Leeds Health & Care Partnership

NHS West Yorkshire Integrated Care Board

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

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

AGENDA

No.	Item	Lead	Page	Time
LC 45/23	**Welcome, Introductions**	**Rebecca Charlwood** Independent Chair	-	13:15
LC 46/23	**Apologies and Declarations of Interest** - To note and record any apologies - A register of interests of members can be found at mydeclarations.co.uk - Those in attendance are asked to declare any specific interests presenting an actual/potential conflict of interest arising from matters under discussion	**Rebecca Charlwood** Independent Chair	-	
LC 47/23	**Minutes of the Previous Meeting** - To approve the minutes of the meeting held 4th October 2023	**Rebecca Charlwood** Independent Chair	3	
LC 48/23	**Matters Arising** - To consider any outstanding matter arising from the minutes that is not covered elsewhere on the agenda	**Rebecca Charlwood** Independent Chair	-	
LC 49/23	**Action Tracker** - To receive the action tracker for review	**Rebecca Charlwood** Independent Chair	15	
LC 50/23	**People's Voice** - To receive the 'How does it feel for me?' Sophia's story summary report	**Jonathan Philips** Healthwatch Leeds	17	13:20
LC 51/23	**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 52/23	**Place Lead Update** - To receive a report from the Place Lead	**Tim Ryley** Place Lead	45	13:45
LC 53/23	**Population and Care Delivery Board Update** - To receive a highlight update from the Long Term Conditions Population Board	**Lindsay McFarlane** Head of Pathway Integration for Long Term Conditions	-	14:00
ROUTINE REPORTS				
LC 54/23	**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	53	14:15

No.	Item	Lead	Page	Time
LC 55/23	**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	55	
LC 56/23	**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	57	
FINANCE				
LC 57/23	**2023-24 Financial Position at Month 7** - To receive the financial position update	**Visseh Pejhan-Sykes** Place Finance Lead	59	14:30
BREAK 14:40 – 14:50				
ITEMS FOR DECISION/ASSURANCE/STRATEGIC UPDATES				
LC 58/23	**Transforming Community Mental Health in Leeds** - To receive and discuss the update	**Helen Lewis** Director of Pathway Integration	79	14:50
RISK MANAGEMENT				
LC 59/23	**Risk Management Report** - To receive and consider the risk management information provided	**Tim Ryley** Place Lead	120	15:10
FORWARD PLANNING				
LC 60/23	**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	-	15:20
LC 61/23	**Forward Work Plan** - To consider the forward work plan	**Rebecca Charlwood** Independent Chair	149	
LC 62/23	**Any Other Business** - To discuss any other business	**Rebecca Charlwood** Independent Chair	-	
LC 63/23	**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 13th March 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
64/23	**Private Minutes of the Previous Meeting** - To approve the private minutes of the meeting held 4th October 2023	**Rebecca Charlwood** Independent Chair	-	15:25
65/23	**Financial Planning 2024/25** - To receive and discuss the update	**Visseh Pejhan-Sykes** Place Finance Lead **Tim Ryley** Place Lead	-	15:30

Draft Minutes

Leeds Committee of the West Yorkshire Integrated Care Board (WYICB)

Wednesday 4 October 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		✓
Sam Prince	**SP**	Interim 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)		✓
Clare Smith (deputising for PW)	**CS**	Chief Operating Officer, Leeds Teaching Hospital NHS Trust (LTHT)	✓	
Dr George Winder	**GW**	Chair, Leeds GP Confederation	✓	
Caroline Baria	**CB**	Interim Director of Adults & Health, Leeds City Council (LCC)		✓
Tony Meadows (deputising for CB)	**TM**	Interim Deputy Director, Integrated Commissioning, LCC	✓	
Victoria Eaton	**VE**	Director of Public Health, LCC		✓
Tim Fielding (deputising for VE)	**TF**	Deputy Director of Public Health, LCC	✓	
Shanaz Gul	**SG**	Third Sector Representative		✓
Pip Goff (Deputising for SG)	**PG**	Chief Executive, Forum Central	✓	
Dr John Beal	**JB**	Chair, Healthwatch Leeds	✓	
Dr Sarah Forbes	**SF**	Medical Director, ICB in Leeds	✓	
Jo Harding	**JH**	Director of Nursing and Quality, ICB in Leeds	✓	

Members	Initials	Role	Present	Apologies
Additional Attendees				
Sam Ramsey	**SR**	Head of Corporate Governance & Risk, ICB in Leeds	✓	
Harriet Speight	**HS**	Corporate Governance Manager, ICB in Leeds	✓	
Hannah Davies (Item 27/23)	**HD**	Chief Executive, Healthwatch Leeds	✓	
Anna Ross (Item 38/23)	**AR**	Head of Public Health, LCC	✓	
Victoria Treddenick (Item 30/23)	**VT**	Senior Pathway Integration Manager, LCC	✓	
Julie Longworth	**JL**	Director of Children and Families, LCC	✓	
Gaynor Connor	**GC**	Director of Primary Care and Same Day Response, ICB in Leeds	✓	

Members of public/staff observing – 2

No.	Agenda Item	Action
22/23	**Welcome and Introductions** The Chair opened the meeting of the Leeds Committee of the West Yorkshire Integrated Care Board (WY ICB) and welcomed all attendees to the meeting. The Chair noted that Sam Prince, Interim Chief Executive of Leeds Community Healthcare, had joined the meeting as a new member of the Committee and thanked her for her attendance.	
23/23	**Apologies and Declarations of Interest** Apologies had been received from Yasmin Khan, Professor Phil Wood, Caroline Baria, Victoria Eaton and Shanaz Gul. Clare Smith, Tony Meadows, and Tim Fielding were in attendance as deputies. Pip Goff (PG) advised that she was in attendance as deputy on behalf of Forum Central as Shanaz Gul (SG) had stepped down from her role as third sector representative. Members were asked to declare any interests presenting an actual or potential conflict of interest arising from matters under discussion. In reference to the items on the agenda relating to Social Emotional Needs and Disability (SEND) provision in schools and communities, Cheryl Hobson (CH) noted that she currently holds the position of the Chair of Governors for Wellspring Multi-Academy Trust, which includes specialist SEND provision across Leeds. For clarity, Dr Sarah Forbes (SF) noted that herself and Dr George Winder (GW) work as practicing GPs at Oakwood Lane Medical Practice, not to be confused with Oakwood Surgery, the practice included in the proposed merger report at Item 37.	

No.	Agenda Item	Action
24/23	**Minutes of the Previous Meeting – 5 July 2023** 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 5 July 2023.	
25/23	**Matters Arising** There were no matters raised on this occasion.	
26/23	**Action tracker** The committee noted the completed actions set out in the action tracker. Tim Fielding (TF) welcomed the addition of an item added to the forward workplan to provide an update on the Marmot City work taking place in Leeds (action 1), however suggested that March 2024 would be a more suitable date. **ACTION –** To postpone the Marmot City Update to March 2023.	**HS**
27/23	**People's Voice** Hannah Davies (HD) introduced a video from the 'How does it feel for me?' series depicting the experiences of Laura, and her children, Abigail (10) and James (6), who live on the border between Leeds and Wakefield. Members were advised that a different video from the series had been played at each of the sub-committee meetings. Throughout the series of videos, Laura described the family's experiences of accessing health services across Yorkshire due to the complexity of James' health conditions. The video shown at the meeting was focused on educational support, including the process for obtaining an Education Health and Care Plan (EHCP) for James and how the Specialist Inclusive Learning Centre (SILC) had responded to his needs to date. The Chair highlighted that throughout the series of videos, the need for digital transformation had arisen as a consistent theme, particularly in terms of sharing of information between organisations to ensure that scheduling of appointments is synchronised and the patient is kept well informed. Julie Longworth (JL) provided the Committee with an update on recent changes to the EHCP application and assessment process, advising that in Leeds, the Special Educational Needs Statutory Assessment and Provision (SENSAP) team is responsible for overseeing all EHCPs and assessments. JL advised members that the service had seen an increase in demand in recent years and alongside issues with recruitment and retention of educational psychologists to support the assessment process. In response to this, members were advised that LCC had increased the number of SENSAP case workers, improved accessibility of the	

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	telephone system, and more recently explored potential for virtual assessments with school leaders across the city. ***SM joined the meeting at 13:30 p.m. during discussion of this item.***	
28/23	**Questions from Members of the Public** There were no questions received from members of the public on this occasion.	
29/23	**Place Lead Update** Tim Ryley (TR) provided an overview of the report, highlighting that financial pressures remain a significant challenge and that health and care partners in Leeds continue to work together to identify the best approach to planning for the next financial year that ensures safety and quality of services, whilst not losing the important upstream work that reduces demand. TR emphasised that there will be some difficult decisions required by all partners and their decision-making bodies as the year progresses. In addition to financial pressures, TR alerted the committee to other significant areas of concern within the system, including the Tier 3 Weight Management service, within which the list had been closed to new referrals, and the lengths of wait for children and young people waiting for a diagnosis of Autism and ADHD. TR reflected on the ongoing major transformation of community mental health services, with work being undertaken by a strong partnership of health, social care, primary care and third sector partners along with people with lived experience. It was requested that this be added as a full update item to the agenda of the next meeting. **ACTION** – To add Community Mental Health Update to the forward workplan for December 2023. In reference to the new 'right to choose' legislation, which allows patients to choose their mental healthcare provider and team, Dr John Beal (JB) highlighted that this may drive further health inequalities by enabling more affluent families to switch to private providers and gain earlier access to assessment for a neurodiversity diagnosis. Dr Sarah Forbes (SF) noted that private providers had also reportedly shut their waiting lists due to being overwhelmed by the demand for assessments. The Chair highlighted the importance of challenging national policy where it has potential to exacerbate health inequalities. There was some discussion around the impact of a diagnosis of ADHD or autism on the support received. Sam Prince (SP) highlighted that 96% of children referred for an assessment receive a diagnosis, which challenges the value of an assessment. Sara Munro (SM) advised that parents had reported that diagnosis does make a difference and unlocks expanded response from schools, however, a WY wide summit had been scheduled for December 2023 to identify reasonable	**HS**

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	adjustments that can be taken by all parts of the system to support people with AHAD and autism. SM noted the success of a national scheme - Autism in Schools' – which had focused on making all learning settings sensory friendly and has been shown to benefit all children as well as ensuring that children with ADHD and autism can remain in mainstream schooling. **<u>The Leeds Committee of the WY ICB:</u>** a) **Considered** and **noted** the contents of the report	
30/23	**Population and Care Delivery Board Update** Victoria Treddenick (VT) attended the meeting on behalf of the Learning Disability and Neurodiversity Population Board and delivered a PowerPoint presentation, highlighting that the defined population does not include neurodiversity beyond autism due to the availability of current data. VT also advised that 83% of the population are classed as having a Long Term Condition (LTC) and therefore joined up work with the LTC Population Board is key. VT highlighted that 3,459 children with learning disabilities and/or neurodiversity are not included In the population, however recognised the importance of working closely with the Children's Population Board as those children move into adulthood. VT highlighted the following areas of focus for the Board: - Identification and assessment – focus on thereafter responding to the need rather than relying on a diagnosis - Staying well – reducing the chance of developing a LTC and early detection of LTCs - Transforming Care Programme – improving people's access to mental health provision - Health inequalities – WY ambition to reduce the gap in life expectancy by 10% TR thanked VT for the update and the Board for the work undertaken to date. TR highlighted that respiratory conditions continue to be the most common cause of death (47%) amongst people with a learning disability and / or autism and the importance of the Board working with the LTC Population Board to share data and reduce the risk of respiratory disease. **<u>The Leeds Committee of the WY ICB:</u>** a) **Received** the update.	
31/23	**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:	

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	- The sub-committee noted that a thematic review of alternative provision for children and young people with Special Educational Needs and Disabilities (SEND) had been announced on 4 September 2023. The three-week review by OFSTED and the Care Quality Commission (CQC) would use the Area framework and would involve engagement with carers, children and young people, teachers and strategic leadership. The review would culminate in a report, in November 2023, which would feed into the national picture. Members noted that no judgements would result from the review due to its purpose as a research exercise. - Full assurance was provided to the sub-committee through the Leeds ICB Safeguarding Team Annual report, the Leeds Safeguarding Children Partnership (LSCP) annual report and the Leeds Safeguarding Adults Board (LSAB) annual report. The reports highlighted key achievements and challenges facing safeguarding services in Leeds. - In terms of the update received from the Long-Term Conditions (LTC) Population Board, members were informed of a successful bid with Leeds University to secure £200k seed funding from the National Institute of Health Research (NIHR) for Systems Engineering Innovation hubs for Multiple Long-Term Conditions (SEISMIC) to progress the Board's ambitions around multimorbidity. - As part of the work of the Cancer Population Board, members were informed of the Migrant Access project which aimed to raise awareness of cancer signs, symptoms and screening programmes and engaged those communities in bidding for funds. The sub-committee was assured of strong patient experience representation on the Cancer Population Board. Jo Harding (JH) updated members following recent developments regarding the recent OFSTED inspection referenced, advising that a draft version had been received, to provide teams with opportunity to review and comment prior to publication. **<u>The Leeds Committee of the WY ICB:</u>** **a) Received** the update.	
32/23	**Delivery Sub-Committee Update** In the absence of the Chair of the Sub-Committee, Yasmin Khan (YK), Cheryl Hobson (CH) provided a brief overview of the assurance report included in the agenda pack and highlighted the following key points: - In regard to the Population and Delivery Board reports, discussions specifically highlighted the considerable challenge of the Boards in terms of capacity to tackle health inequalities, given the current financial pressures and reduction of funding in some areas, as well as the reactive nature of their work as a result of periods of industrial, action and medication	

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	shortages. The sub-committee also identified some areas of concern or risk for the Leeds Committee to be alerted to, specifically, gaps in community provision for smoking cessation and the decommissioning of the Community Cancer Support Service. - The sub-committee noted the positive feedback from Laura in the 'How does it feel for me?' video regarding the Leeds Dental Hospital Dentistry and Orthodontics – which has received an outstanding CQC rating - and wished to highlight this to the Leeds Committee. The sub-committee discussed several issues raised in the video, such as cross-border coordination of services and appointments. - The sub-committee received an update report on system winter plans to deliver access to services over the winter period. Partners reported confidence in the management of the plans, particularly given the financial pressures experienced by NHS partners and Leeds City Council and the 'cost of living' pressures that continue to impact the communities of Leeds. Members welcomed the proactive and data driven approach taken, as well as the improved communication and presentation of the plans, and therefore noted assurance of the work undertaken. **<u>The Leeds Committee of the WY ICB:</u>** a) **Received** the update.	
33/23	**Finance and Best Value Sub-Committee Update** The Chair of the Sub-Committee, CH, provided a brief overview of the assurance report included in the agenda pack and highlighted the following key points: - The sub-committee recognised the financial position remains a significant challenge, with a deficit projected in year as well as for 2024/25. The sub-committee was updated on the process and progress in relation to planning for 2024/25 and was assured that work continues to take place to address and manage the risk, however, was not able to be fully assured that Leeds Place will be able to present a balanced budget for either financial year at this stage. - The sub-committee received a report providing an update on the Risk Register and the risks aligned to the Finance and Best Value Sub-Committee. There was some discussion around whether a new risk should be added to the Leeds Place risk register associated with the capital regime, in recognition of the impact on the Leeds system's ability to reduce spend without adversely affecting patient outcomes. It was agreed that this would be developed and added to the risk register, in line with similar risks across other places across West Yorkshire. **<u>The Leeds Committee of the WY ICB:</u>** a) **Received** the update.	

