancers diagnosed at stages 1 and 2	**Start date:** April 2022
CAN3	Earlier Diagnosis - Teledermatology	Rollout of new cameras for teledermatology in primary care. Work is ongoing to identify funding to also replace dermatascopes and to create a larger pool of camera stock	People with cancer in Leeds will be diagnosed earlier when evidence shows this to be beneficial	Goal 2 – Increase early identification and intervention	Early Diagnosis Rates for Cancer	Meet the cancer faster diagnosis standard by March 2024 Increase the percentage of cancers diagnosed at stages 1 and 2	**Start date:** June 2023
CAN4	Earlier Diagnosis – Open Access Chest x-ray	Re-starting of the open access chest x-ray service for patients with concerns around lung cancer symptoms. The re-launch will be accompanied by a publicity campaign to ensure that as many people as possible can benefit from the service.	People with cancer in Leeds will be diagnosed earlier when evidence shows this to be beneficial	Goal 1 - Reduce avoidable unplanned care utilisation across health settings through a focus on keeping people well	Early Diagnosis Rates for Cancer	Meet the cancer faster diagnosis standard by March 2024 Increase the percentage of cancers diagnosed at stages 1 and 2	**Start date:** September 2023

No	Workstream / Project	Description	Related Population Outcome	Impact on Place Goals	Impact on West Yorkshire 10 Ambitions	Impact on NHS National Objective	Timescales for Implementation
CAN5	Earlier Diagnosis – Practice Nurse Training enable to request chest x-rays	Training to enable practice nurses to access ICE and request chest x-rays for patients for whom they have a concern of lung cancer. This will cut down on the need for GPs to make these referrals and for patients to reattend following a nurse appointment	People with cancer in Leeds will be diagnosed earlier when evidence shows this to be beneficial	Goal 2 – Increase early identification and intervention	Early Diagnosis Rates for Cancer	Meet the cancer faster diagnosis standard by March 2024 Increase the percentage of cancers diagnosed at stages 1 and 2	**Start date:** April 2023
CAN6	Earlier Diagnosis – Brain and central nervous pathway	Work to develop a straight to test pathway for brain 2 week wait referrals	People with cancer in Leeds will be diagnosed earlier when evidence shows this to be beneficial	Goal 2 – Increase early identification and intervention	Early Diagnosis Rates for Cancer	Meet the cancer faster diagnosis standard by March 2024 Increase the percentage of cancers diagnosed at stages 1 and 2	**Start date:** June 2023
CAN7	Screening and Prevention - Primary Care Screening Champions	Funding to pay for protected time for individuals in the 45 most deprived practices in Leeds to put in place programmes to encourage increased uptake of cervical and bowel screening amongst their patient populations	People living with cancer will receive person centred care	Goal 2 – Increase early identification and intervention	Early Diagnosis Rates for Cancer	N/A	**Start date:** April 2023
CAN8	Person Centred Care – Breast Pain Clinic	Implementation of a specific breast pain clinic to ensure that patients who are suffering from breast pain but who otherwise do not meet the 2 week wait (2ww) criteria for referral are able to access advice, support, and treatment as necessary	People living with cancer will receive person centred care	Goal 2 – Increase early identification and intervention	Early Diagnosis Rates for Cancer	Increase the percentage of cancers diagnosed at stages 1 and 2	**Start date:** Oct 22
CAN9	Person Centred Care – Pre-hab	Launch of a service funded by Macmillan to ensure that patients undergoing cancer treatment are physically prepared and fit enough to withstand the treatment that they are due to	People living with cancer will receive person centred care	N/A	Early Diagnosis Rates for Cancer	N/A	**Start date:** June 2023

No	Workstream / Project	Description	Related Population Outcome	Impact on Place Goals	Impact on West Yorkshire 10 Ambitions	Impact on NHS National Objective	Timescales for Implementation
		undergo and that patients maintain a healthy lifestyle after treatment. This will help to ensure that as many treatments as possible are successful					
CAN10	Person Centred Care – 2 week wait (2ww) frailty assessment clinics	Developing frailty clinics to assess frail patients who have been referred on the 2ww pathway (starting with Lower GI) to ensure that they are fit for investigations, that they are aware of what pathways entail and that they want to continue with diagnosis and treatment.	People living with cancer will receive person centred care	Goal 1 - Reduce avoidable unplanned care utilisation across health settings through a focus on keeping people well	N/A	Meet the cancer faster diagnosis standard by March 2024 Cancer - Continue to reduce the number of patients waiting over 62 days	**Start date:** October 2022
CAN11	LTHT Transformation Programmes	A range of programmes being led within LTHT by the Corporate Cancer Team, including: Lung screening, MDT streamlining, Cardio-Oncology, Pelvic Exenteration, patient education programmes, end of treatments summaries, health needs assessments/ cancer care reviews Optimal Pathways: Head & Neck, Gynae, Prostate, Bladder, Lung, Skin, Colorectal, Upper GI, Pancreas	People will receive the safest and most effective cancer treatments that are available	N/A	Early Diagnosis Rates for Cancer	Meet the cancer faster diagnosis standard by March 2024 Cancer - Continue to reduce the number of patients waiting over 62 days Increase the percentage of cancers diagnosed at stages 1 and 2	**Start date:** Across 2023

Implementation Plan 23/24 Children and Young People

No	Workstream / Project	Description	Related Population Outcome	Impact on Place Goals	Impact on West Yorkshire 10 Ambitions	Impact on NHS National Objective	Timescales for Implementation
CYP1	Keeping Children Safe From Harm – Compassionate Leeds	The Compassionate Leeds case identifies areas where our current systems are failing to provide the intervention and support that children and families need which align to the themes of improvement identified through the national Early Help Review. The case develops our response to supporting our most vulnerable cohorts of children and young people with the ultimate aim of addressing the impact of trauma and adverse life experiences. There are 7 discreet projects that sit within the case: 1. Integrated Trauma Resource Team 2. Futures 3. Community mental health offer 4. Child and Family hubs 5. Cluster based neurodevelopmental support 6. Neurodevelopment assessment and training for children looked after 7. Therapy for adolescents on the edge of care.	Children are safe from harm	Goal 2 – Increase early identification and intervention	We will increase the years of life that people live in good health Halt the trend in childhood obesity	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 Continue to address health inequalities and deliver on the Core20PLUS5 approach	**Start date:** June 2023
CYP2	Children's System Flow	Aim to deliver better system flow for children, which creates a proactive and reactive model of population health management, in which children are seen earlier, and in the most appropriate location. The case describes an approach to system flow in two parts:	Children in Leeds are healthy	Goal 1 - Reduce avoidable unplanned care utilisation across health settings through a focus on keeping people well	We will increase the years of life that people live in good health	Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals	**Start date:** April 2023

No	Workstream / Project	Description	Related Population Outcome	Impact on Place Goals	Impact on West Yorkshire 10 Ambitions	Impact on NHS National Objective	Timescales for Implementation
		1.Children's Care in the Community 1a. Child and Family Community Hubs 1b. Children's Ambulatory Paediatric Service (CAPS) 2.Optimisation of the Children's Assessment and Treatment (CAT) Unit 2a. Healthier at Home 2b. Community IV antibiotics service 2c. Other virtual wards This is all underpinned by an expansion of the CAT workforce which also enables better optimisation of the CAT rota.					
CYP3	Children's Mental Health Prevention (Children are happy and have fun) - Prevention/timely access to services	Several projects are included within this workstream to ensure children and young people receive timely access to community based mental health services these also involve a number of thematic reviews to ensure best value. These include: - Role out of the Mental Health Support Teams - Review of our third sector SEMH offer (The Market Place and Leeds Mind (THRU)) - Review of our locality-based support offer (including MindMate Wellbeing cluster support) - Review of the digital support offer	Children are happy and have fun	Goal 2 – Increase early identification and intervention	We will increase the years of life that people live in good 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 Continue to address health inequalities and deliver on the Core20PLUS5 approach	**Start date:** From 2020 – 2023 (multiple projects)

Implementation Plan 23/24 End of Life

No	Workstream / Project	Description	Related Population Outcome	Impact on Place Goals	Impact on West Yorkshire 10 Ambitions	Impact on NHS National Objective	Timescales for Implementation
EoL1	Advanced Care Planning (ACP). End of Life	- Launch of new public ACP guide with Public Health 'What if Things Change'. - Full review of system wide ACP training	People approaching the end of their life are recognised and supported on time All people approaching the end of life receive high quality, well-coordinated care at the right place at the right time and with the right people	Goal 2 – Increase early identification and intervention	N/A	N/A	**Start date:** April 2023
EoL2	Early Identification - End of Life – TIMELY Recognition Tool project	Progress trial in Systm1 practices. Engagement with practices regarding outcomes of trial, and its use in supporting early recognition of people nearing the end of their life. Academic validation.	People approaching the end of their life are recognised and supported on time	Goal 2 – Increase early identification and intervention	N/A	N/A	**Start date:** Q4 23/24
EoL3	End of Life Education Programme	Clinical educator funded for 12 months by the Leeds Palliative Care Network to train 2,000 clinical support workers.	All people approaching the end of life receive high quality, well-coordinated care at the right place at the right time and with the right people People approaching the end of life and their carers are able to talk about death with those close to them and in their communities. They feel their loved ones are well supported during and after their care.	Goal 1 - Reduce avoidable unplanned care utilisation across health settings through a focus on keeping people well	N/A	N/A	**Start date:** June 2023