No.	Agenda Item	Action
34/23	**Finance Update at Month 5 (August) 2023-24** Visseh Pejhan-Sykes (VPS) introduced the report, advising that WY ICB continues to forecast a deficit of £25.1m in formal reports but are already signalling that the most likely scenario outturn position is significantly more challenging (£103.7m). VPS advised members that given the emerging risks currently experienced in the first 5 months of the year, the likely position for Leeds Place is a deficit forecast of £22.9m. Members were advised that pressures contributing to the projected deficit were associated with prescribing cost policies, primary care, junior doctor and consultant strikes, agency costs and waiting times. Members were also alerted to a significant issue that had emerged around the support to people with learning disabilities to move out of inpatient placements and into communities, following recent national policy changes. Members were advised that teams were working closely with NHS England colleagues to provide further detail on the situation to determine if any further support can be requested. Given the significance of the financial challenged experienced, George Winder (GW) queried to what extent communication with the people of Leeds had taken place. TR noted the value of a collective voice, with all partners across West Yorkshire, in terms of public messaging around finance, as well as ultimately the key role of the government in funding NHS organisations and supporting them through financial hardship. VPS advised that the WYICB had lobbied central government via the regional office of NHS England and colleagues had recently developed a process for patient engagement to take place in the coming months regarding the financial strain on services. **<u>The Leeds Committee of the WY ICB:</u>** **a)** **Reviewed** and **commented** on the month 5 position. **b)** **Reviewed** and **commented** on the QIPP delivery for 23-24 and to discuss what further actions it will be pursuing to improve the position. **c)** **Noted** progress to date on the 24-25 QIPP programme. ***VPS and TM left the meeting at 3:05 p.m. at the close of this item. TF left the meeting at 3.05 p.m. and returned during the break.*** ***The meeting adjourned for a comfort break at 3.05 p.m. until 3:15 p.m.***	
35/23	**Risk Management Report** TR provided an overview of the report, noting that all high rated risks should be represented by items and discussions at each meeting. TR highlighted that the financial pressures associated with out of area placements had not been covered on the agenda to date and suggested that a dedicated deep dive on this be added to the forward workplan. TR also reflected that the Tier 3 Weight Management list	

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	closure to new referrals was not featured on the risk register and suggested that an update be provided in March 2024. **ACTION –** To add a 'deep dive' into the prevalence of high cost out of area placements to the forward workplan. **ACTION –** To add an update regarding the Tier 3 Weight Management service to the forward workplan. **<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.	**HS** **HS**
36/23	**Leeds Joint Working Agreement (JWA) with Astra Zeneca for Improving Cardio-renal Outcomes** Gaynor Connor (GC) introduced the report, advising members that several partners had been involved in developing the proposal presented to optimise clinical management of people with kidney disease. GC noted that the WYICB Joint Working Policy framework requires approval from the Leeds Committee due to working with pharmaceuticals company. Sam Ramsey (SR) confirmed that the joint working agreement had been developed in line with the principles outlined within the policy. For transparency, GW and SF noted their association with the Seacroft Primary Care Network (PCN), included in the report as one of the pilot PCNs for additional support during roll-out. In response to a query, TR advised that the four practices set out in the report for the pilot scheme had been selected to quicken the process, with a clear focus on health inequalities, with potential to expand the pilot scheme to further practices later in the year. TR noted that the policy had been developed in response to national guidance which must be adopted by all GP practices, and that the pilot scheme had been developed in Leeds to offer additional support. GW added that the GP Confederation also have a key role in support to adhere to the policy at individual practice level. **<u>The Leeds Committee of the WY ICB:</u>** **a) Approved** the recommendation that the Leeds place enters into a Joint Working Agreement (JWA) with AstraZeneca for the Improving Cardio-renal Outcomes project as described within this paper.	

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37/23	**Proposal to Merge Shadwell, Rutland and Oakwood Practices** Gaynor Connor (GC) introduced the report, highlighting that the Primary Care Board had reviewed the business case, engagement feedback and provided approval for the partners of Shadwell Medical Centre, Rutland Lodge Medical Practice, and Oakwood Surgery to merge the three practices in November 2023. The Chair queried whether a clear strategy had been developed to steer the market in relation to merges of practices, or whether a more 'bottom up' approach was preferable. GC advised that the informal strategy for primary care provision was focused on the balance of maintaining local provision whilst stimulating the local market. TR added that the recent work with Staten Island had shown the impact of incentives and payments to drive specific pieces of work, which will be critical for responding to market pressures. **The Leeds Committee of the WY ICB:** a) **Noted** the feedback from patients and local stakeholders around the impact of the proposed changes at Shadwell Medical Centre, Oakwood Surgery and Rutland Lodge Medical Practice b) **Approved** the proposal for the merger of Shadwell Medical Centre, Rutland Lodge Medical Practice, and Oakwood Surgery in November 2023	
38/23	**In Our Shoes: The Director of Public Health Annual Report 2022** Anna Ross, Head of Public Health (LCC), introduced the report and delivered a PowerPoint presentation, focused on the current state of children and young people's health in Leeds, this included exploring the impact of the COVID-19 pandemic on their lives. Members welcomed the report and the helpful insight into the impact of the pandemic on children's lives, particularly noting the increased health inequalities evidenced and increased demand for mental health services. There was some discussion regarding the access delays to dentistry as set out in the report, in recognition that responsibility for dentistry had been transferred to the WYICB, however, not yet delegated to Place Committees. TR noted that the demand and capacity for dentistry remains a significant national issue and there is still work to be done at West Yorkshire level to determine arrangements. It was agreed that recommendations 3 and 9 as set out in the report be delegated to the Children and Young People Population Board to progress, with a particular focus on protecting these areas of work in most deprived communities. **ACTION –** To delegate recommendations 3 and 9, as set out in the In Our Shoes: Director of Public Health Annual Report 2019, to the Children and Young People Population Board.	**HS**

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	The Leeds Committee of the WY ICB: a) **Noted** the content of the Director of Public Health annual report and accompanying film b) **Supported** and **committed** to delivering the recommendations of the report with a particular focus on recommendations 3 and 9 by the Children's Population Board.	
39/23	**Items for the Attention of the ICB Board** The Chair outlined that the Committee would submit a report to the West Yorkshire ICB on items to be alerted on, assured on, action to be taken and any positive items to note. The key areas to highlight were set out as follows: - Opportunities to improve access and support for the EHCP application and assessment process - Increasingly challenging financial position, including cost pressures associated with moving people with learning disabilities out of inpatient care into community care setting - Assurance of winter plans in place - The key messages from the Director of Public Health Annual Report 2022 - Notification of decisions approved - Joint Working Agreement with Astra Zeneca for Improving Cardio-renal Outcomes and Proposal to Merge Shadwell, Rutland and Oakwood Practices	
40/23	**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. The Chair noted that proposed items would be discussed with the Governance team to ensure the Committee was the most appropriate forum. The Chair noted that there had been several earlier actions relating to additions or amendments to the forward workplan, which had been reflected in the relevant minute items.	
41/23	**Any Other Business** There were no items raised for discussion.	
42/23	**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 13th December 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	

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	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.	

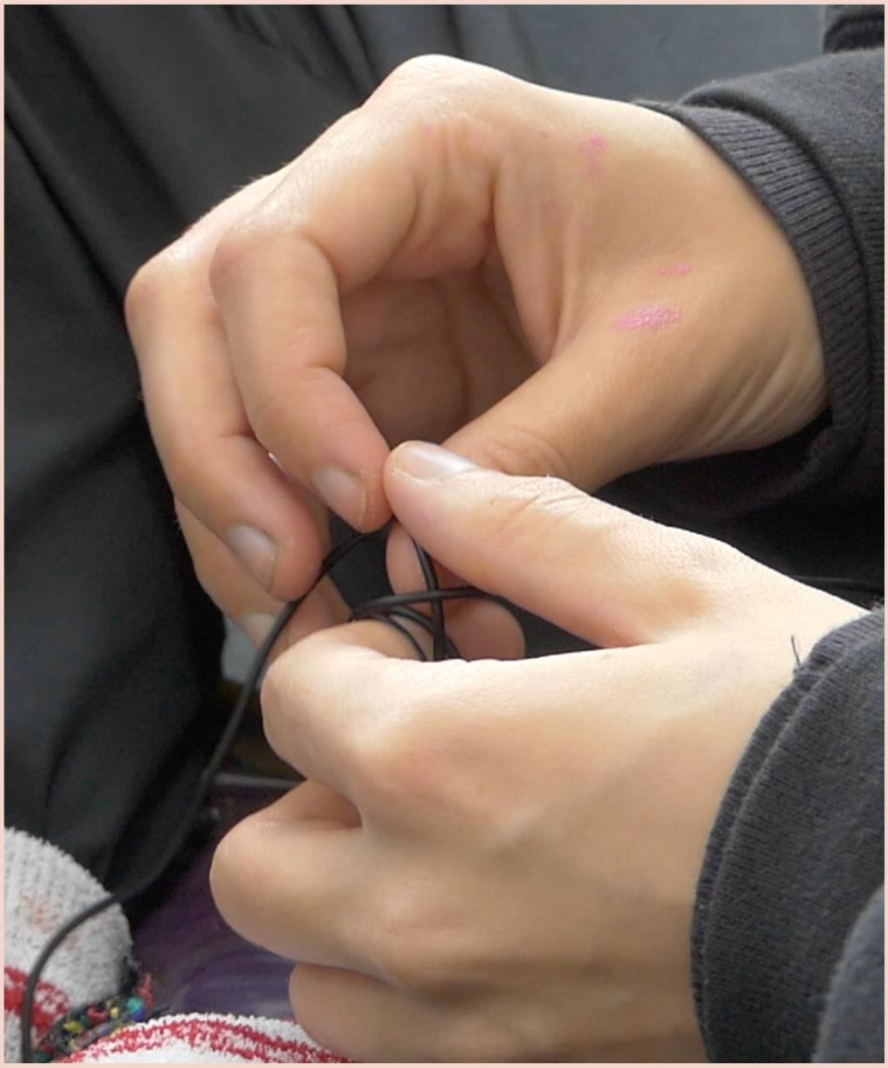
Action Tracker

Leeds Committee of the WY ICB

Action No.	Meeting Date	Item Title	Actions agreed	Lead(s)	Accountable body / board / committee	Status	Update
4	**04/10/2023**	**Action Tracker**	To postpone the Marmot City Update to March 2024.	**Harriet Speight**	**LCICB**		**Complete** Amended on the forward work plan
5	**04/10/2023**	**Place Lead Update**	To add Community Mental Health Update to the forward workplan for December 2023.	**Harriet Speight**	**LCICB**		**Complete** Added to the forward work plan
6	**04/10/2023**	**Risk Management Report**	To add a 'deep dive' into the prevalence of high cost out of area placements to the forward workplan.	**Harriet Speight**	**LCICB**		**Complete** 'Deep dive' undertaken by the Finance and Best Value Sub-Committee at its meeting on 29th November 2023 (Item 56 refers.)
7	**04/10/2023**	**Risk Management Report**	To add an update regarding the Tier 3 Weight Management service to the forward workplan.	**Harriet Speight**	**LCICB**		**Complete** Added to the forward work plan
Completed Actions							
1	**05/07/2023**	**Place Lead Update**	To add Marmot City Update to the forward workplan, to include updates from partners and to be coordinated by the Director of Public Health.	**Harriet Speight**	**LCICB**		**Complete** Added to the forward work plan

Action No.	Meeting Date	Item Title	Actions agreed	Lead(s)	Accountable body / board / committee	Status	Update
2	**05/07/2023**	**Risk Management Report**	To add a risk to the risk register relating to the implications of the 30% reduction in funding allocation associated with the West Yorkshire Operating Model	**Tim Ryley / Sam Ramsey**	**LCICB**		**Complete** A corporate risk has been added as the Operating Model work sits organisationally across West Yorkshire
3	**05/07/2023**	**Any Other Business**	To invite the Director of Children and Families at Leeds City Council to attend future committee meetings.	**Harriet Speight**	**LCICB**		**Complete** Invites sent to Director of Children Services

HOW DOES IT FEEL FOR ME?



Sophia's story summary report

Context

This work is part of a wider approach being taken in Leeds to understand people's experiences as they move around health and care services, called the 'How does it feel for me?' programme. As well as the real time journeys that we are following, there are three additional components to the programme: case note reviews, understanding what citywide complaints tell us, and developing a set of metrics (data measures for tracking progress) that will be used to measure joined up health and care services. The project involves all health and care partners, including representatives from Healthwatch Leeds, Leeds Teaching Hospitals Trust, Leeds Community Healthcare NHS Trust, GP Confederation, Leeds and York Partnership NHS Foundation Trust, Leeds City Council, Carers Leeds, Age UK and St Gemma's Hospice. It is designed to support them to understand what people's experiences are like as they move through 'the system'; identify what is working and what is not; and to think about how they can plan and deliver services better. Increasingly, as health and care services work more and more in partnership, this work will feed into the Integrated Care Partnership for Leeds.

For more information on this project, please visit our website https://healthwatchleeds.co.uk/our-work/how-does-it-feel-for-me/ or contact harriet@healthwatchleeds.co.uk

Background

Sophia is a young woman who has a diagnosis of complex PTSD (Post Traumatic Stress Disorder) which massively affects her day-to-day life. She also struggles with severe migraine episodes, insomnia, and IBS which affect both her physical and mental health.

She wanted to take part in the How does it feel for me? video project as she wanted to be listened to when providing feedback on services. Her experience in the past has sometimes been that she hasn't been taken seriously when she has tried to give feedback, particularly when she has been in crisis.

Sophia is not her real name. We have used it to protect her identity.

We followed Sophia's journey between April 2022 and April 2023 through a series of audio recorded updates.

Themes and key messages

Below we have summarised some of the key themes arising in Sophia's journey. We start with the '3 Cs'- communication, compassion, and co-ordination - essential building blocks for good person-centred care, but also cover some other themes that come up in Sophia's experiences.

Co-ordination

As someone who uses a lot of different mental health services, Sophia's experiences frequently touch on the need for good co-ordination both within and between services.

She shares some good examples of co-ordination (mainly involving her care co-ordinator at Emerge) but also recounts poor experiences, particularly around discharge.

Sophia describes how the three professionals that she sees from Emerge (care co-ordinator, youth worker and occupational therapist) work together to co-ordinate her care.

"They all kind of seem to communicate, so I haven't really got to say the same thing twice too much, which I think is a good thing because saying the same thing three times a week is just really, really irritating. And also, especially if the thing you need to say is difficult you don't want to have, to have that difficult conversation three times… I think it just makes the care feel a bit more joined up." (Nov 2022, part 1)

She also describes how them all being up to date with how other sessions have gone means that they can tailor their approach better and provide better care. She explains how good co-ordination means that they can cover for each other during staff absence (e.g., when her occupational therapist stands in for care co-ordinator at her benefits review).

Sophia has a good relationship with her care co-ordinator whom she sees regularly, knows her well, and recognises when she needs more support. Her care co-ordinator also acts as an advocate for Sophia when she is not well. In April 2023, part 2, we see her care co-ordinator explaining to the male police and paramedics how to not to further antagonise Sophia by touching her unwarrantedly. Her experiences demonstrate the importance of continuity of care, and the resulting trust that is built up over time.

Her care co-ordinator also organises a Multi-disciplinary Team (MDT) meeting with all the professionals involved in Sophia's care with the aim of sharing her history and the best ways to support her (April 2023, part 2).

Repeatedly from Sophia, we hear about poorly co-ordinated discharges where there appears to be no clear plan and that often happen at very short notice:

- In April 2022, she describes being discharged from A&E by the Acute Liaison Psychiatry Service (ALPS) without any support.
  "The next day, my care coordinator from Emerge came round the house, to speak to me and she agreed to refer to ISS, which is something that, you know, ALPS could have done the night before. I would have preferred to know what the plan was, last night when I was in crisis." (April 2022)
- In the May-Sept 2022 update, she describes being told about her discharge on the day of discharge.
  "When I was being discharged from Oasis I was literally told on the day, with no real warning that that was going to happen, and that was quite stressful, because obviously you go from having all the support around you to nothing." (May-Sept 2022, part 1)
- In February 2023, she describes discharge from A&E without a plan or mental health review despite being deemed to not have mental capacity earlier on in the day.
- In February 2023, she also recounts discharge from Oasis with no plan because she refused to engage with the person from ISS who they "kept sending", despite her previously having a bad experience with them in terms of the detrimental way she had been spoken to. In this instance, she reflects on the impact of not having a structured plan for discharge:

"I think if I'd have had a discharge plan, I don't think it would have escalated to how it escalated, but because they made me feel so unsettled with like, what was happening next, and it was stressing me out, that's why I was just like, 'Well, nothing is going to get better then, so may as well just die'." (Feb 2023)

- In April 2023 part 1, Sophia talks about her discharge from the 136 suite. She feels pressured to leave immediately because the taxi was waiting outside, leaving her no time to check for her house keys (which turned out not to be in the bag she was given). This resulted in her having a panic attack in the taxi and having to be brought inside again to be calmed down and medicated.
- In April 2023, Sophia is given mixed messages about what day she will be discharged from Becklin which "***** around with your head when you're mentally preparing yourself". She says that she is given one day's notice which didn't give her enough time to arrange someone to come and pick her up. Ideally, she would have liked to have three- or four-days' notice so that she could get things in place and also to mentally prepare herself for going home. When she does get home on this occasion, poor communication and planning from ISS resulted in no face-to-face support after discharge, just a short phone call.

Sophia's care co-ordinator does unsuccessfully try to push for better co-ordination of discharge, and on more than one occasion advocates for her to stay a couple more days and have a structured plan that works towards discharge (May-Sept 2022, parts 1 and 2).

Sophia's experience with the Intensive Support Service (ISS) is a good example of the variation that can happen in a service over time in terms of co-ordination, but also in terms of communication and compassion. When we first meet Sophia, she describes ISS as a good service:

"They're always really good, just got a really nice bunch of people. They're not very judgemental and they don't tend to ask you too many annoying questions that don't make sense… You get seen once a day. You can also ring the duty line as well, which is open 'til 9pm. And they also really try to get you to see people that you've seen before, so when I've been under the service, I've always got the same like, three, four people that I know already, so that helps." (April 2022)

Six months later in September 2022, her view of the service feels very different and continues in this vein until our last interview with Sophia in April 2023.

"They were sending round a male worker when I had specifically said, "Don't send round a male worker because I'm not going to engage." And then they wouldn't tell me what time they were coming…. Before, they'd supported me for a bit longer and like, had always been a bit more consistent… telling me in advance. You know, they'd tell you the day before, "Okay tomorrow we're going to come roughly at about 3 o'clock." But this time it was like, "We could come anytime between 11 and 4", which is like a big chunk of time. You're already really isolated and then you… can't even just go outside to go for a shop." (May-Sept 2022 part 1)

She also describes how she feels the support has become too short-term. On one occasion she describes only two visits from ISS, and on another just a 13-minute phone call (May-Sept 2022, part 2) before discharge.

When Sophia is in hospital following an overdose, she doesn't feel confident that staff from different services are clear about who is responsible for keeping her safe if she "walks off" or "does something daft".

"When I was on the general ward at Jimmy's it felt like there wasn't really a plan of like, who was in charge of my care… because technically I was under the care of the Becklin Centre, but then I was also under the care of Jimmy's." (May-Sept 2022, part 1)

This example highlights the need for services to be clear about roles and responsibilities and the potential impact on patient safety if this doesn't happen effectively.

Finally, Sophia highlights the link between good record keeping, information sharing, professionals reading her notes and how this impacts her care.

"It's just not joined up. Everybody is working on a different system, and it does more harm than good." (April 2022)

She also indicates how this can affect how safe she feels when receiving care.

"If they'd have read my records properly, they would have realised that... I feel very unsafe around men." (April 2023, part 1)

Compassion

Compassion, or lack of it, is another key theme of Sophia's experiences. Her experiences demonstrate clearly that when professionals prioritise compassion, trust, co-operation and recovery are more likely to happen.

Sophia shares many examples of individual compassionate staff across the different services that she accesses. Often when asked about what she most valued about her care in each update, Sophia gives an example of compassionate care, which is often something as simple as a hug or someone holding her hand when she is in crisis.

"When I was at CAU (Crisis Assessment Unit), this nurse who I'd met previously on Ward 5, happened to come to this ward that I was on, told me off, and then she gave me a hug. So, I valued that." (Feb 2023)

Professionals that stand out for her as being consistently compassionate are staff from Oasis, an A&E doctor, the ambulance service and her care co-ordinator.

"Usually when the ambulance crew sees you're really, you're still quite really distressed so they're seeing you when you're really not in a good way at all, but then they're still able to speak to you like a person and they're still able to have some compassion." (April 2022)

Her care co-ordinator is a "nice person" but also what makes Sophia like her is that she "understands how to talk to me and get the best out of me," and offers appropriate challenge and boundaries (Nov 2022 part 1).

Sophia experiences a huge variation in compassion from the crisis team. More than once, she describes not feeling heard by the crisis team who she reports saying things like, "have a cup of tea,", "go for a walk" or "have a bath", when she has called them in crisis.

"It's just so demeaning when they say things like that." (May-Sept 2022 part 2)

She describes one crisis team staff member saying to her, "We don't think you're going to kill yourself." (May-Sept 2022 part 1). This has a lasting impact, when this same person gets repeatedly sent out to see her several months later during a stay at Oasis, resulting in her refusing to engage and being discharged without any kind of plan (Feb 2023).

She compares this kind of attitude to the "best response I've ever had from the Crisis Team", where the person on the phone, "just listened to me with a bit of like, compassion". The result is that Sophia trusts her enough to be open with her about her suicide attempt, and then co-operates when an ambulance is sent out to do her observations.

"Because of how nice she'd been to me, it meant that I was really honest with her and told her what I'd taken." (April 2023, part 2)

Compassion is shown in the 'trauma-informed' practice Sophia experiences from a doctor in A&E, who by listening and understanding what might be behind her behaviour very skilfully de-escalates a very difficult situation.

"I felt like they listened to me, and they also got what they wanted out of the situation without it, escalating into a big kerfuffle." (April 2023, part 1)

Sophia says that the one thing that would make her experience of crisis services better would be more of this kind of trauma-informed approach:

"I would say that they should be looking at someone as a whole person, rather than just looking at a someone's behaviour right now, in the here and now and being like, 'what is wrong with them?' Like, 'what has that person been through? What is that person's circumstances?'" (April 2022)

Stigma

"The one thing that I would really like to see improved in services… is the way that people with personality disorders or complex trauma… are treated in the system. So just treating people with like, dignity and respect and actually like they're worth treating, because most of the time we're written off and we need people to fight for us, and nobody is." (Nov 2022 part 1)

In her audio recordings, Sophia touches on the stigma surrounding Emotionally Unstable Personality Disorder (EUPD) or complex trauma and how this can affect how she feels treated.

"We're always labelled as attention seeking." (April 2023 part 2)

She describes a doctor at the 136-suite diagnosing her with EUPD after having only just met her and asking her "three questions". She states that the doctor also didn't read her records, where she would have seen that Sophia had recently had this diagnosis removed.

"She wrote me off as just like untreatable and discharged me." (May-Sept 2022 part 1)

Communication

Much of Sophia's experiences of communication has already been covered under 'Co-ordination' and 'Compassion'. However, a notable exception is the language used by the Acute Liaison Psychiatry Service (ALPS) both verbally and in her medical records. She describes them as nearly always "condescending":

"The way they speak to you, I feel like I'm being told of by my schoolteacher." (April 2022)

Contrast that with how she later describes her care co-ordinator:

"When she talks to me, I don't feel like she's talking down to me like I'm a child." (Nov 2022 part 1)

More than once Sophia also describes what she feels is judgemental rather than descriptive and factual language used by ALPS in their reports. She cites the example of using language such as "refused" as opposed to "didn't want to" (April 2022). On another occasion she feels that she is being labelled as attention seeking when she says that an ALPS states, "I always bring myself to the attention of services in order, so that I can be saved." (April 2023, part 2).

"It really infuriates me, because it basically makes me look like an attention seeker, and that's not what happened." (April 2023, part 2)

Sophia also highlights the need to get initial communication right when being contacted by a service. She describes how the phone 'induction' with Live Well Leeds felt invasive and unnecessary, and that it could have been done more sensitively and appropriately via a questionnaire at the first session of the art group she was attending.

"I'd just come out of hospital. I didn't really want to talk about what had happened because I just tried to kill myself. It's not really the conversation you want to have with some bloke that you don't know on the phone. It just didn't feel very safe." (Nov 2022, part 2)

Importance of Community support

Sophia is under the care of Emerge Leeds and gets three visits a week from different professionals within the team – her care co-ordinator, occupational therapist and youth worker. In addition to this, she often accesses other services such as Dial House, Well Bean café as well as creative and community sessions run by Live Well Leeds and Inkwell Arts. She enjoys the arts and crafts sessions run by Live Well Leeds which she says are "high quality" and likes the peer support element of being able to relate to other people in the room who all have lived experience of mental health (Nov 2022, part 2).

She values this community-based provision as a key factor in preventing her health from deteriorating….

"If that stuff wasn't there, I'd probably be at home or be somewhere doing daft things." (May-Sept 2022 part 3)

…and keeping her out of hospital.

"I've avoided hospital thus far because I have been using other services like Dial House and Well Bean café" (Feb 2023)

Despite this, Sophia sometimes finds it difficult to understand which service to access when she is unwell or in crisis, and it would be helpful for there to be a really clear message about this.

"I always find it hard to know like, 'Which level of crisis am I on today?' Like, 'Am I at Dial House level? Or am I like, Well Bean Cafe level?" (May-Sept 2022, part 3)

Interplay of physical and mental health

In her introductory video, Sophia describes her various health conditions – complex PTSD, insomnia, migraines and Irritable Bowel Syndrome (IBS), and how they interact with each other. For example, how insomnia affects her mood and IBS flares up when she's anxious.

"I also have IBS… I feel that gets worse when I'm anxious, so I feel like they're kind of interconnected, to what I experience with my mental health." (Intro, April 2022)

Mental health and employment

Sophia describes the impact that unpredictable changes in her mental health have on her employment. Working as a freelancer, she describes the stress and embarrassment that becoming very unwell on a job can cause. She also describes the difficulty around deciding whether or not she is well enough to work as well as the impact on her of deciding not to work.

"It's really hard to not work because obviously like, money. And also like you just feel like you're failing... From work like, you you're engaging with people, you're meeting new people… You're going to places… And like, it can be fun… and like, by going to work you also gain more work, especially as a freelancer because like word of mouth is probably the biggest advertisement for you." (May-Sept 2022 Mental health and employment)

Involvement of person receiving care

Sophia says she doesn't always feel like a partner in her own care and we see multiple occasions where her wishes are not acted upon regarding gender preferences, medication and discharge. However, she says that with the Community Mental Health Team (CMHT) and Emerge she has felt more actively involved.

"…with CMHT and Emerge, I've felt like I've had a lot more control about what's happening with me, and my care and treatment." (April 2022)

We know that having a female worker is important to Sophia. She tells us, "I don't have a great history with men." (May-Sept 2022, part 1).

"I would like to be asked my preference, that's never actually been asked [by ALPs]. That's been asked with ISS, and…with Emerge and with CMHT [Community Mental Health Team]" (April 2022)

The impact of gender preference not being taken on board can really be felt when Sophia describes a situation that happens in the 136 suite.

"I was quite confused, and the doctors came in to assess me literally about half an hour after me getting there, and I just dropped off to sleep because I was knackered, and then the next minute I woke up and there was like five people standing around my bed, and then one doctor sat really close to me. And I think the majority of them were all male as well... and that freaked me out." (April 2023, part 1)

The second time is better because staff have understood what trauma - informed care looks like for Sophia.

“So, the second time was better because it was two females and one male. And they'd also, what helped is, that they’d, like, sat down a little bit, like on the floor. So, then they weren't like, like, looking over at me, like, from a height. It felt less confrontational.” (April 2023, part 1)

Her wishes around medication are not always listened to. For example, despite her repeated request for ISS to action a prescription for Diazepam as agreed by her GP, it never happened. She feels that had it been, further crises could have been prevented.

“It was just like a domino effect of things, and that could have… been the one thing that just changed the path, but it didn’t, because I wasn’t prescribed it.” (May-Sept 2022 part 2)

Environment

What Sophia had to say about Oasis was really striking and provided a good example of how therapeutic she found a much less ‘clinical’ homely environment, and a relationship with staff with lived experience which felt more equal.