Implementation Plan 23/24 Frailty

No	Workstream / Project	Description	Related Population Outcome	Impact on Place Goals	Impact on West Yorkshire 10 Ambitions	Impact on NHS National Objective	Timescales for Implementation
FR1	Proactive care - National Anticipatory Care Framework (now Proactive Care Framework)	National Framework - Proactive Care Framework: provision of proactive, personalised health & care for people with multiple long-term conditions	Identifying and supporting all people in this population group and assessing their needs and assets, as an individual and as a carer Reducing avoidable disruption to people's lives as a result of contact with services	1 - Reduce avoidable unplanned care utilisation across health settings through a focus on keeping people well	N/A	N/A	**Start date:** Oct – Dec 2023
FR2	Proactive care - Restore 2 & stumble training	Training for care home staff in soft signs of deterioration and falls management	Identifying and supporting all people in this population group and assessing their needs and assets, as an individual and as a carer	1 - Reduce avoidable unplanned care utilisation across health settings through a focus on keeping people well	N/A	N/A	**Start date:** April 2023
FR3	Proactive care – Frailty Training	In year funding - frailty training days led by community geriatrician for health and social care staff plus bespoke training for care home staff	Identifying and supporting all people in this population group and assessing their needs and assets, as an individual and as a carer	2 - Increase early identification and intervention (of both risk factors and actual physical and mental illness)	N/A	N/A	**Start date:** June 2023

Implementation Plan 23/24 Home First Programme – linked to Frailty Board

No	Workstream / Project	Description	Related Population Outcome	Impact on Place Goals	Impact on West Yorkshire 10 Ambitions	Impact on NHS National Objective	Timescales for Implementation
HF1	Enhanced Care at Home - Improving our urgent community offer to support people at home and reduce	Home Ward (virtual ward) Remote Health Monitoring Quick Response (urgent or crisis response) – 2-hour element Emergency Cover for Carers (emergency carer support)	N/A	1 - Reduce avoidable unplanned care utilisation across health settings through a focus on keeping people well	N/A	Consistently meet or exceed the 70% 2-hour urgent community response (UCR) standard Improve A&E waiting times so that no less	**Start date:** May 2023

No	Workstream / Project	Description	Related Population Outcome	Impact on Place Goals	Impact on West Yorkshire 10 Ambitions	Impact on NHS National Objective	Timescales for Implementation
	unplanned admissions	Rapid Response to Falls Home Comfort Also includes early intervention – how we reduce avoidable admissions and attendances at hospital.				than 76% of patients are seen within 4 hours by March 2024 with further improvement in 2024/25	
HF2	Active Recovery at Home - Increasing the number of people who are able to be supported at home following hospital discharge	Combining the current Reablement & National Housing Trust (NHT) services Expanding the offer of these combined services to support more people at home	N/A	1 - Reduce avoidable unplanned care utilisation across health settings through a focus on keeping people well	N/A	Reduce adult general and acute (G&A) bed occupancy to 92% or below 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	**Start date:** May 2023
HF3	Rehab and Recovery Beds - optimising and recommissioning intermediate care beds in Leeds	Reducing our reliance on spot purchased beds Optimising the current CCB to reduce length of stay Designing the model for and recommissioning the rehab and recovery beds in Leeds to a reduced number	N/A	1 - Reduce avoidable unplanned care utilisation across health settings through a focus on keeping people well	N/A	Reduce adult general and acute (G&A) bed occupancy to 92% or below 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	**Start date:** May 2023
HF4	Transfers of Care - streamlining our transfers of care between acute and intermediate care services to reduce the non-value-added time	As per workstream title, final details in development	N/A	1 - Reduce avoidable unplanned care utilisation across health settings through a focus on keeping people well	N/A	Reduce adult general and acute (G&A) bed occupancy to 92% or below 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	**Start date:** May 2023

Implementation Plan 23/24 Healthy Adults

No	Workstream / Project	Description	Related Population Outcome	Impact on Place Goals	Impact on West Yorkshire 10 Ambitions	Impact on NHS National Objective	Timescales for Implementation
HA1	System Flow Health Inclusion - Out of Hospital Project for those with no fixed abode / multiple complex disadvantages	This workstream has several parts: A) defined service spec for matrix transfer of care teams for vulnerable adults B) Development work on scaling up 9 temporary housing unit beds as part of current out of hour project, what does good look like? What could excellent look like? C) Emerging work on those on prison release pathways who end up in LYPFT shortly after release	People in Leeds live well, and have a standard of living which supports their health and wellbeing	1 - Reduce avoidable unplanned care utilisation across health settings through a focus on keeping people well	Increase the years of life that people live in good health	Reduce adult general and acute (G&A) bed occupancy to 92% or below Continue to address health inequalities and deliver on the Core20PLUS5 approach	**Start date:** New Housing Workers in Transition of Care – July 2023
HA2	Women's Health – Healthy Adults	A life course approach to women's health reduces pressures on waiting lists (gynaecology some of the longest waiters and second most used service in planned care) and increases overall health of women. Focus on pelvic floor health, endometriosis and menopause pathways also link to mental health of women	People in Leeds will be physically healthy	2 - Increase early identification and intervention (of both risk factors and actual physical and mental illness)	Increase the years of life that people live in good health	Maternity - Make progress towards the national safety ambition to reduce stillbirth, neonatal mortality, maternal mortality and serious intrapartum brain injury Continue to address health inequalities and deliver on the Core20PLUS5 approach	**Start date:** TBC
HA3	Community Strengths – Local Care Partnership (LCP) community grants, Social Prescribing (SP) community of practice, digital health hubs.	- Community Grants Scheme: 8 LCP funded to define, develop and implement hyper local health and wellbeing intervention - Social Prescribing: Proactive person-centred approach to working with people in their communities to address non-clinical health and wellbeing needs, and to connect with services to address WDH	People in Leeds will be mentally and physically healthier for longer and where needed, supported to live well.	1 - Reduce avoidable unplanned care utilisation across health settings through a focus on keeping people well	Increase the years of life that people live in good health	Continue to address health inequalities and deliver on the Core20PLUS5 approach Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up	**Start date:** LCP Grants – March 23 Social Prescribing – March 23 SP Community of Practice – TBC Digital Health Hubs – March 23

No	Workstream / Project	Description	Related Population Outcome	Impact on Place Goals	Impact on West Yorkshire 10 Ambitions	Impact on NHS National Objective	Timescales for Implementation
		- Working hyperlocal to develop and pilot a social prescribing community of practice that bring together disparate parts of the system under a shared purpose. - Community hubs delivering support in and with communities experiencing the greatest health inequalities to enable connection with health and care services using digital means				local pathways for direct referrals	
HA4	System Flow Healthy Adults - Social Prescribing (SP) in A&E; home plus; unplanned care for healthy adults	Pilot project with SP embedded in A&E working with repeat high intensity users of the service. - Home Plus, The Home Independence & Warmth Service (branded as Home Plus (Leeds)) is aimed at enabling and maintaining independent living through improving health at home. It does this through addressing: · risk of falling · energy efficiency and affordability · warmth and condensation / damp · hazards relating to electrics, plumbing and gas that require repairs - data driven approach to understand unplanned care usage by the Healthy Adults segment. Data cut by method of attendance, conveyancing rates, admission conditions, non-admission conditions. All to be cut by age, gender, ethnicity, Indices of multiple deprivation (IMD)/ Primary Care Network (PCN).	People in Leeds will be mentally and physically healthier for longer and where needed, supported to live well.	1 - Reduce avoidable unplanned care utilisation across health settings through a focus on keeping people well	Increase the years of life that people live in good health	Continue to address health inequalities and deliver on the Core20PLUS5 approach Improve A&E waiting times so that no less than 76% of patients are seen within 4 hours by March 2024	**Start date:** - SP in A&E - March 23 Home Plus - March 23 Unplanned care for HA - October 23