“Oasis feels a bit more like staying at like a hotel, it’s not clinical. It looks more cosy…You’ve got proper duvets… and they refer to you as patients or service users, they refer to you as guests, which I think is quite nice… They prioritise the actual supporting people, talking with people, even just sitting with people… Whereas at Becklin, the staff were just constantly updating paperwork, that’s why you never got any time with them. So Oasis… definitely made me feel more supported.” (May-Sept 2022 part 3)

The Becklin Centre, on the other hand, she describes as "meds focused", with little meaningful activity (e.g. group therapy) for the times when people are not in crisis (April 2023). She said that she knew from talking to staff at Oasis that part of their induction was to visit the Becklin Centre to see how it operated. She suggested that could be helpful also for Becklin staff in terms of learning to visit Oasis as part of their induction.

Digital and phone

The majority of Sophia's interactions with services are face to face. However, there was one occasion where Sophia felt that an opportunity was missed by a GP in communications via e-consult and phone.

"This whole shenanigans could have potentially been avoided… obviously I wrote that E-consult, the GP that rang me isn't the one that knows me very well. If it had been the one that knows me very well, she would have got me to come in, and then she would have assessed whether she needed to call the police, or whatever else, or try and get the crisis team to her... I think doing things over the phone, in general, especially if it's like mental health, and somebody is literally talking mumbo jumbo at you, like, be concerned." (February 2023)

How this report should be used

The insights from this report should be used by all health and care organisations in Leeds as part of their ongoing Quality Improvement work. They should also be used by relevant Population Boards to inform their thinking. In addition, the reports will feed directly into the Leeds Health and Care Partnership, including the citywide Person-Centred Care Board and the Quality and People's Experiences Committee.

Please do let us know by emailing harriet@healthwatchleeds.co.uk how you have used this report and any improvements it has prompted within your services or the wider system.

Questions for Leeds Health and Care Partnership:

The Leeds Health and Care Partnership is made up of health and care organisations that work together and use their resources collectively to improve people's health and reduce inequalities by delivering joined up person-centred care. We would like the Leeds Health and Care Partnership to consider the following questions:

1. At a system level what needs to happen differently for all our services to co-ordinate well?
2. What do Sophia's experiences tell us about the importance of having a culture of compassionate care, and how can we ensure that this is consistent across the system?
3. What do we need to do as a system to improve communication so that people like Sophia will always have a good quality experience and good outcomes?

4. How might Sophia's experiences have been different if services had been operating to the principles of an integrated care model – i.e. co-designed, jointly commissioned and delivered in partnership to achieve shared outcomes?

Questions for individual organisations and Population Boards:

We would like health and care services to use this report and Sophia's videos within their teams as a learning and development tool. Below are a series of questions that could be used as conversation starters in conjunction with this report and the videos:

1. What would your services need to do differently to make sure Sophia was always felt like she was treated with compassion and empathy and without stigma?
2. What would your services need to change to ensure that Sophia was always involved as an equal partner in plans and decisions about her care, and make use of any skills and knowledge she brings?
3. How can you work with other services to ensure better co-ordination of care and reduce the risk of negative impacts for Sophia?
4. How will you make sure that people like Sophia are kept informed and involved in their discharge planning so that they feel in control?
5. What opportunities exist for staff to work across organisational boundaries so that they acquire new skills, adopt ways of working and communicate better with each other?
6. Within your service what's the smallest change that could make the biggest difference to people like Sophia?

Appendix 1: Actions from Partners

Organisation	What actions have you taken, or will you take as a result? And where will you share the videos or updates?
Leeds and York NHS Partnership Foundation Trust	Videos have been shared and discussed at the following groups: • **Patient Experience and Involvement Strategic Steering Group (PEISSG)** This group is co-chaired by the Director of Nursing, Professions and Quality alongside a lived experience partner. The purpose of this overarching meeting is to make sure that priorities identified by service users and carers in their three sub-groups; **Experience, Carers and Involvement**, are actioned and progressed. • **Experience Sub-Group** This group is co-chaired by the Deputy Director of Nursing and a lived experience partner. • **Unified Clinical Governance Meetings** These meetings are held monthly and are attended by Heads of Services (or their representatives) to share good practice and to escalate any barriers to delivering care. • **ALPs and Crisis teams' clinical governance forums (April 2022)** In Jan 2023, the Operations and Clinical Team managers of ALPS (Acute Liaison Psychiatry Service) met with Sophia where they were able to listen first hand to her experiences. The meeting resulted in the following set of learning points being identified by ALPS that were shared with the wider ALPS team: • Use a trauma informed approach to care; ask people about a preference for a male of female worker (whenever possible and if not possible, explain why)

	• Ask people if it is okay for a second assessor to be present during assessments. In circumstances where ALPS have assessed that a second assessor is required – an explanation should be provided to the person receiving care as to why. • Be transparent about meeting people's expectations – be explicit about what can and cannot be offered. • Include carers (wherever possible) • Ensure notes/assessments are written in a clear, jargon free and non-judgemental way, that can be easily understood. Write notes as if service users are reading them. The links to all Sophia's videos, along with the above learning points have been emailed to all Heads of Services who have been encouraged to share the videos and learning points with their teams and implement into everyday practice. **May-Sept 2022 - Food provision at Becklin Centre** This video was shared with the matrons and clinical lead of the acute inpatient wards. The matron of the ward also shared the video at their clinical governance forum to remind staff that service users should be offered menus the day before and that they do have the choice to eat their food in their rooms should they wish to do so. The acute inpatient leadership team apologised that this had not been the case for Sophia.
Leeds Community Healthcare NHS Trust	Videos will be shared with: • Clinical/Quality Leads to be shared within services/ teams. • The LCH services referred to within them directly with an ask to review and consider where improvements can be made/feedback to share.

	• Trust Boards meetings where appropriate as part of the Patient Story agenda item. • They will also consider how else the videos can be used across the organisation as part of current Engagement principle development work. • Learning will be highlighted in newsletter/reporting structures.
Carers Leeds	Videos have been shared with the Carers Leeds team as a learning and reflection tool.
Leeds Teaching Hospitals NHS Trust	Videos have been shared at the Trust Patient Experience Group. They have also been shared with the following: • April 2022 – shared with the Emergency Departments as the ALPs service is hosted by LTHT and often present in the Emergency Department. • May-Sept 2022 – Positive feedback regarding experience in emergency department and inpatient stay at St James Hospital will be shared with the urgent care clinical service unit. • Feb 2023 - shared with the urgent care clinical service unit for learning about discharge without plan or mental health review. • April 2023 – positive experience of compassionate care at St James Emergency Department shared with the urgent care clinical service unit
Other places the videos have been shared.	Videos have been shown and discussed at the following groups: • Leeds Integrated Care Board subcommittees: Delivery; Quality and Patient Experience; Finance • Person-centred care expert advisory group • Mental Health Partnership Board

Appendix 2: Index of Sophia's updates

All Sophia's updates are available at https://healthwatchleeds.co.uk/how-does-it-feel-for-me-sophia/

Video/ update title and link	Summary of content
Intro – April 2022 https://youtu.be/-Ry-hu3R0xw	• Complex PTSD and how it affects day to day life and relationships with other people. • Migraines can also impact mental health. • IBS affects what she can eat and also flares up when mental health gets worse. • Insomnia and how this affects mood. • Would like to try and raise awareness as feels that feedback as an individual to services often doesn't get back to the right person.
April 2022 Update https://youtu.be/X6gLcsxRc8U	• Recent experience of mental health crisis – crisis team, Acute liaison Psychiatry (ALPs) in A&E, and Intensive Support Service (ISS). • Felt let down by ALPs as discharged with no further support when other professionals had expressed concern. • Didn't know what the plan was until next day Care-co-ordinator from Emerge referred to ISS. • Positive experience of ISS • Feels that language used by ALPs team both verbally and in reports is "condescending" and "judgemental". • Compares this with a positive experience from ALPs in a different geographical area. • Never been asked preference about whether she would like to see a male or female member of staff in ALPs which causes issues for her when presented with a male member of staff. Has been asked preference when accessing Community Mental Health Team (CMHT), ISS and Emerge.

Video/ update title and link	Summary of content
	• Feels that her patient information is out of date. Records not joined up. "Everyone working from a different system." • Doesn't feel like an active partner in own care in A&E. • CMHT and Emerge – feels like has much more control and say in own care. • Positive experience of Care Co-ordinator from Emerge. Good relationship. • Would like crisis services to look more at a person as a whole person rather than someone's behaviour right now. Also need to record information more accurately.
Paramedic experience – April 2022 https://youtu.be/IyBf6R1fvL0	• Positive experience of paramedics when in crisis.
May-Sept 2022 Part 1 https://youtu.be/bOH84SvZENY	• Recent experience of mental health crisis: A&E, ALPs, crisis team, Becklin Centre, Oasis, ISS, 136 suite. • Didn't feel that crisis team listened to her or her care co-ordinator in terms of discharge from Oasis. • Impact of not respecting gender preferences of workers. • Positive and negative experiences of assessment at 136 suite by mental health act assessment staff. • Positive experience of A&E staff. • Uncertainty about responsibilities when under care of both Becklin Centre and LTHT whilst on general ward following overdose.

Video/ update title and link	Summary of content
May-Sept 2022 Part 2 https://youtu.be/Fvqs5jglpw4	• Discharge from Becklin Centre with no notice and didn't feel involved in decision. • ISS - Importance of being clear about which worker is coming out and when. Also supporting people for an adequate length of time and involving them in and giving more advance notice of discharge. • Feels it is 'belittling' to be told things like to have a cup of tea when in crisis. • Impact of prescriptions not being sorted.
May-Sept 2022 Part 3 https://youtu.be/5rNzcXB5UnE	• Dial House and Well Bean café – difficult sometimes to self-assess what level of crisis you are in order to access the right service. • Emerge – 3 visits a week - OT, care-co-ordinator and youth worker. • Live well Leeds – been on waiting list for year – finally accepted onto art group. • Probably be at home or "doing daft things" if I wasn't at these groups. • Sometimes difficult to find out about these groups etc. • Really valued Oasis. Support from individual staff, lived experience of staff, feels less clinical and cosier. Refer to people as 'guests' not 'patients' or 'service users.' • Feels like staff at Oasis have more time to be with people rather than doing paperwork like at Becklin Centre. • "I don't think telling somebody that they're not going to kill themselves in neither helpful nor appropriate."
May-Sept 2022 Employment	• Sophia is self-employed. Can't always predict when mental health is going to mean she is too unwell to work.

Video/ update title and link	Summary of content
and mental health https://youtu.be/oBuZ45dayKA	• Can cause a lot of stress and sometimes isn't in a place to communicate with employer or person you have contract with. Has been helpful to have an advocate to help her do this. • Not all employers are going to understand, especially if they don't know you really well. • Currently not working. Difficult financially, emotionally and for career progression. • Huge contrast in capabilities when well and unwell – this can be frustrating. • Gets enhanced PIP and universal credit which makes things less stressful.
May- Sept 2022 Becklin centre https://youtu.be/0lvFg90ClQ8	• Experience of food at the Becklin centre
Nov 2022 – Part 1 https://youtu.be/Tp09l88J994	• Experience of working with the different professionals from Emerge. • Why she likes her care co-ordinator. • How they work well and communicate to each other and how this has a positive impact on her. • Importance of the Emerge team when having intense flashbacks – "good at calming me down". • Wants the way that people with "personality disorder" or "complex trauma" are treated in the system to improve. Need to be treated with dignity and respect, as currently often feels "written off".
Nov 2022 – Part 2: Live Well Leeds	• Experience of attending art group with Live Well Leeds. • Importance of sensitive first contact. • Need for more efficient waiting list system.

Video/ update title and link	Summary of content
https://youtu.be/Ws-M5UDc9XM	
Feb 2023 https://youtu.be/ZVjtAx52hkI	• Period of crisis over Christmas and new year. • Phone conversation with GP. • Discharged from A&E after being found unconscious and became very agitated. • Stay at Oasis where she was visited by person from Crisis team who she has had problems with, in the past, resulting in her refusing to engage. • Planned discharge without adequate discharge plan in place. Mixed messages from Dial House about whether could accept her referral. • Lack of support made her feel unsettled and suicidal. • Taken to 136 suite and voluntary admission to Crisis Assessment Unit (CAU). • Difficult environment – scary and unable to sleep. • Discharged because risk deemed to have increased in CAU, which she feels was not the case. • One phone call and visit from ISS then discharged to Emerge's care. • Accessing support from Well bean café and Dial House. • Feels telephone GP consultation with someone in crisis isn't appropriate for someone in crisis. Also feels that opportunities missed in A&E when discharged without a plan and wasn't seen by ALPS. • Appreciated kindness of a nurse in CAU.
April 2023 part 1	• Experiencing mental health crisis • Contact with Crisis team, care co-ordinator at Emerge, police, A&E and 136 suite.

Video/ update title and link	Summary of content
https://youtu.be/_GKtpJMOWCs	• Varied experiences of communication and compassion at 136 suite, with crisis team and at A&E and impact it has on Sophia. • Trauma informed communication and response from doctor at A&E.
April 2023 part 2 https://youtu.be/zVS1Ij5g094	• ALPs assessment – doesn't feel involved in process. • Stigma of EUPD, complex PTSD etc. • Good communication with ambulance crew and compassion from Emerge care co-ordinators whilst in crisis. • Feels that poor communication and not enough support from ISS on discharge following being sectioned and inpatient at Becklin Centre. • Positive experience of MDT organised by Emerge. • Positive experience of crisis team.
April 2023 – Becklin Centre and Discharge https://youtu.be/wn2EWDm2p4c	• Experience of the Becklin Centre and discharge process
Evaluation – April 2023 https://youtu.be/V2Zu-Jf07YA	• Sophia shares her thoughts on what has gone well being part of the How does it feel for me? project and her ideas for how it could be made better.

Meeting name:	Leeds Committee of the West Yorkshire Integrated Care Board (ICB)
Agenda item no.	LC 52/23
Meeting date:	13 December 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:

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

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

☒ Improve healthcare outcomes for residents in their system

☒ Tackle inequalities in access, experience and outcomes

☒ Enhance productivity and value for money

☒ Support broader social and economic development

Recommendation(s)

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

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

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

N/A

Appendices

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

What are the implications for?

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

1. Purpose

1.1 This report provides an update on significant national and local developments that affect the context within which we operate. This report is intended to help shape the conversation at the Board. Members are asked to **consider** and **note** the contents of the report; and **advise** on the content of future reports.

2. National Context

2.1 Since the last meeting we have a new Health Secretary, Victoria Atkins. To date no significant changes in health policy have been announced and the priorities of the government remain as previously; reduction of back-log in elective waiting times, improving GP Access and ensuring safe urgent and emergency care through winter. Victoria Atkins was previously Financial Secretary to the Treasury.

2.2 There was little mention of the NHS, or indeed Social Care, in the Autumn Statement at the end of last month. We are about to enter the third year of a three-year planning round and there is a strong view from government that the NHS in general has become less productive and will need to find resources from within rather than anticipate additional funding. In this light the appointment is interesting.