Implementation Plan 23/24 Long Term Conditions

No	Workstream / Project	Description	Related Population Outcome	Impact on Place Goals	Impact on West Yorkshire 10 Ambitions	Impact on NHS National Objective	Timescales for Implementation
LTC1	Multimorbidity (3 Long Term Conditions (LTC) Plus Mental Health) -	Digital - remote monitoring implementation for 3 plus LTCs and mental health	People with a LTC take an active role in managing and improving their condition and the prevention of future multi-morbidities	1 - Reduce avoidable unplanned care utilisation across health settings through a focus on keeping people well	N/A	Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals	**Start date:** September 23
LTC2	Multimorbidity (3 Long Term Conditions Plus Mental Health)) - Long Covid review and rehabilitation model development	Long Covid review and rehabilitation model development	N/A	1 - Reduce avoidable unplanned care utilisation across health settings through a focus on keeping people well	N/A	Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals	**Start date:** In development
LTC3	Multimorbidity (3 Long Term Conditions (LTC) Plus Mental Health) – delivery of respiratory Steering Group Work	MART - Implementation of AZ work with target 3 Primary Care Networks Expansion of pulmonary rehab Spirometry next steps	I'm as healthy and as well as I can be with my LTCs	1 - Reduce avoidable unplanned care utilisation across health settings through a focus on keeping people well	N/A	Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals	**Start date:** January 23
LTC4	Multimorbidity (3 Long Term Conditions (LTC) Plus Mental Health) - delivery of Diabetes Steering Group Work	Conclude local diabetes remission pilot (learnings blend with Integrated weight management model) Facilitation of NHS Diabetes Prevention Programme (NDPP) referrals Treatment and care implementation and continuous glucose monitoring implementation	I'm as healthy and as well as I can be with my LTCs	1 - Reduce avoidable unplanned care utilisation across health settings through a focus on keeping people well	N/A	Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals	**Start date:** - January 22
LTC5	Multimorbidity (3 Long Term Conditions Plus Mental Health)) - delivery of cardiovascular disease (CVD) Steering Group Work	Coordination of hypertension and lipids work Heart failure work exit Anticoagulation next steps	I'm as healthy and as well as I can be with my LTCs	1 - Reduce avoidable unplanned care utilisation across health settings through a focus on keeping people well	N/A	Increase percentage of patients with hypertension treated to NICE guidance to 77% by March 2024	**Start date:** - January 22
LTC6	Multimorbidity (3 Long Term Conditions Plus Mental Health) -	CNRS Phase 1 implementation and phase 2 business case development, FND pathway mapping and next steps	I'm as healthy and as well as I can be with my LTCs	1 - Reduce avoidable unplanned care utilisation across	N/A	N/A	**Start date:** October 22

No	Workstream / Project	Description	Related Population Outcome	Impact on Place Goals	Impact on West Yorkshire 10 Ambitions	Impact on NHS National Objective	Timescales for Implementation
	delivery of Neurology Steering Group Work			health settings through a focus on keeping people well			
LTC7	Lipids - Innovation for Healthcare Inequalities Programme (InHIP) project delivery	West Yorkshire/Academic Health Science Network funded Health Inequalities project	N/A	2 - Increase early identification and intervention (of both risk factors and actual physical and mental illness)	N/A	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%	**Start date:** July 23
LTC8	Lipids – System Transformation Fund Project Lipids	Project delivery on behalf of West Yorkshire and Leeds	N/A	2 - Increase early identification and intervention (of both risk factors and actual physical and mental illness)	N/A	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%	**Start date:** July 23
LTC9	Home Oxygen - Delivery of home oxygen contract across Yorkshire and Humber	Delivery of home oxygen contract across West Yorkshire (WY) plus implementation of WY Quality, Innovation, Productivity and Prevention (QIPP) with VAT legal change granted	N/A	2 - Increase early identification and intervention (of both risk factors and actual physical and mental illness)	N/A	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%	**Start date:** July 23
LTC10	Integrated Weight Management	Options appraisal if Integrated Weight Management is not supported	People with a LTC take an active role in managing and improving their condition and the prevention of future multi-morbidities	2 - Increase early identification and intervention (of both risk factors and actual physical and mental illness)	N/A	Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals	**Start date:** July 23

Implementation Plan 23/24 Maternity

No	Workstream / Project	Description	Related Population Outcome	Impact on Place Goals	Impact on West Yorkshire 10 Ambitions	Impact on NHS National Objective	Timescales for Implementation
M1	MNVP (Maternity and Neonatal Voices Partnership)	Deep dive into engagement with service users to ensure care is accessible and close to home. Work with LTHT on staff satisfaction survey's / staff feedback	People receive personalised maternity care People receive the support they need to improve or maintain their emotional wellbeing Safe and effective high-quality maternity care is accessible for everyone People are prepared for parenthood	2 - Increase early identification and intervention (of both risk factors and actual physical and mental illness)	Achieve a 50% reduction in stillbirths, neonatal deaths, brain injuries and a reduction in maternal morbidity and mortality by 2025	Maternity - Make progress towards the national safety ambition to reduce stillbirth, neonatal mortality, maternal mortality and serious intrapartum brain injury	**Start date:** May 2023
M2	Gestational Diabetes	Provide targeted healthy eating and physical activity interventions, infant feeding support, future pregnancy planning education, and deliver community-based group peer support sessions to manage diabetes and unhealthy maternal weight	People receive personalised maternity care People receive the support they need to improve or maintain their emotional wellbeing Safe and effective high-quality maternity care is accessible for everyone People are prepared for parenthood	2 - Increase early identification and intervention (of both risk factors and actual physical and mental illness)	Achieve a 50% reduction in stillbirths, neonatal deaths, brain injuries and a reduction in maternal morbidity and mortality by 2025	Maternity - Make progress towards the national safety ambition to reduce stillbirth, neonatal mortality, maternal mortality and serious intrapartum brain injury	**Start date:** May 2023
M3	Doula's	Health Inequalities non recurrent funding was used to mobilise the Leeds doula service. This would require further funding from September 2023 (identified in the health inequalities in community pre value proposition). The maternity population board though their logic models have identified this as a key priority to ensure "people received personalised maternity care safely"	Families and babies are supported to achieve optimum physical health.	2 - Increase early identification and intervention (of both risk factors and actual physical and mental illness	Achieve a 50% reduction in stillbirths, neonatal deaths, brain injuries and a reduction in maternal morbidity and mortality by 2025	Maternity - Make progress towards the national safety ambition to reduce stillbirth, neonatal mortality, maternal mortality and serious intrapartum brain injury	**Start date:** July 2023

No	Workstream / Project	Description	Related Population Outcome	Impact on Place Goals	Impact on West Yorkshire 10 Ambitions	Impact on NHS National Objective	Timescales for Implementation
M4	Maternity Mental Health (for West Yorkshire)	The aim of MMHS is to fill the gap not already met by other services and provide support to women experiencing moderate to severe or complex mental health difficulties, including trauma relating to their birth experience, fear of birth itself (tokophobia), and trauma relating to pregnancy and baby loss (including loss through removal into social care).	People receive personalised maternity care safely People receive the support they need to improve or maintain their emotional wellbeing	1 - Reduce avoidable unplanned care utilisation across health settings through a focus on keeping people well	Achieve a 50% reduction in stillbirths, neonatal deaths, brain injuries and a reduction in maternal morbidity and mortality by 2025	Maternity - Make progress towards the national safety ambition to reduce stillbirth, neonatal mortality, maternal mortality and serious intrapartum brain injury Improve access to perinatal / mental health services	**Start date:** May 2023

Implementation Plan 23/24 Mental Health

No	Workstream / Project	Description	Related Population Outcome	Impact on Place Goals	Impact on West Yorkshire 10 Ambitions	Impact on NHS National Objective	Timescales for Implementation
MH1	Community Mental Health Transformation - Mobilisation of new integrated model of care for community mental health with Local Care Partnerships (LCPs) and Primary Care Networks (PCNs)	Piloting and testing of newly designed multiagency integrated MH hub model in 3 local care partnership areas (4 PCNs) ahead of phased roll out across all LCP/PCNs in Leeds	People's quality of life will be improved by timely access to appropriate mental health information, support and services	N/A	Reduce the gap in life expectancy for people with Mental Health Conditions	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	**Start date:** July 2022
MH2	Community Mental Health Transformation – psychological therapies	Developing and increasing capacity in psychological therapies for people with SMI and more complex needs	People's quality of life will be improved by timely access to appropriate mental health information, support and services	N/A	Reduce the gap in life expectancy for people with Mental Health Conditions	Achieve a 5% year on year increase in the number of adults and older adults supported by community mental health services	**Start date:** April 2023