2.3 NHS England recently identified £800m to provide additional support, in part from repurposing capital spend. This translated to an additional £32m for the ICB in west Yorkshire. This is an acknowledgement of increases in prescribing costs and the additional costs associated with industrial action. As part of this injection of additional support all ICB's were asked over a short two-week window in November to set a balanced financial plan for the year ahead and commit to delivering the required performance standards in elective care, cancer, and urgent and emergency care. The Board of West Yorkshire ICB has approved submission of these plans whilst recognising significant risks remain in both financial and performance terms.

2.4 There is a strong emphasis on winter preparedness at a national level. All ICB's have had to submit winter plans and our System Control Centres which operate 24/7 365 days per year are co-ordinating activity across West Yorkshire. The Leeds's element of the Winter Plan has been approved both locally and at a regional level. A small additional fund of £40m has been made available to the most challenged systems, none of this has come to West Yorkshire.

2.5 The BMA and the government have reached an agreement to settle the Consultants' industrial action. However, there is no agreement currently on the junior doctor's action.

2.6 His Royal Highness King Charles III delivered his first speech on 7 November 2023. This focussed on growing the economy, strengthening society and crime reduction. Health-specific announcements included tackling smoking by raising the age of sale for tobacco products and implementing the NHS Long Term Workforce Plan, both of which we support and look forward to supporting as plans develop.

2.7 During the COVID-19 pandemic, we lived through the most extraordinary times and our collaboration allowed us to work together to support staff and local communities. COVID-19 continues to impact on many people's lives and especially for those who lost loved ones.

2.8 The testimony provided to the COVID-19 Inquiry, which has been set up to examine the UK's response to and impact of the pandemic and learn lessons for the future, has been covered substantially in the media. It is fair to say that much of the testimony has revealed behaviours that fall short of expected standards and that some will have been upsetting and triggering to staff and communities.

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3. Care Quality Commission State of Care Report

3.1. The Care Quality Commission (CQC) has published its latest State of Care Report - its annual assessment of health care and social care in England. The report looks at the quality of care over the past year. Issues identified last year, such as staffing levels, have continued to escalate, in conjunction with newer issues such as the cost-of-living crisis.

3.2. The report summarises that the quality of care that people experience is affected by many different factors. It goes on to say that increasing demand and workforce pressures are impacting on staff mental health and wellbeing and these challenges have a direct impact on the ability to deliver safe and good quality care.

3.3. It also highlights that access to care across England remains an issue. Record numbers of people are waiting for planned care and treatment, and people are facing ongoing struggles with getting GP and NHS dental appointments resulting in some people using urgent and emergency care services as the first point of contact, or not seeking help until their condition has worsened. There are delays in discharging people from hospital because there is a lack of capacity in settings they can be discharged to.

3.4. Inequalities is one of our 10 big ambitions as a West Yorkshire Partnership and Leeds Health & Care System and the report specifically highlights some people who are more likely to face inequalities in access to care and

experience when using health and care services including people from ethnic minority groups using maternity services, an emergency department or with a long-term health condition.

4. Leeds System

4.1. As you will be aware, Leeds Teaching Hospitals have been working with colleagues to build a comprehensive business case for an Elective Care Hub at Chapel Allerton Hospital. This proposed £27m investment would have allowed more non-emergency surgeries to take place and reduce waiting times for patients.

4.2. We were really disappointed to receive the news that the Outline Business Case for the proposed Elective Care Hub would not be supported by the Secretary of State and therefore we will not be progressing the Full Business Case and project. This is part a consequence of the use of capital by NHS England as described above and will impact on our ability to deliver some elective backlog improvements.

4.3. We continue to have high numbers of people in out of area placements as a result of complex mental illness. This is both a significant concern for the people and their families and not what we want to offer as a city, and it is also extremely costly. Partners are continuing to look at possible solutions and recognise that part of the solution will be reducing demand through the Community Mental Health Services programme described under agenda item 58/23.

4.4. One of the areas we have been looking to develop is perinatal mental health support. As part of this national priority Leeds and York Partnership Foundation Trust have been asked to establish a 6 bed ward and work is in progress for delivery next year.

4.5. In more positive news the Synergi Partnership, won the Health Service Journal Awards for Mental Health innovation. We are delighted for the team at the recognition for all the incredible work they do in addressing inequalities in mental health across the city.

4.6. The Home First programme working to transform intermediate tier services in a truly partnership-based model continues to improve care in a cost-effective manner. The programme has been piloting a range of alternatives over the past six months and the results have been impressive reducing the number of days people stay in rehab and recovery beds, discharge beds at the hospital and in active recovery. This had a positive impact on system flow and reduced the number of patients waiting discharge who are

medically fit to move on. These have positive implications for individuals in terms of maximising the independence and reducing potential harm, and to date the financial benefits accruing from better care are ahead of trajectory. Over the next year, as this work is implemented in full, we expect to realise significant additional benefits.

4.7. Leeds Health & Care Partnership hosted colleagues from Staten Island in early October. This is an important Learning Collaborative for us. Their visit confirmed our focus on developing our capabilities in the use of data to initiate and shape change, the importance of a socio-medical model of response to many of our challenges including the importance of primary care and the third sector, and the need to focus on a few common goals and associated programmes of work. They shared with us their journey and expertise in all these areas as well as describing their governance and other arrangements.

4.8. They also spent time visiting a couple of our third sector partners, the GP Confederation Paediatric Asthma clinic and the LGI Emergency Department. They noted the remarkable depth to our collective commitment to addressing health inequalities and the strength of relationships. We want to note our thanks to them for sharing their insight and also to all colleagues that organised the visit and contributed to it. We look forward to working further with them in the new year.

4.9. One area that was noted in the visit was the Healthy Leeds Plan. This was launched formally on the 7th of December and focusses on a small number of key priority areas associated with addressing health inequalities and poor health in such a way as to reduce the need for unplanned care. The current five priority areas are Home First, Three or more Long-Term conditions and an SMI, Respiratory concerns in children, respiratory at end of life and falls/fractures in those living with frailty and cancer. The focus of our programmes being built around the last four of these will be among our most deprived communities as they suffer disproportionally. Learning from Staten Island we will be looking not only to address clinical issues but recognising the significance of social determinants work with communities to develop truly tailored socio-medical solutions.

4.10. The Healthy Leeds plan is part of the Leeds Health & Care Partnership's response to the refreshed Leeds Health and Wellbeing Strategy. This was also launched on the 7th of December and looks to build on the good work we have already done as a city. This can be read here.

4.11. The Third Sector in Leeds is essential to delivery of both the Health & Wellbeing Strategy and the Healthy Leeds plan. Alongside the Public Sector

this is a tough time for the Third Sector financially and we collectively need to look at how we imagine our work together to support communities and individuals. Colleagues from the sector have led the development on behalf of us all with partners across the city to create the Leeds Third Sector Strategy 2023-2028. This sets out the ambitions for how the sector might adapt and continue to address the needs of the city in partnership.

5. Leeds Partnership Development

5.1. The Leeds Health & Care Partnership commenced a piece of work in September to further develop the partnership; clarifying decision making, ensuring the scope of the partnership was effective and looking at how we do business together. This work continues. In part it is to ensure that we collectively deliver for the people of Leeds and in part it is to respond to the West Yorkshire ICS operating model that is looking to continue and potentially enhance delegation to place partnerships going forward.

5.2. On the 13th of December colleagues from across the West Yorkshire Partnership will meet to consider what form and to what degree the next evolution of the ICB and ICS might take. Leeds will continue to shape this work.

5.3. Each place in West Yorkshire is moving to having a place finance lead that is an NHS Provider Director of Finance. Simon Worthington, the Director of Finance at Leeds Teaching Hospital Trust, has agreed to take on this role and is leading the financial planning for next year. As part of this process NHS colleagues have come together to form the Strategic Finance Executive Group (SFEG) which will advise the Leeds Committee of the ICB and its sub-committees going forward. The membership includes finance directors and chief officers, plus one other executive member from each organisation.

5.4. We would like to acknowledge the work and leadership Visseh Pejhan-Sykes has provided in this space as she moves on to a new role in the new West Yorkshire ICB operating model. There will be a period of transition over the next few months to ensure continuity.

5.5. The ICB Operating Model continues to evolve. The ICB was asked to reduce that element of its running cost by 30% by April 2025. In West Yorkshire we have looked across all staff areas (both running cost and others) and will have reduced by the necessary combined 20% by April 2024. This has meant the consolidation of some functions such as finance, contracting and quality into one West Yorkshire wide team albeit with staff facing each of the five places. All places have been left with resources under their direction to provide them with capacity to support population level planning, facilitating

necessary transformation programmes, and co-ordinating and developing partnerships.

5.6. This is a significantly different role and will require continual work well beyond the end of structural changes. There will be a considerable period of time needed for staff who will have been through a hard process of change to adjust and there will be a need to reduce *what is done* and restructure *how it is done*. We will be looking to work with partners to ensure we shape the new relationships effectively and continue to support the development and effectiveness of the partnership in Leeds.

5.7. In the Leeds team of the ICB 20% of posts will have been lost. Strict vacancy control and voluntary redundancy will have reduced the need for compulsory redundancy. This is on top of 5 years of no growth in running costs allowances. On the 11th of December the outcome of the staff consultation that has been running will be announced. Following this staff who are being slotted-in will hear before Christmas. Staff who are ring-fenced will begin slotting-in through competitive interviews from the 8th of January. It is anticipated that the vast majority of processes will be complete by the end of March 2024.

5.8. We would like to congratulate Selina Douglas who has been appointed as the new Chief Executive of Leeds Community HealthCare Trust. We look forward to welcoming her to Leeds in the new year. Selina has a background in adult social care, and brings extensive experience to the LCH role, having worked for 20 years across a range of high level strategic and operational positions within the NHS, the public sector and a national charity. Most recently, she has led the transformation, strategic and partnership agenda for Northeast London Foundation Trust

6. Recommendations

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

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

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

Committee Escalation and Assurance Report – Alert, Advise, Assure

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

Date of meeting: 15 November 2023

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

Date of meeting reported to: 13 December 2023

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

Key escalation and discussion points from the meeting
Alert:
Quality Highlight Report Members were informed of significant impact on capacity at the children's hospital at NHS Leeds Teaching Hospitals Trust (LTHT) due to a ward closure to accommodate a young person needing enhanced care and security. Regular executive meetings were in place to monitor the situation.
Advise:
People's Experience Report The subcommittee received the People's Experience report, which provided detail of current experiences of people living with complex mental health conditions. The report included Sophia's Story Summary report as well as insight from the community mental health involvement work focusing on the experiences of unpaid carers and culturally diverse communities. Members noted issues accessing mental health services and the work of the Community Mental Health (CMH) Transformation Programme in addressing these. Assurance would be sought on the progress of the CMH Transformation Programme at the next QPEC meeting in March 2024. **Risk Report** The subcommittee discussed the governance relating to Population Boards' risk registers and the development of these across the Boards. An action was agreed to review the Children & Young People (CYP) Board's risk register to consider whether there were any risks that required escalation through to the subcommittee. **West Yorkshire Quality Committee (WYQC) Update** Following the addition of a new risk to the WYICB corporate risk register, the WYQC had requested information from places regarding numbers of people arriving seeking asylum, anticipated numbers and approaches to their safeguarding. The subcommittee were informed that approximately eighty unaccompanied children had arrived in Leeds; this number was expected to increase. Concern was expressed

that some children were being erroneously assessed as adults and accommodated in hotels. It was noted that 1100 adults were seeking asylum in the city; however, the figure was unlikely to include people who were not in the system.

Assure:

Population and Care Delivery Board Biannual Reports

The subcommittee received positive assurance from the reports of the Maternity, Children and Young People (CYP) and Healthy Adults Population Boards.

The priorities and outcome goals of the Maternity Board had been aligned with national guidance. These included: reducing stillbirth rates via workstreams for gestational diabetes, smoking cessation and continuity of carer; and access to perinatal mental health services. Members were assured that regular maternity and neonatal assurance meetings were held, comprising representation from providers, the Local Maternity System (LMS), the ICB in Leeds Quality team and the Maternal Voices Partnership. Data from LTHT's maternity quality dashboard provided high levels of assurance. Further assurance was given regarding the recent *good* rating by the Care Quality Commission for the maternity service and a subsequent visit by the LMS. The subcommittee noted the considerable level of scrutiny around maternity services and an anticipated focus on neonatal services.

With regards to the CYP report, programmes of work focussed on: CYP's mental health; physical health; and complex needs and special educational needs and disability. The CYP board had engaged in a number of difficult conversations regarding funding decisions and how services could be jointly commissioned going forward.

The Healthy Adults report detailed work in women's health; the health inclusion sub-board workstream; and the Quality, Innovation, Productivity and Prevention (QIPP) programme workstream. The diversity of the Healthy Adults population segment was highlighted. Assurance was given that data analytics continued to be developed to further identify minority groups, in terms of addressing health inequalities.

Quality Highlight Report

The Quality Highlight report was presented for assurance purposes. No GP practices were rated as inadequate. Two care homes were rated as inadequate, resulting in a system-wide review of the provider. With regards to continuing care beds, assurance was given that management structures were becoming more stabilised. Assurance was also given that oversight of the recent para protein incident was ongoing.

Risk Report

Members received the risk report for cycle four. Ten risks were aligned to the QPEC Subcommittee, with eight of these being shared with the Leeds Delivery Subcommittee. Five of the risks were common risks. All risks with a likelihood of five had been reviewed; of these, risk 2017 – community dermatology service cooperation risk - had been marked for closure as this was now seen as an issue to manage. Assurance was given that rationale had been provided for high scoring risks scores remaining static.

Committee Escalation and Assurance Report – Alert, Advise, Assure

Report from: Leeds Delivery Sub-Committee

Date of meeting: 22 November 2023

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

Date of meeting reported to: 13 December 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>Population and Care Delivery Board Reports</u> The sub-committee received reports submitted by the Children's, Maternity, and Healthy Adults Population and Care Delivery Boards. The sub-committee welcomed the comprehensive set of reports, noting the clear alignment with the refreshed Healthy Leeds Plan priorities and evidence of strong partnership working across the Leeds health and care system. The sub-committee also noted the Population and Care Delivery Boards contribution to addressing the financial challenge to the Leeds Health and Care Partnership through the QIPP identification process. The sub-committee was advised of pressures faced by the third sector to temporarily fund some targeted maternity support services, following the end of non-recurrent funding from the WYICB. Members were advised that the Maternity Population Board were in the process of determining potential options to fund schemes moving forward as part of a 'business as usual' approach. Members were supportive of the innovative approach taken by the board to address the issue, however wished to alert the Leeds Committee to the increased level of risk to continuing with targeted schemes that aim to reduce health inequalities, in the current financial climate.
Advise:
<u>Population and Care Delivery Board Reports</u> Members discussed the approach taken to date to support the Healthy Adults Population Board, recognising that most work to support the cohort has historically been undertaken by Public Health colleagues, in terms of broader priorities to support people to live healthy lifestyles. Members agreed that the board has a clear role in supporting the prevention and early identification agenda and encouraged

further focus on supporting people to access health checks and screening appointments, with suggestions for developing more agile appointment booking processes.