No	Workstream / Project	Description	Related Population Outcome	Impact on Place Goals	Impact on West Yorkshire 10 Ambitions	Impact on NHS National Objective	Timescales for Implementation
						Work towards eliminating inappropriate adult acute out of area placements	
MH3	Community Mental Health Transformation - Developing and testing new workforce roles	Including within primary care (including Additional Roles Reimbursement Scheme roles) and in the 3rd sector	People's quality of life will be improved by timely access to appropriate mental health information, support and services	N/A	Reduce the gap in life expectancy for people with Mental Health Conditions	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	**Start date:** Commenced in 22/23 and progressing to full delivery within new model of care from Q2 23/24.
MH4	Improving Access to Psychological Therapy (IAPT)	Working to reduce waiting times to access NHS Talking Therapies	People's quality of life will be improved by timely access to appropriate mental health information, support and services	N/A	Reduce the gap in life expectancy for people with Mental Health Conditions	Increase the number of adults and older adults accessing IAPT treatment	**Start date:** 2022/23, in progress
MH5	Mental Health Crisis - Review and evaluation of Mental Health crisis provision and models of crisis alternatives	Undertaking a deep dive analysis of value and outcomes being delivered in our crisis services pathway, to help inform how we can, reduce the inequalities in access, and improve the experience and outcomes for people accessing support, making the best use of available resources.	People's quality of life will be improved by timely access to appropriate mental health information, support and services	N/A	Reduce the gap in life expectancy for people with Mental Health Conditions	Work towards eliminating inappropriate adult acute out of area placements	**Start date:** June 23
MH6	Community Mental Health Transformation - Physical Health Severe Mental Illness (SMI)	Further develop outreach and pathways improve access to physical health checks and interventions for people with SMI	N/A	2 - Increase early identification and intervention (of both risk factors and actual physical and mental illness)	Reduce the gap in life expectancy for people with Mental Health Conditions	N/A	**Start date:** Q4 22/23 testing outreach models in early implementer sites for new model of care
MH7	Community Mental Health Transformation - Early intervention in psychosis pathway	Further develop Early Intervention in Psychosis (EIP) to incorporate identification and intervention for those with at-risk mental states.	N/A	2 - Increase early identification and intervention (of both risk factors and actual	Reduce the gap in life expectancy for people with Mental Health Conditions	Achieve a 5% year on year increase in the number of adults and older adults supported	**Start date:** April 2023 (investment for ARRS pathway in Q3 22/23 for

No	Workstream / Project	Description	Related Population Outcome	Impact on Place Goals	Impact on West Yorkshire 10 Ambitions	Impact on NHS National Objective	Timescales for Implementation
				physical and mental illness)		by community mental health service	recruitment-recurrent investment for delivery from 1 April 23)
MH8	Mental Health Crisis – Street Triage	Implementation and evaluation of new delivery model for Street Triage	N/A	1 - Reduce avoidable unplanned care utilisation across health settings through a focus on keeping people well	Reduce the gap in life expectancy for people with Mental Health Conditions	Work towards eliminating inappropriate adult acute out of area placements	**Start date:** Redesigned model implementation commenced April 2023

Implementation Plan 23/24 Planned Care

No	Workstream / Project	Description	Related Population Outcome	Impact on Place Goals	Impact on West Yorkshire 10 Ambitions	Impact on NHS National Objective	Timescales for Implementation
PC1	Earlier Diagnosis - Community Diagnostic Centres (CDC)	Business case approved to develop 3 sites as part of the CDC model for Leeds, this will expand diagnostic capacity at Seacroft Hospital, Armley and Beeston medical centres for a range of diagnostic tests, including CT, MRI, plain film x-ray, ultrasound, phlebotomy.	Planned Care services are accessible to all regardless of who they are	2 - Increase early identification and intervention (of both risk factors and actual physical and mental illness)	N/A	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	**Start date:** Implementation underway across all 3 x sites, to be delivering additional diagnostic activity by Q2 2023/24. Business Case for 23/24 & 24/25 submission due June 2023
PC2	Earlier diagnosis - LTHT Transformation Programme -Diagnostics	Multiple projects: - Delivery of 6 week wait recovery - Responsible requesting	N/A	2 - Increase early identification and intervention (of both risk factors and	N/A	Increase the percentage of patients that receive a diagnostic test within six weeks in line with	**Start date:** In progress

No	Workstream / Project	Description	Related Population Outcome	Impact on Place Goals	Impact on West Yorkshire 10 Ambitions	Impact on NHS National Objective	Timescales for Implementation
		- Opening new Pathology Estate - Community Diagnostic Centres - Launch Pathology Lab Information System		actual physical and mental illness)		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	
PC3	Managing Capacity and Elective Recovery - Covid Urgent Eyecare Service (CUES)	Service established August 2020 during Covid, mandated request by NHS England as routine eye screening had ceased. The service is delivered by Primary Eyecare Services Ltd, the lead for the network of 35 optical practices. Month on month increasing demand for service and evaluation evidencing impact on primary care and A&E services (to a lesser degree)	N/A	1 - Reduce avoidable unplanned care utilisation across health settings through a focus on keeping people well	N/A	Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals 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	**Start date:** Service is already established however due to rising demand for service, review of usage and funding model to be undertaken to sustain the service longer term.
PC4	Managing Capacity and Elective Recovery – Ear, Nose and Throat (ENT) and Adult Hearing Loss re-procurement	Procurement of community services - new contract to be in place April 2024 Potential Quality, Innovation, Productivity and Prevention (QIPP) opportunities to be identified - longer term savings in bulk buying of hearing aids/ reduction in costs of replacement batteries as rechargeable etc	Planned Care services are accessible to all regardless of who they are	2 - Increase early identification and intervention (of both risk factors and actual physical and mental illness)	N/A	Eliminate waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer or in specific specialties) Elective activity levels as a proportion of 19/20 activity reaching 108%	**Start date:** April 2024
PC5	Managing Capacity and Elective Recovery - Gastro re-procurement	Procurement of community services - new contract to be in place July 2024	Planned Care services are accessible to all regardless of who they are	2 - Increase early identification and intervention (of both risk factors and	N/A	Eliminate waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer	**Start date:** July 2024

No	Workstream / Project	Description	Related Population Outcome	Impact on Place Goals	Impact on West Yorkshire 10 Ambitions	Impact on NHS National Objective	Timescales for Implementation
		Potential Quality, Innovation, Productivity and Prevention (QIPP) opportunities to be identified in current contract and for new services	People are supported whilst waiting for planned care services	actual physical and mental illness)		or in specific specialties) Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%	
PC6	Managing Capacity and Elective Recovery - Harmonisation Commissioning Policies	Contribution to ensuring commissioning policies and access to treatments is consistent and equitable across the Integrated Care Board (cuts across population and care delivery boards)	N/A	N/A	N/A	N/A	**Start date:** September 2023
PC7	Managing Capacity and Elective Recovery - LTHT Transformation Programme - Planned Care	Multiple projects: - Theatre Productivity - Day Case - Patient optimisation - Reducing non-elective pressures - BADS	N/A	N/A	N/A	N/A	**Start date:** In progress
PC8	Manging Capacity and Elective Recovery - Ophthalmology Re-procurement	Re-procurement of community-based ophthalmology services – Any Qualified Provider (AQP) window to be re-opened to extend current contracts for 1 year until 30/09/24. Review of services to identify Quality, Innovation, Productivity and Prevention (QIPP) opportunities – Single Point of Access Cataracts (in line with regional approach) - priorities TBC	People are supported whilst waiting for planned care services Planned Care services are accessible to all regardless of who they are	2 - Increase early identification and intervention (of both risk factors and actual physical and mental illness)	N/A	Eliminate waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer or in specific specialties) Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals	**Start date:** October 2024
PC9	Outpatients Redesign - Increased use of Patient Initiated Follow Up (PIFU)	Converting appropriate patients from routine planned follow up, to follow up initiated by the	People are supported whilst waiting for planned care services	N/A	N/A	Elective activity levels as a proportion of 19/20 activity reaching 108%	**Start date:** In progress

No	Workstream / Project	Description	Related Population Outcome	Impact on Place Goals	Impact on West Yorkshire 10 Ambitions	Impact on NHS National Objective	Timescales for Implementation
		patient as clinically indicated.					
PC10	Outpatients (OP) Redesign - Advice and Guidance	Encouraging clinicians to seek advice and guidance on management and treatment of their patients from an appropriate specialist, so that their condition can be appropriately and safely managed without the need for OP referral	People are supported whilst waiting for planned care services	N/A	N/A	Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals Eliminate waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer or in specific specialties)	**Start date:** In progress
PC11	Outpatients Redesign - Reduction in outpatient follow up (OPFU)	Supporting LTHT project team in developing and delivering phased reduction in OPFU activity by 25% (compared to 19/20 activity), through programme of Clinical Service Unit targeted benchmarking, identification of opportunities, and implementation.	People are supported whilst waiting for planned care services	N/A	N/A	Eliminate waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer or in specific specialties Elective activity levels as a proportion of 19/20 activity reaching 108%	**Start date:** February 2023
PC12	Outpatients Redesign - LTHT Transformation Programme - Outpatients	Multiple projects: - Pathway optimisation, inc. reducing DNA/Canx, clinic utilisation, video/telephone consults, patient hub, estate optimisation - OP Quality and improvement, inc. standardisation of process, Robotic Process Automation (RPA), enhanced patient	N/A	N/A	N/A	N/A	**Start date:** February 2023