Risk Management Report

There was some discussion around how the risks faced by the third sector, in relation to health and care service delivery, could be reflected as part of the service delivery risks held and overseen by the Leeds Committee of the ICB, including the Population and Care Delivery Board risk registers. It was noted that the three top risks for the sector continue to be reported to the Leeds Committee through the risk management report, however it was agreed that a discussion should take place outside of the meeting to how best to mitigate the risks as a partnership.

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. Members were advised that there were some key areas of progress since the last report, including reductions in the number of patients in acute hospital beds that no longer meet the criteria to reside and reductions in the waits for Cognitive Behavioural Therapy. However, it was also recognised by members that the recent periods of industrial action had impacted performance locally and seasonal winter demand pressures continued to be challenging, particularly for urgent and emergency care services.

Members discussed opportunities to improve the assurance process for performance monitoring, and it was requested that West Yorkshire performance data relating to Leeds place be included in future reports, alongside the current metrics, to enable a more joined up partnership approach and support the statutory performance management process at West Yorkshire.

Risk Management Report

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. Members were assured that all high scoring risks had been addressed throughout discussions at the meeting and by the mitigations in place to address.

Committee Escalation and Assurance Report – Alert, Advise, Assure

Report from: Leeds Finance and Best Value Sub-Committee

Date of meeting: 29 November 2023

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

Date of meeting reported to: 13 December 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:
Finance Update at Month 7 2023-24 and Financial Plan for 2024/25 The sub-committee received the finance update. Members were advised that at Month 7, the formal reported position for the Leeds Place of the ICB corresponds to the best-case scenarios across the system. Given the emerging risks currently experienced in the first 6 months of the year, the more likely position had been reported as a deficit forecast of £28.7m. The sub-committee was assured that the QIPP ask of £160m had been forecast to be met within 2023/24, however recognised the financial position remains a significant challenge, with a deficit projected in year as well as for 2024/25. The sub-committee also recognised the work undertaken at pace by the newly established Strategic Financial Executive Group to underpinning assumptions for 2023/24 and were assured by the planned approach, including undertaking equality impact assessments, refining the role of the Population and Care Delivery Boards in terms of supporting the QIPP process, and engagement with clinicians and the public.
Advise:
Deep Dive into NHS spend on people with a Learning Disability Following referral from the Leeds Committee at its meeting on 4th October 2023, the sub-committee received a comprehensive report detailing the financial position regarding contributions into the Learning Disability Pooled Budget in 2023/24. Members were advised that the pooled budget related to a small cohort with high-cost complex care packages. Members recognised that planning and forecasting would be key moving forward, including continued careful case management and regular review of packages. The sub-committee noted the likelihood in the future for difficult financial decisions to be

considered in relation to slowing the pace of repatriation to support the ongoing financial challenges. Members were advised that along with increasing numbers of individuals requiring specialist care, costs had also increased due to the private market prices. The sub-committee was supportive of exploring opportunities for 'not for profit' collaborative as a potential market solution.

Risk Management Report

The sub-committee received a report providing an update on the Risk Register and the risks aligned to the Finance and Best Value Sub-Committee. Following on from the last meeting, there was further discussion around whether a new risk should be added to the Leeds Place risk register associated with the capital regime. The sub-committee considered three potential options:

a) That challenges associated with capital flow should be incorporated into the gaps, assurances and controls of existing risks where relevant;
b) That the corporate risk related to capital funding is sufficient in managing the risk and therefore no further action should be taken;
c) That an overarching infrastructure risk, to incorporate capital funding along with estates and technology, be added to the Leeds Place risk register.

It was noted that further discussion on the options set out above would take place outside of the meeting with partners.

Assure:

Population and Care Delivery Board Bi-annual Reports

The sub-committee received reports submitted by the Children's, Maternity, and Healthy Adults Population and Care Delivery Boards. The sub-committee welcomed the second set of reports, noting the improved structure of reports to evidence successes and challenges. The sub-committee also reflected on the role of the sub-committees in supporting the financial planning processes, noting earlier discussions around the importance of the boards' input to the QIPP programme. In recognition of feedback received from the respective Chairs, members noted that for the boards to fulfil their roles in supporting best value, efficiency, and finance, they must be provided with relevant information in a timely way.

Meeting name:	Leeds Committee of the West Yorkshire Integrated Care Board
Agenda item no.	LC 57/23
Meeting date:	Wednesday 13th December 2023
Report title:	Finance Update at Month 7 (October) 2023-24
Report presented by:	Visseh Pejhan-Sykes, Place Finance Lead
Report approved by:	Visseh Pejhan-Sykes, Place Finance Lead
Report prepared by:	Matthew Turner, Associate Director of Financial Resource Integration & Visseh Pejhan-Sykes, Place Finance Lead

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

Previous considerations:

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.

This report provides an update on the financial position of the Leeds Place of the West Yorkshire ICB and in context of the wider Leeds and West Yorkshire NHS systems.

Executive summary and points for discussion:

This is the Month 7 update on the Leeds Place of the ICB financial position and likely forecast for the year. The WY Integrated Care System is under NHS England financial intervention measures since the submission of its monthly positions from May 2023. The year-to-date adverse variance on month 7 when extrapolated for the full year, suggests that we are on track to a (post mitigation applied) most likely forecast deficit of £117m against an expected forecast deficit of £25.1m in the ICB books only. The bigger share of the variation above the initial deficit of £25.1m was driven by Provider Trusts, but Leeds and other Places of the ICB are also now experiencing continued pressure from increasing costs of Independent Sector spend, prescribing costs and in Leeds, our LD Pool activity jointly Commissioned with Leeds City Council is also a source of cost pressures.

Following a review of the overall financial position a Strategic Finance Executive Group comprising Chief Executive Officers, Finance Directors and a third Executive Board level member from each of the four NHS bodies in Leeds has been set up. The workplan for this group includes a coordinated review cost pressures, potential savings, efficiencies, and service reduction considerations as well as transformation opportunities.

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. **REVIEW** and **COMMENT** on the month 7 position. 2. **REVIEW** and **COMMENT** on the QIPP delivery for 23-24 and beyond.
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:
Achieving financial balance and being financially sustainable in Leeds.
Appendices
1. ICB Running Costs 2. Terms of Reference for Strategic Finance Executive Group 3. Draft Workplan for Strategic Finance Executive Group
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) 9. SFEG - Strategic Finance Executive Group

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 Purpose of this report

1.1 The purpose of this report is to inform, advise and assure the committee of our continued focus on the financial stewardship of our NHS resources. The paper provides details of current and future actions to ensure the city has a sustainable financial position.

2 Context and Background information

2.1 This paper provides the Leeds Place of the West Yorkshire Integrated Care Board with an update of the ICB in Leeds's financial position as at the end of Month 7 of the 2023-24 financial year, in context of the overall plan for 23-24.

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

2.3 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, by 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. Given the magnitude of the emerging variances from month 3 which continue in month 7, the ICB Board Directors have continued to meet with the NHSE Regional Team to signal our likely forecast position, but it was previously agreed not to show this earlier than month 6, is now likely to be in month 9, although we will start to show some of these pressures in our YTD position in month 8 reporting.

2.4 Therefore the reported position shown at month 7 for the ICB in Leeds still reflects a best case scenario in terms of outturn for the current financial year, but the most likely scenario (post mitigation impact) is also now an emerging line of reporting given that the Board of the WY ICB have entered into discussions with the NHSE Regional Team around the risk assessed position and the most likely outturn position of £117m adverse variance against plan.

2.5 WY ICS level Governance arrangements have been enhanced since August across all Places and Organisations as part of the assurance sought by NHSE during the discussions with the WY ICB Executive Team over the summer months. Places and Trusts also report progress on efficiency and savings plans via the newly established Transformation and Efficiency Group and System Oversight and Assurance Group as well as offering continued assurance that measures continue to be in place to mitigate the emerging cost pressures.

2.6 Given our underlying deficit position and our lack of technical flexibilities both in Leeds and across the ICB to mitigate, our system is very exposed to risks as they emerge with no headroom for mitigation.

3 Key Points

3.1 The Leeds wide position at M7:

	Final 23-24 Plan	QIPP	Month 7 Variance	Reported Forecast Outturn
Plans	£m	£m	£m	£m
LTHT	(6.9)	119.3	(10.0)	(0.0)
LCH	0.0	8.2	0.0	0.0
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	(28.7)	(8.6)
Leeds Place TOTALS	(5.3)	160	(38.7)	(8.6)

3.2 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.

3.3 At month 7 the year to date and forecast outturn positions are as follows:

3.4

West Yorkshire ICB	Leeds
Finance Report 2022/23	
Month 07	

Leeds ICB 2023-24 - Month 6	YTD Plan Budget £'000	YTD Spend £'000	YTD Variance (Under)/ Overspend £'000	Annual Plan Budget £'000	Forecast Spend £'000	Annual Variance (best Case) £'000	Likely Case Variance	Worst Case Variance	Best Case Variance
Programme Services									
Acute Services	486,180	487,136	956	832,176	833,908	1,732	1,732	9,232	1,732
Mental Health Services	126,787	134,002	7,216	217,348	228,497	11,149	11,149	15,249	11,149
Community Health Services	127,742	128,315	573	218,987	219,169	183	183	3,283	183
Continuing Care Services	40,568	44,006	3,439	69,545	72,528	2,983	2,983	4,983	2,983
Prescribing and Primary Care Services	96,021	97,574	1,552	164,241	167,492	3,252	3,252	9,552	3,252
Primary Care Co-Commissioning	93,512	93,546	34	156,191	156,191	0	0	1,700	0
Other Services	5,967	6,108	141	10,229	10,389	160	160	160	160
Reserves	-9,140	-11,952	-2,813	-21,529	-31,566	-10,037	10,057	12,157	-10,037
Total Programme Services	**967,638**	**978,736**	**11,099**	**1,647,187**	**1,656,607**	**9,420**	**29,514**	**56,314**	**9,420**
Running costs	**7,430**	**6,731**	**-699**	**12,737**	**11,873**	**-864**	**-864**	**0**	**-864**
Leeds Place Net Expenditure	**975,067**	**985,467**	**10,400**	**1,659,924**	**1,668,480**	**8,556**	**28,650**	**56,314**	**8,556**
In Year - Surplus/Deficit Plan & Suspense	**942**	**0**	**-942**	**1,615**	**0**	**-1,615**			

3.5 The formal reported position for the Leeds Place of the ICB corresponds to the best-case scenarios across the system. Given the emerging risks currently experienced in the first 6 months of the year, the more likely position is a deficit forecast of £28.7m - after assuming that our QIPP of £15m will be delivered in 23-24. Should all anticipated risks crystallise in year, the worst-case scenario – despite significant progress towards the achievement of £15m QIPP for 23-24 - would be a deficit of £56.3m. The financial gap we report in March 2024 for the 23-24 financial year will be the opening QIPP position for our 24-25 QIPP target before we adjust for any non-recurrent QIPP in 23-24 and any aspirations for any further headroom in our

system from 24-25 if we are to return to a financially sustainable position that can support Transformation.

3.6 The first main driver of our current deterioration is the emerging numbers of very expensive LD Pool Mental Health packages – see Mental Health line in the table above. EMT colleagues are requested to consider if any further measures, lobbying to NHSE or any other options are to be pursued while we await the outcome of an in-depth review of the root cause of this increase in Leeds from the Leeds City Council team.

3.7 The second driver is the Prescribing budgets where we are seeing cost pressures from price concessions, Category M drugs as well as some other smaller specific areas. August 23 data showed Leeds growth at 6.7% against August 22 which is not out of line to national growth and is slightly lower than the 9.7% seen YTD. This means our M7 position has remained consistent at £3.4m over plan with a worst-case potential of £9.7m. For comparison we had assumed growth levels of 4% within our financial plan.

3.8 The third driver is the spend on acute Independent Sector providers. For M7 we are showing a pressure of £7.8m over planned levels. There are potential mitigations from our agreement with LTHT to redistribute Elective Recovery Funds (ERF) monies, savings from non-WY providers who are underachieving, and additional ERF monies provided nationally from other ICBs who are underperforming against their elective activity targets. The net position is £3.4m with potential this could be further reduced.

3.9 A population health board apportioned view of the Best and Most Likely case scenarios for forecast outturn positions are as follows:

Population Board Split (best)									
	Maternity	Children & Young People	End of Life	Serious Mental Illness	LD & Autism	Adult Cancer	Frailty	Long Term Conditions	Healthy Adults
Expenditure									
Acute	69	52	17	17	0	277	398	675	225
Mental Health	0	0	0	2,812	8,336	0	0	0	0
Community	0	0	0	0	0	0	91	91	0
Continuing Care Services	0	0	0	0	0	0	1,491	1,491	0
Prescribing and Primary Care	32	228	97	195	65	358	845	1,203	228
Primary Care Co-Commissioning	0	0	0	0	0	0	0	0	0
Other	9	11	6	20	6	11	37	46	14
Programme Reserves	(523)	(721)	(321)	(1,204)	(438)	(754)	(2,349)	(2,791)	(936)
	(413)	(430)	(201)	1,842	7,969	(100)	515	716	(469)

Population Board Split (likely)									
	Maternity	Children & Young People	End of Life	Serious Mental Illness	LD & Autism	Adult Cancer	Frailty	Long Term Conditions	Healthy Adults
Expenditure									
Acute	69	52	17	17	0	277	398	675	225
Mental Health	0	0	0	2,812	8,336	0	0	0	0
Community	0	0	0	0	0	0	91	91	0
Continuing Care Services	0	0	0	0	0	0	1,491	1,491	0
Prescribing and Primary Care	32	228	97	195	65	358	845	1,203	228
Primary Care Co-Commissioning	0	0	0	0	0	0	0	0	0
Other	9	11	6	20	6	11	37	46	14
Programme Reserves	524	723	322	1,206	438	756	2,353	2,796	938
	634	**1,014**	**442**	**4,251**	**8,846**	**1,402**	**5,217**	**6,303**	**1,405**

3.10 Despite the good progress on 2023-24 QIPP schemes, the financial challenges we are currently facing mean that we are still a long way off a financially balanced forecast for 2023-24 and the introduction of NHS England intervention regime across West Yorkshire will significantly impact on our ability to undertake discretionary spending decisions as a Place and as a wider system – particularly around recruitment and workforce resourcing.

4 Financial Planning for 2024-25

4.1 The impact of the current year's underlying position means that the 2024-25 starting position is a forecast deficit position in excess of £40m. The 4 NHS Organisations in Leeds are currently working together under a newly formed Strategic Finance Executive Group (see section 5 for more details) to agree a coordinated process in relation to financial planning for 2024-25. The very high level and initial list of cost pressures, risk and additional activity spend next year total a further £43m. The majority of these do not currently reflect committed spend, but they do reflect the level of the growing gap between demand and resource that the system will need to factor into its efficiency plans.