No	Workstream / Project	Description	Related Population Outcome	Impact on Place Goals	Impact on West Yorkshire 10 Ambitions	Impact on NHS National Objective	Timescales for Implementation
		information and patient interface					
PC13	Waiting support - Waiting well for Planned Care	Funding for 1 x Care Navigator/ Support worker (HI Funding) start date 2 May 2023. This scheme will target the most deprived people on elective surgical waiting lists to support them to wait well and to reduce the number of acute attendances whilst waiting for care. 4 x Primary Care Network areas where we are seeing the highest numbers of people presenting at A&E whilst they are on planned care waiting list – these are York Road/ Crossgates/ Middleton & Hunslet and Burmantofts/ Harehills and Richmond Hill.	People are supported whilst waiting for all planned care services People agree appropriate and realistic shared health goals, and actively participate in their achievement	1 - Reduce avoidable unplanned care utilisation across health settings through a focus on keeping people well	N/A	Continue to address health inequalities and deliver on the Core20PLUS5 approach Eliminate waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer or in specific specialties)	**Start date:** April 2023

Implementation Plan 23/24 Primary Care

No	Workstream / Project	Description	Related Population Outcome	Impact on Place Goals	Impact on West Yorkshire 10 Ambitions	Impact on NHS National Objective	Timescales for Implementation
PRI1	Optimising access to primary care	Implementation of the access recovery plan which will improve access to primary care through focussing on cloud-based telephony, reviewing models of care through capacity and demand. Roll out of new online consultation system.	N/A	1 - Reduce avoidable unplanned care utilisation across health settings through a focus on keeping people well	N/A	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	**Start date:** October 2022

No	Workstream / Project	Description	Related Population Outcome	Impact on Place Goals	Impact on West Yorkshire 10 Ambitions	Impact on NHS National Objective	Timescales for Implementation
PRI2	24/7 Integrated Primary Care Services	Enhanced Access Service (since October replacing GP Extended Access)	People's same day care needs are met wherever they present (if possible), and where they need to be cared for elsewhere, this feels seamless and integrated.	1 - Reduce avoidable unplanned care utilisation across health settings through a focus on keeping people well	N/A	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 Continue on the trajectory to deliver 50 million more appointments in general practice by the end of March 2024	**Start date:** April 2023
PRI3	Annual health checks for people with LD	Focus on those patients who have not received an annual health check in previous 18 months (Quality Improvement Scheme)	N/A	2 - Increase early identification and intervention (of both risk factors and actual physical and mental illness)	10% reduction in the gap in life expectancy between people with mental health conditions, learning disabilities and / or autism	Ensure 75% of people aged over 14 on GP learning disability registers receive an annual health check and health action plan by March 2024	**Start date:** April 2023
PRI4	Dementia Diagnosis	Practices to review their dementia prevalence rate and identify patients at clinical risk of dementia and offer assessment and referral (Quality Improvement Scheme)	N/A	2 - Increase early identification and intervention (of both risk factors and actual physical and mental illness)	N/A	Recover the dementia diagnosis rate to 66.7%	**Start date:** April 2023
PRI5	Increasing the primary care workforce	Delivery of the Primary Care Workforce Action plan including increasing the number of Additional Roles Reimbursement Scheme (ARRS) employed workforce, developing recruitment and retention measures, supporting the health and wellbeing of the workforce to support increasing capacity of primary care services	N/A	1 - Reduce avoidable unplanned care utilisation across health settings through a focus on keeping people well	N/A	Continue to recruit 26,000 Additional Roles Reimbursement Scheme (ARRS) roles by the end of March 2024 Continue on the trajectory to deliver 50 million more appointments in general practice by the end of March 2024	**Start date:** April 2023
PRI6	Increase uptake of vaccinations and immunisations	Continue to support the delivery of all the vaccination programmes	N/A	2 - Increase early identification and intervention (of both risk factors and actual	N/A	N/A	**Start date:** N/A

No	Workstream / Project	Description	Related Population Outcome	Impact on Place Goals	Impact on West Yorkshire 10 Ambitions	Impact on NHS National Objective	Timescales for Implementation
	(including flu and covid)			physical and mental illness)			

Implementation Plan 23/24 Same Day Response

No	Workstream / Project	Description	Related Population Outcome	Impact on Place Goals	Impact on West Yorkshire 10 Ambitions	Impact on NHS National Objective	Timescales for Implementation
SDR1	Same Day Response (reducing people attending A&E) - PCAL+ Creating a new single gateway that brings together the Primary Care Advice Line (PCAL) and the Single Point Urgent Referral (SPUR) & Yorkshire Ambulance Service (YAS) push model	Working with YAS in testing out their ability to identify and 'push' referral to Urgent Community Response (UCR) via SPUR as clinically triaged from the ambulance stack and then secondly assessing the impact of primary / community clinicians 'pulling' patients from the stack and providing an UCR response	People are easily able to access the service that can provide the most responsive and appropriate care to meet their unplanned sane day needs People's same day care needs are met wherever they present (if possible), and where they need to be cared for elsewhere, this feels seamless and integrated	1 - Reduce avoidable unplanned care utilisation across health settings through a focus on keeping people well	N/A	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 Reduce adult general and acute (G&A) bed occupancy to 92% or below	**Start date:** In progress
SDR2	Same Day Response (reducing people attending A&E) - Children Urgent Care	Paediatric ARI hub – Community Ambulatory Paediatric Service (CAPS) service aims to provide same day provision for children that have been clinically assessed/triaged as requiring face to face physical examination and present with respiratory symptoms	People are easily able to access the service that can provide the most responsive and appropriate care to meet their unplanned sane day needs People's same day care needs are met wherever they present (if possible), and where they need to	1 - Reduce avoidable unplanned care utilisation across health settings through a focus on keeping people well	N/A	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 Reduce adult general and acute (G&A) bed occupancy to 92% or below	**Start date:** December 2022

No	Workstream / Project	Description	Related Population Outcome	Impact on Place Goals	Impact on West Yorkshire 10 Ambitions	Impact on NHS National Objective	Timescales for Implementation
			be cared for elsewhere, this feels seamless and integrated				
SDR3	Same Day Response (reducing people attending A&E) - Maximise PCAL	Avoid unnecessary ED attendances by facilitating healthcare providers to get patients to the right place for their care sooner to enable better patient outcomes and experience. The service currently has access to approximately 50 same day emergency care pathways within LTHT	People are easily able to access the service that can provide the most responsive and appropriate care to meet their unplanned sane day needs People's same day care needs are met wherever they present (if possible), and where they need to be cared for elsewhere, this feels seamless and integrated	1 - Reduce avoidable unplanned care utilisation across health settings through a focus on keeping people well	N/A	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	**Start date:** In progress
SDR4	Same Day Response (reducing people attending A&E) – Developing Same Day Emergency Care (SDEC)	Same Day Emergency Care (SDEC) aims to reduce admissions and ED attendances by providing timely assessment, diagnosis and treatment, improving patient experience and care.	People are easily able to access the service that can provide the most responsive and appropriate care to meet their unplanned same day needs People's same day care needs are met wherever they present (if possible), and where they need to be cared for elsewhere, this feels seamless and integrated	1 - Reduce avoidable unplanned care utilisation across health settings through a focus on keeping people well	N/A	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	**Start date:** In progress

No	Workstream / Project	Description	Related Population Outcome	Impact on Place Goals	Impact on West Yorkshire 10 Ambitions	Impact on NHS National Objective	Timescales for Implementation
			Care is high quality, person-centred, and appropriate to people's same day care needs now, whilst considering how these might change in the future				
SDR5	Urgent community response	Enhanced Community Response is to deliver urgent community response services aiming to reduce disruption to people's lives via alternatives to Emergency Department (ED) attendance/admissions to hospital; shorten length of stay. Workstreams include: • Same Day elements - 2-Hour Crisis Response offer, Telecare Rapid Falls Response • Virtual Wards (Hospital	People are easily able to access the service that can provide the most responsive and appropriate care to meet their unplanned sane day needs People's same day care needs are met wherever they present (if possible), and where they need to be cared for elsewhere, this feels seamless and integrated	1 - Reduce avoidable unplanned care utilisation across health settings through a focus on keeping people well	N/A	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 Reduce adult general and acute (G&A) bed occupancy to 92% or below Consistently meet or exceed the 70% 2-hour urgent community response (UCR) standard	**Start date:** In progress
SDR6	BARCA High Volume Service User Service	The BOST service works with service users and providers to identify the root cause of urgent and same day services high volume service use and work to resolve these causes. The exact intervention(s) needed for each individual cannot be prescribed (due to the potentially diverse requirements), but the focus should be on reducing UEC usage and overall system spend on this group of service users.	People are easily able to access the service that can provide the most responsive and appropriate care to meet their unplanned sane day needs People's same day care needs are met wherever they present (if possible), and where they need to	1 - Reduce avoidable unplanned care utilisation across health settings through a focus on keeping people well	N/A	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	**Start date:** In progress