4.2 A milestone stocktake of the QIPP position took place at the end of Q1. A significant number of 24-25 schemes long lists were presented and are now being stratified by level of progress and depth of engagement needed to progress. In parallel, contract notice letters were issued across all Leeds based partners on 29th September 2023 outlining the need for us to collectively reduce spend by 3% across the Leeds system and in effect giving notice that we would be seeking to reduce total commissioning spend by 3%. The letters also noted that we would continue to work in partnership to develop the QIPP schemes in support of the cost reductions that needed to happen system wide to support the contract spend reductions proposed. System partners were encouraged to work together to propose alternatives to a blanket 3% reduction on all areas, offering more targeted approaches to specific services and contracts to achieve the same savings, between October 2023 and March 2024, in readiness for the 2024-25 contracting

round. The 3% target will reduce ICB level spend by around £30m-£35m and reduce the financial gap.

4.3 The figures above reflect the Leeds Place of the ICB only and do not reflect efficiency targets in the three NHS Providers in Leeds who typically face efficiency levels of anywhere between 3% and 6% each year. This will be over and above the 3% target reduction in contracts with the ICB.

4.4 The next stages for the 24-25 QIPP delivery plan are being agreed with key dates around stakeholder assurance workshops (end of November); informal scrutiny board planning discussions in mid-December and likely public scrutiny board reporting for mid-January 2024. Detailed, and aggregated QEIAs by populations are to be prepared to these timelines. Contracts coming up for renewal or tender waivers for early 24-25 renewals will need to be fast tracked prior to the introduction of the new Provider Selection Regime in January 2024 if we are to avoid a large bottleneck of contract renewals work due to our restricted capacity and the added burden of the new data capture and recording requirements under the new arrangements. A separate slide set is included as a QIPP update with the papers for this meeting.

4.5 A detailed review of all Leeds based contracts has been undertaken with a clear audit trail between individual contracts and the range of services they cover with the follow through to population board indicative target QIPP values. Depending on the level of risk appetite, the 3% savings target can be flexed to include higher risk areas for higher levels of QIPP and potential for some transformation and investment headroom.

4.6 The Running Costs table is provided in the Appendix 1. We are currently on track to meet our reduced budget for 23-24 of £12.7m and any over achievement of savings will be used to offset shortfalls in our overall programme QIPP schemes. Accelerating our current trajectory of a 10% reduction in year towards a 20% target from 24-25 is also possible if we continue to hold vacancies. However, there is a risk to capacity in teams and overall staff morale while the New Operating Model is being developed and implemented.

5 2024/25 Financial Planning Process: The Newly Established Strategic Finance Executive Group

5.1 The three NHS Statutory organisations plus the Leeds Place of the ICB have a statutory responsibility to contain system spend within the limits set by the West Yorkshire ICB who in turn is set its allocations nationally by NHSE.

5.2 As part of planning for 2024-25 and the review and coordination of our governance processes, a review was undertaken by the Partnership Executive Group, of how we work better in partnership. One of the key workstreams identified related to Financial Governance and decision making. One of the first actions was to set up a Strategic Finance Executive Group comprising Chief Executive Officers, Finance Directors and a third Executive Board level member to be identified by each of the four NHS bodies in Leeds.

5.3 Terms of reference are included in appendix 2.

5.4 The workplan for the next few weeks in included in appendix 3 and focuses in detail on 4 key aspects of financial planning – initially for 2024-25 – and which can be extended to outer years once processes and principles have been tested for year 1.

5.5 The 4 areas for coordination include principles underpinning:

- Sources of information used to identify opportunities for efficiencies – benchmarking, clinical pathway reviews, etc. This area includes the review of service cost structures across the organisations to inform benchmarking and opportunity for efficiencies analysis.
- cost pressures and risks identification
- savings / efficiencies / waste reductions opportunities and identified schemes – including disinvestments in services
- Identification of where transformation opportunities are developed and mobilised across Leeds and a review of schemes in train

5.6 The various task groups will take stock in the new year (February) with their finding to help develop the 2024-25 financial plans.

6 Recommendations

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

a) **REVIEW** and **COMMENT** on the month 7 position.
b) **REVIEW** and **COMMENT** on the QIPP delivery for 23-24 and beyond.

APPENDIX 1 – Running Costs

WY ICB - Leeds Finance Report - Running Costs	2023/24			Year to Date			Full year		
As at 31 October	7								
Leeds Place Business Unit Name	ICB Cost centr	Budget Holder	Note	YTD Plan £'000	YTD Spend £'000	YTD Variance £'000	Annual Plan £000	Forecast Spend £000	Annual Variance £000
Programme, Improvement & Integration	945561	Sabrina Armstrong	2	805	810	5	1,380	1,364	-17
Office of Data Analytics	945564	Leonardo Tantari	2	1,208	1,136	-72	2,071	2,004	-67
Clinical Leadership	945569	Sarah Forbes	1	118	128	9	203	220	18
Primary Care Integration	945570	Gaynor Connor	1	446	471	24	765	784	18
Pathway Integration	945571	Helen Lewis	1	861	905	43	1,477	1,528	51
Insight, Communication & Involvement	945572	Sabrina Armstrong	2	401	322	-79	687	581	-106
Partner Relationship Management	945574	Visseh Pejhan-Sykes	2	304	283	-21	521	476	-45
Corporate Costs & Services	945575	Sabrina Armstrong	2	26	23	-3	45	38	-8
Corporate Governance & Risk	945576	Sabrina Armstrong	2	119	108	-11	204	174	-30
Organisation Development	945577	Sabrina Armstrong	2	37	2	-35	64	40	-24
NHS111/999 contract mgmt	945578	Visseh Pejhan-Sykes		102	102	0	176	177	1
Estates & Facilities	945580	Visseh Pejhan-Sykes	2	246	175	-71	421	374	-47
Finance	945581	Visseh Pejhan-Sykes	2	664	545	-120	1,139	904	-234
Admin Reserves	945582	Visseh Pejhan-Sykes	3	120	18	-102	206	18	-188
Equality and Diversity/HR	945584	Sabrina Armstrong	2	50	42	-8	85	72	-13
IT, IG & Digital	945585	Leonardo Tantari	2	261	188	-74	448	413	-35
IT recharges/NHSE	945586	Leonardo Tantari		0	-1	-1	0	-2	-2
National Data Lab Funding	945587	Leonardo Tantari		0	0	0	0	0	0
Public & Patient Involvement - PPI	945592	Sabrina Armstrong	2	75	4	-71	129	100	-29
Population Health Planning	945593	Jenny Cooke	2	332	261	-71	570	456	-114
Nursing and Quality Assurance	945596	Jo Harding	1	413	444	31	708	756	48
Recharges to Programme (orig incl reserve for ICB core RC rechg)	945597	Visseh Pejhan-Sykes		0	0	0	0	0	0
Network Development	945599	Tim Ryley	2	106	73	-33	182	126	-57
Investment fund	945600	Tim Ryley	2	76	14	-63	131	45	-86
Planning & Performance	945601	Jenny Cooke	1	33	36	3	57	63	5
Leeds Place Committee	945602	Tim Ryley	1	624	645	21	1,069	1,164	94
RUNNING COSTS TOTAL				7,430	6,731	- 699	12,737	11,873	- 864

Comments

Overall Running costs budget is £699k underspent for first 7 months of the year.
Budget transfer done in August to move £50k from Leeds OD budget to Core training budget for Leeds share
Forecast for full year is that, if current levels of vacancies will be maintained, Leeds Place running costs would achieve £864k underspend which has now been reflected in forecast.
Whilst some individual business units may not achieve the full efficiency/pay savings targets allocation to their budget, other business units are able to exceed their target and offset.
Forecast overall underspends in Running Costs is being utilised to reduce the forecast overspend in Programme costs for Leeds Place

Notes

1. Forecast overspend relates to pressures caused by non-achievement of pay savings target
2. Currently High level of vacancies above pay savings target and non-pay savings
3. Budget for services transferred to core. Expect some underspend

Terms of Reference

NHS in Leeds Strategic Finance Executive Group

Version: 1.0

1.0 Name

Full name: NHS in Leeds Strategic Finance Executive Group (SFEG)

2.0 Context

The Leeds Health & Wellbeing Strategy aims to make Leeds a healthy and caring city for all ages, where people who are the poorest will improve their health the fastest. That's why, as leaders of statutory organisations across the city, we have come together to create a sustainable, high-quality health and social care system.

We want to ensure that services in Leeds can continue to provide high quality support that meets or exceeds the expectations of children, young people and adults across the city; the patients and carers of today and tomorrow.

We know that we will only meet the needs of individuals and our population if health and social care workers and their organisations work together in partnership.

We understand that the needs of patients and citizens are changing; the way in which people want to receive care is changing, and that people expect more flexible approaches that fit in with their lives and families.

2.1 Role of the group

The group will report directly to the Leeds Committee of the West Yorkshire Integrated Care Board (WYICB). The role of the group is to advise and support the Leeds Committee of the WYICB through oversight of key financial plans, indicators and/or targets, including good stewardship of resources, and ensuring delivery of the Leeds Health and Care Partnership's strategic and operational plans, in order to ensure best value.

The group is responsible for advising and supporting the Leeds Committee of the WYICB in:

- scrutinising and tracking the delivery of key financial and service priorities, outcomes and targets as specified in the Leeds Health and Care Partnership's strategic and operational plans.
- ensuring that the Leeds Committee of the WYICB develops and adopts appropriate policies and procedures to support effective governance of financial matters.

3.0 Specific functions undertaken by the group

The group does not replace organisational sovereignty or statutory obligations or internal governance. In the spirit of partnership working, and on behalf of the Leeds Committee of the WYICB, the group will lead on:

- Developing and recommending the strategic financial plans in light of the agreed priorities of the Leeds Health & care Partnership and in line with available revenue resources
- Developing and recommending as necessary strategic Waste Reduction Programme (WRP) and efficiencies processes

- Overseeing the annual resource and financial allocation / WRP process – revenue only
- Scrutiny of major cross organisation business cases to support transformation and service shift
- Leadership of major in year cross-organisational finance risk management
- Advise on financial messaging required by our system for staff and public

3.1 Considerations for the future

As the role of the group develops, consideration will be given to whether the group formally holds/oversees funds on behalf of the partnership. The Terms of Reference will be reviewed on an annual basis.

4.0 Budget

A budget is not allocated to support the group and any work is to be undertaken in kind by partners.

5.0 Membership

5.1 Core members

Core membership will consist of the following representatives:

Place Accountable Officer, Leeds Office of the WYICB (Chair)

Place Finance Lead, tbc (Deputy Chair)

Chief Executive Officer, Leeds Community Healthcare NHS Trust (LCH)

Chief Executive Officer, Leeds Teaching Hospitals NHS Trust (LTHT)

Chief Executive Officer, Leeds and York Partnership NHS Foundation Trust (LYPFT)

Director of Finance, Leeds Community Healthcare NHS Trust (LCHT)

Director of Finance, Leeds Teaching Hospitals NHS Trust (LTHT)

Director of Finance, Leeds and York Partnership NHS Foundation Trust (LYPFT)

Director of Operational Finance (Leeds), West Yorkshire ICB

Executive Member, Leeds Office of the WYICB

Executive Member, Leeds Community Healthcare NHS Trust (LCH)

Executive Member, Leeds Teaching Hospitals NHS Trust (LTHT)

Executive Member, Leeds and York Partnership NHS Foundation Trust (LYPFT)

The above executive members will collectively represent clinical, strategic and operational views.

5.2 In attendance

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

5.3 Patient / service user / third sector representation

The group will adopt the 4Pi (Principles, Purpose, Presence and Process) National Involvement Standards which have been developed by the National Involvement Partnership (NIP), within the decision-making process. The purpose behind the 4Pi standard is to 'hard wire' the service user and carer voice and experience into the planning, delivery and evaluation of health and social care services.

5.4 Substitutes

All members will prioritise attendance at each meeting. Each member is to identify one substitute officer who can act on their behalf.

Members should not be absent from two consecutive group meetings or not be present at less than nine formal meetings in any 12-month period unless there are exceptional circumstances.

5.5 Special advisors

The group may request special advisors to be present for specific agenda items. These may include those representing enabling groups, advising on policy, providing communications support, etc.

Requests for special advisors to be in attendance are to be made via the Partnerships Governance function who administer the group.

6.0 Governance

6.1 Decision making

The group draws together senior officers from the partnership. All decisions made within the group are through the authority delegated to individual members of the group from their host partner organisation and conducts its business in the spirit of partnership. Each partner retains its own statutory functions and responsibilities.

Agreement from individual organisations is signified by appropriate documents going through internal organisation governance in good time prior to them being presented at the Strategic Finance Executive Group.

The Group will make recommendations to the Leeds Committee of the WYICB, in line with their decision-making power under the West Yorkshire ICB Scheme of Reservation and Delegation, as it deems appropriate in any area within its remit where action or improvement is required.

6.2 Voting

The group will be expected to reach a consensus when agreeing matters of business. This will mean that members are expected to compromise and demonstrate the behaviours listed within the Terms of Reference. If unable to reach a consensus, this would be escalated to the Leeds Committee of the WY ICB.

6.3 Quorum

Quorum for the group will be at least 50% of core members present (or their appointed deputy) which must include:

- Two members or representatives from Leeds Office of the WYICB
- Two members from each partner organisation (LCHT, LTHT and LYPFT)

6.4 Conflict resolution / arbitration

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

If the group cannot reach a consensus on a specific matter, the group will consider inviting an independent facilitator to assist with resolving the specific matter or escalate to Leeds Committee of the WYICB.

6.5 Considerations for the future

As the group develops, consideration will be given to more formal governance/decision making models and budget arrangements.

7.0 Meetings

7.1 Frequency

The group will aim to formally meet at least once a month. There may be occasions where this is not possible; however, as much notice as possible will be given to any changes in dates/times.

Additional meetings may be arranged if required.

7.2 Duration

Each formal meeting will be scheduled for two hours.

Meetings may be extended or reduced in duration if appropriate at the discretion of the Chair.

7.3 Bringing agenda items

A forward plan for the group will be developed by the group, supported by the Partnerships Governance function. This will be reviewed and updated in each meeting.

In addition, a referral can be made from the Leeds Committee of the WYICB, or the Partnership Executive Group (PEG).

A request should be made to the Partnerships Governance function who will collate items into a draft agenda, to be discussed and agreed with the Chair.

The following information must be provided for any items requested:

- Title for the item
- Primary group sponsor for the item
- Author(s) for the item
- Reason for coming to the group and expected outcome
- Estimation of minimum amount of time required for the item
- Which group meeting the item is requested to come to and an assessment of the criticality of the item coming. This will assist with prioritising which items must be on the agenda for a specific meeting.

7.4 Structure of meetings

All formal meetings will have an agenda.