No	Workstream / Project	Description	Related Population Outcome	Impact on Place Goals	Impact on West Yorkshire 10 Ambitions	Impact on NHS National Objective	Timescales for Implementation
			be cared for elsewhere, this feels seamless and integrated				

Meeting name:	Leeds Committee of the West Yorkshire Integrated Care Board (WY ICB)
Agenda item no.	LC 16/23
Meeting date:	5th July 2023
Report title:	Embedding Local Care Partnerships in the Leeds system
Report presented by:	Thea Stein, Chief Executive of Leeds Community Healthcare NHS Trust
Report approved by:	Thea Stein, Chief Executive of Leeds Community Healthcare NHS Trust
Report prepared by:	Kim Adams, Programme Director, Local Care Partnerships Development Programme

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

Previous considerations:

This report has been informed through a Programme workshop and an invitation to all partners on the LCP mailing lists to consider what LCPs should be focusing on moving forwards and the barriers to making this happen (comments from survey in appendix one).

Executive summary and points for discussion:

Local care partnerships (LCPs) is the term used in Leeds to describe our model of joined-up working to deliver local care for local people; working in and with local communities.

Local care partnerships build on Leeds City Council's strong history, NHS and third sector (community organisations) staff working together. There are 15 LCPs covering all of Leeds. Recognising the city's diversity, they are tailored to local need and the features of that particular community.

All LCPs share the same key feature – 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 to develop services that support people to access the right support when they need it and thrive using their individual and community assets.

Though there has been many successes and positive impacts being felt in communities as a result of work happening through LCPs and despite strong support at a senior level, we need to go much further within the Leeds system to move from 'good to do' to the default way we work at a neighbourhood level. There are a number of challenges in moving from the current position to a place where we can transform how we work together.

This report gives an overview of these challenges, as identified by partners within the system, and outlines ten actions which articulate how we as a system can overcome these challenges:

1. Align the purpose of LCPs with the City priorities, as identified through the Healthy Leeds Plan, with clear asks of all individual LCPs in relation to the Healthy Leeds Plan priority areas of focus.
2. Formerly embed the leadership of LCPs within the system governance structures.
3. Across all organisations, build LCPs into the culture and language of how we do things at a neighbourhood level.
4. Support and embed the narrative outlined in Fuller and by Marmot that we need to work together at a neighbourhood level to address the socio-economic determinants of health and wellbeing and support health equity.
5. Population and care delivery boards to use LCPs as the model for bringing professionals together with communities to progress neighbourhood working. Building on relationships with Adults and Health, opportunities are sought to link shared priorities more closely with locality working within the Council and with the Neighbourhood Improvement Board.
6. Future development and resourcing of Leeds Community Anchor Network and the Communities of Interest Network should include strengthening the ties between LCPs and communities.
7. Progress LCP development in line with the principles of proportionate universalism.
8. Involve LCPs in shaping and implementation of services for their local communities.
9. Follow through on our commitment as a system that we will work in an asset-based way with communities, meeting them where they are.
10. Build profiles of assets and needs around communities, starting with the communities living in the 10% most deprived areas, to support a community first way of working.

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. Support the ten actions outlined in section 2 next steps, to embed LCPs within the Leeds ‘architecture’ and maximise their potential.
2. Note that further work is needed to develop the actions into a plan and determine how this work will be monitored within current governance structures.

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:
No
Appendices
1. Summary feedback from LCP partners on the future direction of the partnerships
Acronyms and Abbreviations explained
1. LCPs – Local Care Partnerships. LCPs bring together health and social care partners (including third sector organisations) on a primary care network footprint to strengthen local relationships between partners, improve joined up working, tackle health inequalities and address wider determinants of health. Partners including housing, employment and skills, digital, education and community services work alongside LCP partners to achieve these aims. 2. PCNs – Primary Care Networks. Groups of GP practices, working together to build on existing primary care services to enable greater provision of proactive, personalised care.

What are the implications for?

Residents and Communities	LCPs have been established across Leeds. To tackle health inequalities this paper asks whether we should be moving to a model of proportionate universalism. This would mean that the LCP offer could look different in different communities. Exactly what that might mean needs to be worked through.
Quality and Safety	Moving from 'nice to do' to an expectation that we work this way at a neighbourhood level will foster more consistent engagement across partners at a local level. Strong LCP leadership teams can identify opportunities for more integrated working, This in turn supports better quality communication and referrals between teams, improving the quality of the support offered to people using multiple services.
Equality, Diversity and Inclusion	The underlying issues contributing to a health problem can differ from one community to another. To address health inequity we need to combine the development of a core service offer for Leeds residents developed at place, with delivery that recognises our diverse communities have different issues, assets and needs. LCPs provide a mechanism to make this happen. We need to make a clear ask of LCPs in delivering the Healthy Leeds Plan and Core 20+5.
Finances and Use of Resources	The report highlights that resource is needed to shift to more proactive work and new ways of working with local communities. Without transformation funding this would require flexibility from providers to

	release staff to work differently in partnership. Without this commitment from partner organisations LCPs will be limited in the transformative impact they can have.
Regulation and Legal Requirements	No regulatory or legal requirements are highlighted in this report but working together differently may require conversations on how partners meet these requirements together in developing more integrated provision.
Conflicts of Interest	None
Data Protection	Data sharing and access to clinical records sits outside of the scope of this report but the report highlights that the inability to easily share data across partners remains a barrier to integration in Leeds.
Transformation and Innovation	LCPs have demonstrated innovative ways of working that contribute to the transformation agenda. However, we need to be better at sharing and building on good practice. Bringing the work of population boards and LCPs together will support this.
Environmental and Climate Change	Environmental and climate change are not specifically dealt with in this report. LCPs support working with communities, building on local assets and the aim of creating flourishing local neighbourhoods. LCPs have been involved in development of Active Travel schemes within their footprints and root Leeds wide developments in local community buildings.
Future Decisions and Policy Making	The focus of this report is on making more effective use of LCPs in delivery of the Healthy Leeds Plan and core 20+5. It also asks that opportunities are sought to make use of the LCP model in localities work as the priority ward plans are developed, to reduce duplication and make effective use of resource when progressing shared priorities.
Citizen and Stakeholder Engagement	There are examples emerging of LCPs developing strong links with their local communities to work in partnership. This moves from service/development specific conversations to development of longer-term relationships between the community and local partners. This is not consistent across LCPs. Further work is needed to learn from the best, understand resource implications and build upon this model.

1. Main Report Detail

1.1 The Fuller Stocktake report described a model of integrated teams with Primary Care Networks (PCNs) coming together with partners to form a "team of teams" to provide joined up care and tackle health inequalities. The report states that these teams should:

"Promote a culture of collaboration and pride, create the time and space within these teams to problem solve together, and build relationships and trust between primary care and other system partners and communities."

1.2 In Leeds we have created these conditions through the Local Care Partnership (LCP) model. Whilst LCPs have been progressed since 2017 and established across the whole of Leeds since March 2020, they remain far from embedded within the structure and governance of health and care within the city. We have some thriving partnerships – particularly in the areas of Leeds that experience greatest health inequity – but we are not capitalising on the potential of LCPs.

1.3 The paper explores some of the underlying challenges that contribute to this issue. It recommends ten actions be taken to strengthen the position of LCPs and fully realise the opportunities they provide.

1.4 Purpose, Accountability and Governance

1.4.1 LCPs have been described as a "*coalition of the willing*" with partners choosing whether to engage or not. This has led to a situation where the LCPs go where the energy is, pushing forward priorities of those who engage rather than reflecting the pressing priorities of the city. The LCPs should retain the flexibility and freedom to be able to pursue issues that are important locally but - to embed LCPs within the consciousness and architecture of the City - they need a clear purpose tied to City priorities and Core 20+5.

1.4.2 Improvements in life expectancy have stalled and health inequalities are widening. To tackle this effectively, we need to work as a system beyond diagnosing and treating illness. There needs to be more focus on prevention and promoting wellbeing, as well as community voice and building on assets in communities. This remains challenging and in the current financial climate increasingly so. Partnership working is key and strong LCPs need to be protected when pressures could see organisations slide back into silos. With the Senior Responsible Officer for LCPs leaving in September it is timely that we consider how we build on LCPs to achieve our shared goals.

1.4.3 Aligning LCPs with Leeds system priorities, specifically Core 20+5 and the Healthy Leeds Plan, provides LCPs with a clear purpose; an ability to call upon partners to collectively address local issues; and ties LCPs into existing monitoring and reporting systems. However, to support the above and the vision set out in the

Fuller Stocktake, LCPs need to have a formalised governance structure linked into governance at place and region.

"Within my role as Clinical Director of a PCN I have accountability. As Chair of an LCP no-one is holding me accountable. If the LCP delivers nothing, I'm not going to be questioned about this."

1.4.4 All LCPs should have a formal leadership team in addition to a broader networking group. The leadership team needs to be representative of the partners, hold the local accountability for delivering priorities, and be able to escalate challenges through governance structures to unblock barriers to implementation of City priorities. Co-ownership across NHS and Council members could be supported by Clinical Directors and Cllr Health and Wellbeing Champions co-chairing LCPs.

1.5 Traction within the Leeds system

1.5.1 Knowledge of LCPs is inconsistent. Whilst many people engage regularly with one or more partnerships there is a significant part of the workforce that do not understand what an LCP is or how it could support their role, don't know the difference between an LCP and a PCN, or have not heard of LCPs.

"There remains a lack of visibility of LCPs in all organisations across the system, at every level".

1.5.2 To embed LCPs within the wider workforce we need to build the language of LCPs into conversations about neighbourhood working. All new starters should attend an Introduction to LCPs session. For roles that are on a neighbourhood footprint this should be an in-person opportunity to meet partners working within the same "team of teams" in their LCP area. For other roles this could be an online session.

1.5.3 LCPs straddle the worlds of health and community but don't sit comfortably in either. When the programme was established in 2019 the development team were asked to support LCPs with Population Health Management (PHM) Frailty rollout and with a locally determined priority. PHM with its data driven approach, working with a cohort united by a condition, was seen as very 'health'. Conversely, locally identified priorities often focused on the most pressing issues that local partners were seeing and sought to address wider determinants of health. The freedom to evolve and respond to local need also means that Citywide services can struggle to know how and when to engage with LCPs and there is a risk of inequity of service provision.

1.5.4 The programme has continued to work with a twin aim of wrapping around health priorities whilst also focusing on wider determinants of health. Projects such as digital health hub rollout, Developing You Employment Scheme and work around Domestic Abuse have been progressed alongside engagement in frailty work, End of Life Pathway redesign and Community Mental Health transformation. For the individuals actively engaged in LCPs from across sectors this way of working

makes perfect sense –but for those on the periphery Council and Third Sector teams can perceive LCPs as being a health partnership whilst NHS staff see LCPs as tackling wider determinants and struggle to see the day-to-day relevance to their role.

1.5.5 This presents the real risk that Council services replicate the broad partnerships established in LCPs through priority ward work rather than building on the LCP foundations. Within the NHS the risk is that health partners plan integration with PCNs, missing out on opportunities to engage other LCP partners in a more holistic approach to care delivery.

1.5.6 In tackling the broader determinants of health, it is important that LCPs retain a focus on health issues but can integrate with the Council's locality work. Colleagues within Adults and Health have been valuable partners throughout the development of LCPs, including bringing the ABCD approach into the partnerships. The Directorate's relationships with departments across the Council could help to identify opportunities to knit the health inequality work of LCPs more closely to locality work.

1.6 Engaging with communities, third sector infrastructure and support

1.6.1 LCPs have strengthened relationships between third sector and community groups and local health and care partners, particularly primary care. LCPs strive to provide a space where all voices are equal and encourages shared decision-making. Relationships established in LCPs have resulted in better joined up care and a more holistic approach to integrated working. Maintaining strong relationships with the breadth of partners is a key function of the LCP Development team, but the designated resource in Forum Central has been instrumental in the success of this aspect of the programme.

1.6.2 However, capacity to maintain engagement is limited, and is a particular challenge for grassroots organisations with close connections to the people and communities experiencing greatest inequality.

"The intention is there, but if you have a couple of members of staff, and every member of staff's time is allocated for a whole week sometimes it's very, very difficult (to engage)"

"(Representation) seems to be an obvious way to reduce the burden on a range of smaller organisations, but it does… rely upon trust and high-quality relationships and reduced competition between Third Sector organisations."

1.6.3 The Leeds Community Anchor Network provides a good platform for Third Sector engagement with LCPs, connecting smaller third sector organisations to the partnerships and supporting an ongoing dialogue between the local community, communities of interest, and health and care partners. Greater connection with the Communities of Interest Network and other Third Sector networks would also

support LCPs to establish trusted relationships with marginalised communities, developing solutions together.

1.7 The strength of this way of working is in connecting health and care professionals directly with local people, in spaces people feel comfortable and on their terms. This way of working switches the balance of power and supports ongoing conversations with communities which build trust. The Community Anchors and many Communities of Interest Network members are long established partners within LCPs but without resourcing for their roles they are unable to fully realise their potential in acting as this link.

1.8 **Proportionate Universalism and Resourcing to LCPs**

1.8.1 Experience of being in an LCP differs in the inner and outer LCPs. There is a greater concentration of resource/breadth of partners in the more deprived areas of the city. LCPs with pockets of deprivation can often be overlooked. However, expectations of LCPs (from partners) remain consistent across areas. Clarity is needed on whether the expectation of – and support to – all LCPs should be the same or whether principles of proportionate universalism should be applied.

1.8.2 Decisions on how funding is spent sit outside of LCPs and, even with funding that is specifically targeted at tackling health inequalities, resource focused on a community is often allocated without working with the LCP. If we, as a system, want to learn from models such as Staten Island we need to be engaging with LCPs to understand the underlying strengths, gaps and issues and the interventions that will work with their communities.

1.8.3 Without new money, LCPs need to be able to influence how the existing workforce are deployed in their neighbourhoods, balancing the need for equitable provision across communities with the need to tailor the delivery model, particularly in areas of greatest health inequity.

1.8.4 Within the Health Inequalities neighbourhood specification for PCNs, it is a requirement (for PCNs) to advocate for resources to be targeted at those populations with the most pressing needs at PCN and system level. Aligned incentives across partner organisations would support neighbourhood working with a shared objective of reducing inequalities in line with core 20+5 and Healthy Leeds Plan.

1.9 **Geography**

1.9.1 Geography has always posed a challenge to integrated working in Leeds. LCPs use PCNs as the basis for their footprint and work with anyone registered with that PCN or anyone living within that community. However, these boundaries differ from ward boundaries and Community Committees, Children's clusters, boundaries for provider trusts, neighbourhood networks and community anchors.

None of these boundaries map perfectly across to the communities that Leeds residents would identify with.

1.9.2 Wrapping LCPs around PCN boundaries enables PCNs to engage with partner organisations. However, LCPs were formed to work with communities and there are a number of communities sitting across LCP boundaries. Working across such large geographies also poses problems in those LCPs that are predominantly affluent with pockets of deprivation. LCP averages mask need and these communities are overlooked. We (the Leeds system) should understand how our boundaries and lists intersect within communities and take mitigating action to best support local residents. In LCPs with smaller pockets of people living in IMD 1 there should be an additional data set for these communities, ensuring they are not masked by an LCP 'average'.

1.9.3 As a city we need to be taking a community first approach, identifying a common language that unites the different locality structures we have in the city. If we are committed to asset-based approaches and looking to challenge inequality by shifting power to communities, we cannot intersect communities with arbitrary boundaries, engaging with people on our terms. We also need to understand fully the intersectionality between geographical communities and communities of interest that experience health inequity.

1.9.4 The LCP which is predominant in a community should lead work, but with an expectation that the LCP needs to include members of the communities that are registered with other PCNs, and organisations supporting communities of interest within that geographical area. This will require co-operation between neighbouring LCPs and PCNs and a much better understanding of our communities as defined by the people of Leeds.

1.10 **Broader Considerations**

1.10.1 In addition to the above barriers, there are several challenges that impact on LCPs but have broader consequences in relation to integrated working (see comments from partners in appendix one). The tools and resources that enable partners from across the system to work within an LCP structure are requirements to work effectively as integrated teams.

2 Next Steps

In response to the challenges highlighted, this report proposes the following next actions to be undertaken as next steps:

1. Align the purpose of LCPs with the City priorities, as identified through the Healthy Leeds Plan, with clear asks of all individual LCPs in relation to the Healthy Leeds Plan priority areas of focus.
2. Formerly embed the leadership of LCPs within the system governance structures.
3. Across all organisations, build LCPs into the culture and language of how we do things at a neighbourhood level.
4. Support and embed the narrative outlined in Fuller and by Marmot that we need to work together at a neighbourhood level to address the socio-economic determinants of health and wellbeing and support health equity.
5. Population and care delivery boards to use LCPs as the model for bringing professionals together with communities to progress neighbourhood working. Building on relationships with Adults and Health, opportunities are sought to link shared priorities more closely with locality working within the Council and with the Neighbourhood Improvement Board.
6. Future development and resourcing of Leeds Community Anchor Network and the Communities of Interest Network should include strengthening the ties between LCPs and communities.
7. Progress LCP development in line with the principles of proportionate universalism.
8. Involve LCPs in shaping and implementation of services for their local communities.
9. Follow through on our commitment as a system that we will work in an asset-based way with communities, meeting them where they are.
10. Build profiles of assets and needs around communities, starting with the communities living in the 10% most deprived areas, to support a community first way of working.

3 Recommendations

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

3.1 Support the ten actions outlined in section 2 next steps, to embed LCPs within the Leeds ‘architecture’ and maximise their potential.

3.2 Note that further work is needed to develop the actions into a plan and determine how this work will be monitored within current governance structures.

Appendix One - LCP Partner Feedback

To inform this paper and the future direction of LCPs the development team emailed the following question to everyone on the LCP mailing list.

"What do you think that Local Care Partnerships should be doing and what are the barriers to making this happen?"

50 people drawn from across partner organisations responded. The responses have been collated into broad themes which are summarised below together with quotes from participants.

Purpose, Accountability and Governance

Partner views on the purpose of LCPs were broad, reflecting the diverse reasons people engage with the partnerships and the broad brief of the LCP development team. The role of the LCP in building and maintaining local relationships came across strongly.

"Even having worked in this area for many years, I am still surprised at how many providers are in the area that I haven't known but I have met through the LCP".

"The risk without LCPs is that partners could work in silos or not take things forward as effectively or at the same speed."

Some partners said that LCPs should continue what they are currently doing – this was described as working together as a team across statutory and third sector, exploring issues and coming up with solutions - having many different perspectives around the table.

"One of the most striking and effective actions they have achieved is incorporating non-clinical partners such as local charities, elected members and organisations into the group."

The role of LCPs in addressing wider determinants of health and bringing partners together to reduce duplication and join up care were equally valued as sitting within the remit of the partnerships. However, partners also expressed frustration that LCPs were seen as a bolt on to the day job.

"Busy colleagues can avoid these meetings – a powerful pull to do something more important."

Concerns about connections between LCPs/neighbourhood working and the broader system governance centred on consistency of offer and ability to learn from good practice - applying learning across Leeds. Secondary care clinicians highlighted that great initiatives are happening but can be focused inward with no cross-city joined up thinking.

"I don't think they should be allowed to choose whether or not to have frailty services, there needs to be commonality in what the services provide as a whole

so that we can work in a joined-up way with citywide services without having to look up a postcode to see differing options."

(Main barriers) ***"when a project is successful and the funding is not available to continue it, or a pilot works and sadly there are no grants available".***

Clearer links between LCPs and Place based boards with shared priorities could balance local testing and service offers that meet the needs of diverse communities with a consistent offer to all. There was a desire to work more closely with colleagues at Place so that any project money used to pilot schemes was linked to future investment plans if successful.

Traction within the Leeds system

"We need to find a way of switching LCP working to being part of our daily work rather than a project or programme".

Most comments received focused on positive relationships and diverse partnerships. However, there were some comments about LCPs needing to have more influence on the system. There was a frustration that it could be hard to get the right partners to engage and that some of the statutory services that are hardest to refer to are also absent from partnerships.

Looking beyond LCP meetings to broader partnership working on an LCP footprint, one third sector partner commented that some health colleagues were excellent at getting out into the community and working with partners, but other health colleagues were reluctant to do this. One of the Enhance providers commented that the scheme had highlighted that many colleagues in neighbourhood teams still did not understand the role third sector could play in supporting people.

Engaging with communities

Respondents wanted to see LCPs build on work with communities. In some LCPs there are models of good practice that could be taken to other areas.

"I think there could be more community involvement and the LCP could lead on this, as far as I know there isn't a strategic partnership taking a lead on this for across a place/community. Community insight could come from the anchor organisations or a community panel for instance, however I would advocate that people are given 'something' for their time."

There was a desire to see residents involved in a more meaningful way but a recognition that this is a challenge in formal partnership meetings. Balancing data with acting on what is already known from communities was seen as a challenge. There was also an ask to ensure that the diverse communities that sit within an LCP footprint are all considered when planning, and that this information is not lost in data for a whole PCN.

"I think there is genuine leadership and desire to really strategically partner with local communities with the work of the LCP……I have also been encouraged overall by the commitment to ABCD approaches, thinking through what implications this has to work in LCPs."

The importance of building in asset-based approaches, the role of community anchors as partners within LCPs, and closer links to PPGs were also themes around community engagement.

Third sector infrastructure and support

One of the most voiced themes when considering the role of LCPs was building links between statutory and third sector.

"In our (LCP) area the third sector organisations are very trusted and proactive".

This included working together on initiatives, sharing information, and utilising the strong, local connections into communities to develop services responsive to local needs. Resourcing third sector organisations to be able to deliver services was the most frequently voiced barrier. Capacity to engage with LCPs was also raised as a barrier but one that was common across all partners.

"LCP development programme has been vital (in recognising value of third sector) I do find in my own experience that the third sector has increased its prominence and recognition. Of course, there is a long way still to go, especially with regard to financial resilience."

"Securing more sustainable and longer-term funding for the third sector should be a goal within health and care in Leeds, from the LCPs to the ICB".

Concern for the sustainability of the third sector came from both statutory and third sector partners, a reflection of the desire to work as an integrated support offer with an understanding of the value third sector offer. There was concern about how very small organisations link to LCPs and do not miss out on opportunities and concern that LCPs are perceived as health driven partnerships.

"a perception of LCPs being medicalised and not the wider scope that it actually is".

Proportionate Universalism and Resourcing to LCPs

Whilst some respondents questioned why some LCPs allocated funding to third sector and others didn't (probably relating to core 20+5 community grants) several respondents felt that LCPs should be focused on areas with greatest health inequalities.

"(I) would prefer that LCP work is concentrated in areas of highest need – so many health inequalities to tackle".

"LCPs should be championing and lobbying for the prevention agenda" "a willingness to take risks and invest in long term prevention now".

"Health and care needs…are long term and endemic issues that will take significant time to overcome".

Geography

Responses relating to geography centred more on the challenges of ensuring that having a local focus did not take away from the "equally vital need" to provide services for the whole of Leeds. As previously mentioned, this included ensuring that learning was shared across areas and rolled out and being clear on minimum requirements set for each area. This was not necessarily isolated to LCPs but covered any services with differential approaches in different parts of the city – feeding into the above on proportionate universalism.

Challenges that are broader than LCPs

Some of the barriers raised, whilst impacting on LCP development, are equally a barrier to integrated and effective working in all parts of the Leeds system. Shared records/disjointed IT was highlighted with frontline staff despondent that progress would ever be made.

"If we could all at least see each other's notes we would have a chance of working out how to work better together".

Understanding the totality of the assets in communities was also raised. Partners want to be able to easily see what support is available in an area and to be able to avoid duplication and plan for gaps. They would also like to see a RAG status with indication of capacity.

Funding was seen as a huge challenge, but partners also wanted flexibility within contracts to be able to make best use of current resource. Recruitment – particularly to short term roles and pilot projects was also a barrier to making things happen.

For those partners who are already involved in LCPs, overwhelmingly they saw LCPs as a good thing but wanted an appreciation from the system that change takes a long time and that we should learn from the LCPs modelling the best of partnership working and support the acceleration of this work.

"Lucky to be part of a thriving LCP community where we are making a difference. Keep on doing what you/we are doing".

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
Population and Care Delivery Board Update	X	X	X	X	Various
GOVERNANCE & FINANCE ITEMS					
Sub-Committee Assurance Reports	X	X	X	X	Relevant Chairs
Risk Management Report	X	X	X	X	TR
Board Assurance Framework (BAF)		X	X	X	TR
Financial Position Update	X	X	X	X	VPS
ITEMS FOR DECISION					
Business Case: Community Diagnostics Centre	X				JBS
Leeds Joint Working Agreement (JWA)		X			LM
GP Procurement / Merger of practices		X			KT
Healthy Leeds Plan / Joint Forward Plan	X				JC
STRATEGY & ASSURANCE					
Local Care Partnership (LCP) Update	X				TS
Winter Planning 2023/24 Update		X	X		HL
Operational Planning Round for 2024/25				X	TR/VPS