Items will normally be accompanied with a supporting paper and as a minimum an item cover sheet will be completed for any items that require a decision/agreement by the group. A template cover sheet will be provided for this purpose.

The following items will be standard on all formal agenda meetings:

- Welcome & Apologies
- Declaration of any conflicts of interest with any of the items that are being discussed as part of the agenda will be raised and noted
- Notes of the previous meeting
- Update on actions from previous meetings
- Additional items as per agenda
- Review of forward plan

8.0 Standards

8.1 Declarations of interest

If any member has an interest, financial or otherwise, in any matter and is present at the meeting at which the matter is under discussion, he/she will declare that interest as early as possible. Subject to any previously agreed arrangements for managing a conflict of interest, the chair of the meeting will determine how a conflict of interest should be managed. All declarations of interest and actions taken in mitigation will be recorded in the notes of the meeting.

Declarations of interest will be circulated and reviewed as a standing item on all meeting agendas.

8.2 Behaviours and practice all members will demonstrate

- Act across the Leeds health and care system in line with Nolan's Seven Principles of Public Life: Selflessness, Integrity, Objectivity, Accountability, Openness, Honesty, Leadership.
- Act in the best interests of the population of Leeds.
- Resolve differences between members and present a united front in the best interests of the people of Leeds.
- Openness and transparency in discussions.
- Actively work to remove barriers that prevent team working.
- Hold each other to account.
- Be clear in language used to reduce any confusion between group members.
- Seek clarity from other group members if unsure of terminology/language used.
- Offer constructive challenge to improve service delivery and ensure financial balance.
- Openness and transparency in decision making, being explicit when not agreeing/supporting a decision.
- Stick to decisions that are made at the group.
- Follow through on actions agreed at the group.
- Meet deadlines agreed at the group.
- Prioritise group meetings and core members will aim to attend the full meeting.
- Read all papers in advance of the meeting and come prepared.
- Undertake the necessary discussions within their own organisations prior to the group meeting in order to make decisions within the meeting.

8.3 Equality

The group shall have due regard to equality in all its activities and shall take steps to demonstrate it has consulted with communities appropriately in its decisions.

8.4 Transparency and communication of discussions and decision taken

The Head of Communications and Engagement (Leeds Office of the WYICB) may be asked to be present at formal group meetings and shall produce a summary of key messages which will then be circulated to staff and published on the staff space.

9.0 Secretariat support

The secretariat support will be provided by the Partnerships Governance function under direction of the Head of Health Partnerships and Head of Corporate Governance and Risk (Leeds Office of the WYICB). This will include:

- Being a central point of contact for the group
- Drafting and preparing the agenda
- Issuing the call for papers on behalf of the group

- Liaising with authors/leads to ensure that papers meet the requirements of the group
- Ensuring group meetings are accurately minuted
- Maintaining an action log for the group
- Formally requesting officers to undertake specific actions on behalf of the group
- Advising the group as required on policy
- Identifying and organising organisational development (OD) for the group
- Developing a programme of work / forward plan to support the group
- Acting as a critical friend to group to ensure that the group is operating and delivering its outcomes and against the Terms of Reference

Additionally, secretariat support can be delegated by the Chair to undertake any other activity as deemed appropriate under authority of the group to ensure that the group fulfils its objectives and function.

APPENDIX 3

DRAFT - Workstream Plans re addressing 24/25 Leeds Place System gap			Who	20-Nov	27-Nov	04-Dec	11-Dec	18-Dec	25-Dec	01-Jan	08-Jan	15-Jan	22-Jan	29-Jan	05-Feb	12-Feb	19-Feb	26-Feb
1		**Governance**																
	a	SFEG Meetings																
2		**Organisational Stretch Review**																
	a	Obtain benchmarking information re WRP levels from other systems																
	b	Review available data sets e.g. Model Hospital re opportunity																
	c	DoF review based on a and b																
	d	Recommendation paper to SFEG - individual organisation review																
	e	SFEG position agreed																
3		**Strategic New Cost Pressure Review**																
	a	Organisations produce ranked list of material (£1m+) local pressures with any options to avoid, impact and consequences																
	b	Organisations produce ranked list of material (£1m+) developments with impact and consequences if stopped																
	c	Initial DoF consistency review and adjustments																
	e	Initial SFEG review and feedback to organisations - recommomended stop / potentially stop list																
	f	Organisational review of e) and feedback to SFEG																
	g	SFEG position agreed																
4		**Strategic Disinvestment review**																
	a	Develop process guidance and communications																
	b	Identify clinical working groups (population health boards plus others)																
	c	Identify accountable clinician / manager agreed for each group																
	d	Generate list of Leeds commisisoned services with indicative value																
	e	Allocate the list to relevant groups (e.g. population heath boards)																
	f	Groups to review list - what potential is there to stop or reduce - ranked options , impact and consequences																
	g	Feedback from groups collated																
	h	Initial DoF consistency review and adjustments																
	i	Benefits costing exercise																
	j	Initial SFEG review and feedback to organisations - recommomended stop / potentially stop list																
	k	Organisational review of j) and feedback to SFEG																
	l	SFEG position agreed																
5		**Strategic Transformation Review**																
	a	Develop process guidance and communications																
	b	Identify clinical working groups (population health boards plus others)																
	c	Identify accountable clinician / manager agreed for each group																
	d	Groups to identifty all viable transformation that could impact in 24/25																
	e	Feedback from groups collated																
	f	Initial DoF consistency review and adjustments																
	g	Benefits costing exercise																
	h	Initial SFEG review and feedback to organisations - recommomended stop / potentially stop list																
	i	Organisational review of j) and feedback to SFEG																
	j	SFEG position agreed																
6		**Cost Structrure Analysis**																
	a	Develop process guidance and communications																
	b	Organisations submit data				0												
	c	Initial DoF consistency review and adjustments					0											
	d	Feedback to organisations						0										

Meeting name:	Leeds Committee of the West Yorkshire Integrated Care Board
Agenda item no.	LC 58/23
Meeting date:	13 December 2023
Report title:	Transforming Community Mental Health in Leeds
Report presented by:	Helen Lewis, Director of Pathway Integration, ICB in Leeds Joanna Forster Adams, Chief Operating Officer, Leeds and York Partnership NHS Foundation Trust (LYPFT) Andrea North, Interim Director of Operations, Leeds Community Healthcare NHS Trust (LCH)
Report approved by:	Helen Lewis, Director of Pathway Integration, Leeds Office of the West Yorkshire ICB Joanna Forster Adams, Chief Operating Officer, Leeds and York Partnership NHS Foundation Trust Eddie Devine, Head of Pathway Integration, Leeds Office of the West Yorkshire ICB Andrea North, Interim Director of Operations, Leeds Community Healthcare NHS Trust.
Report prepared by:	Liz Hindmarsh, Programme Manager.

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

Previous considerations:

This is a 'deep dive' agenda item intended to update on the Community Mental Health Transformation Programme in Leeds. This was requested following reference to this work in the Place Lead update presented to the Leeds Committee of the West Yorkshire Integrated Care Board (ICB) on 4th October 2023.

Executive summary and points for discussion:

This report provides an overview of work happening across Leeds to transform community mental health services. It is intended to provide an update and assurance to members of the Leeds Committee of the West Yorkshire ICB. It is also intended to highlight key risks and issues, particularly around resourcing, where support is welcome in prioritising this work.

The report provides:

- An overview of the national and local strategic context, vision, and drivers
- Scope of the work, key priorities, and outcomes.
- Work delivered to date, including impacts to date.
- Enablers including how we work with communities.
- Key risks and issues

- Next steps.

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

☒ Improve healthcare outcomes for residents in their system

☒ Tackle inequalities in access, experience and outcomes

☒ Enhance productivity and value for money

☐ Support broader social and economic development

Recommendation(s)

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

1. **NOTE** and **CONSIDER** the report.
2. **ADVISE** on any further mitigations relating to risks and issues, not presented in this report.
3. **SUPPORT** with engagement and resourcing of this important and complex transformation programme.

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

N/A

Appendices

1. NHS England (2023) *Roadmap for Community Mental Health Transformation* (attached via paperclip function due to the large file size)
2. Proposed performance and quality metrics and indicators
3. Overview of Transforming Community Mental Health Grants
4. Summary of investment to date

Acronyms and Abbreviations explained

1. LYPFT – Leeds and York Partnership NHS Foundation Trust
2. LCH – Leeds Community Healthcare NHS Trust
3. ICB – Integrated Care Board
4. IG – Information Governance
5. SMI – severe mental illness
6. CMHT – Community Mental Health Teams
7. LCPs – Local Care Partnerships
8. PCNs – Primary Care Networks
9. PCMH – Primary Care Mental Health
10. LMWS – Leeds Mental Wellbeing Service
11. SRO – Senior Responsible Officer
12. LNA – Learning Needs Analysis
13. ARRS – Advance Roles Reimbursement Scheme

14. IPS – Individual Placement and Support service

15. SDF – Service development funding

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 improvements which have been designed and embedded to clinical pathways and community-based support aimed at improving the quality and safety of adults with complex and ongoing mental health needs in Leeds. The report also highlights how the programme is seeking to provide support to people working across the mental health and care system in Leeds, to support them in continuing to deliver safe and effective care.
Equality, Diversity and Inclusion	The report highlights implications for equality, diversity, and inclusion throughout.
Finances and Use of Resources	The report provides information on total financial investment into the programme and how it has been used. It sets out some resourcing constraints from April 2024 onwards.
Regulation and Legal Requirements	None identified.
Conflicts of Interest	None identified.
Data Protection	None identified.
Transformation and Innovation	The report highlights transformation and innovation throughout.
Environmental and Climate Change	Some implications relating to where and how services are delivered. Providing locally based support has the potential to reduce carbon emissions. Likewise, increased use of digital innovations (as appropriate to service user's/person's needs and digital inclusion).
Future Decisions and Policy Making	The work is likely to require future decision making around resourcing of the work. There are synergies with other related work programmes around crisis transformation.
Citizen and Stakeholder Engagement	The report highlights engagement and involvement work undertaken with communities and with service users and carers.

1. Introduction

1.1 Transforming Community Mental Health is a partnership of NHS organisations, Leeds City Council, the Voluntary, Community and Social Enterprise (VCSE) sector, and service users/people with lived experience coming together to transform how primary and community mental health services are currently organised and delivered for adults[1] and older people with ongoing and complex mental health needs (commonly referred to as severe mental illness/SMI). Simply put, we are attempting to reshape the care offer for the adult SMI population, with more joined up and holistic care, with more timely interventions and with attention to the impact of wider determinants on people's mental health and recovery.

1.2 The programme is a key enabler to successful delivery of the Leeds Mental Health Strategy and its eight priorities; hence the transformation is now framed as one of three key workstreams of the Strategy.

1.3 The programme is overseen by a partnership Programme Board, which has responsibility for assurance and oversight of the programme, with devolved decision making through a partnership Delivery Oversight Group and workstreams reporting into that. The Programme Board has an independent chair, with membership from across partner organisations as well as Healthwatch and lived experience membership, and this is mirrored in the Delivery Oversight Group membership. The Programme Board reports into the Mental Health Population Board, both to give assurance of the work, and to escalate risks and issues as required, as well as into the Mental Health Partnership Board, via Eddie Devine as SRO.

1.4 The purpose of this report is to provide an update and assurance to the Leeds Committee of the West Yorkshire ICB on the scope, aims and benefits of the work, deliverables and key impacts to date, and to sight the Committee on key enablers and barriers to delivery and realisation of intended benefits.

2. The Leeds context and vision

3.1 Leeds is a city rich in services provided by many different health, social and voluntary and community organisations that support people experiencing difficulties with their mental health. However, we know that we need to improve how we join up services and support for people with complex and

[1] While the scope of this work does not include children, it does include transition of people from children's mental health services into adult mental health services.

ongoing mental health needs (commonly referred to as ‘severe mental illness’ or ‘SMI’.) We want to move from a system where: people experience long waits to access services; services are often organised around thresholds based on diagnosis rather than need; there is limited integration between services, leading to disjointed and duplications in care and with insufficient attention to people’s social needs, and where people experience inequalities in access to care and in their experiences and outcomes.

3.2 Our **vision** is to ensure that people access the right care and support at their earliest point of need and have wide-ranging support closer to home so they can live as healthy and fulfilling lives as possible in their community.

3.3 The principles of the new model are that people will be able to: access care and support when they need it, manage their condition, or move towards individualised recovery on their own terms, and contribute to and participate in the communities that sustain them, to whatever extent is comfortable to them.

3.4 Central to this vision is an aim to increase access to proactive community mental health support and intervention that will improve outcomes and recovery for people with SMI and complex mental health needs, meaning they spend less time in hospital and live healthier, happier lives.

3.5 There is strong body of evidence that accessing interventions for mental health needs in the community, and remaining at home, achieves better longer-term outcomes for individuals. Lengthy admission to a hospital setting can create further difficulties; this removes an individual from their everyday life, work and daily routines, and connections with family, friends, or other support networks. It can sometimes mean losing a job or benefits, a place to live, and the skills for daily living. The community mental health transformation programme has provided a focus on modernising community-based mental health care to also address these wider holistic needs of a person beyond their diagnosis. Access to mental health inpatient treatment is often an essential and appropriate intervention during the most acute phase of an individual’s needs. The implementation of the new model of community mental health care aims to provide robust access to integrated community support and interventions that enables and maintains recovery, to help facilitate episodes of hospital care being as short as possible to reduce the likelihood of the difficulties associated with longer hospital stays.

3.6 The model of care aligned to local care partnerships and primary care networks has an explicit focus on a data driven understanding of the mental health needs of local communities to proactively target resources for individuals and communities most at risk of admission, to maintain people’s independence, and provide bespoke support and intervention to reduce the

risk of hospital or inpatient admission as far as possible. The explicit focus on wider determinant of mental health through integrating social care and VCSE partners into the planning, delivery, and accountability within the new model of care strengthens a focus on shared outcomes.

3. Policy context and requirements

3.1Transforming community mental health services is a priority set out in the government's NHS Mental Health Implementation Plan 2019 / 20 – 2023 / 24 and in the West Yorkshire and Leeds Integrated Care boards' mental health strategies with a requirement set out in *The NHS Long Term Plan* to "establish new and integrated models of primary and community health care to support adults and older adults who have severe mental illness, so that they will have greater choice and control over their care and supported to live well in their communities".

3.2 Specific requirements include the need to:

- Develop an integrated 'core community offer', which provides continuous care across primary and secondary services, so there is care and support available for people who don't meet existing thresholds for secondary care and to avoid people losing care and support following discharge from Community Mental Health Teams (CMHTs).

- Improve access to evidence based care and support, including psychological therapies, physical health care, employment support, personalised and trauma informed care, medicines management and ongoing support available to people to support them post discharge.

- Improve access to high quality evidence based care and reduce waits for adults with: eating disorders, people with complex emotional needs associated with a diagnosis of personality disorder and people with community based mental health rehabilitation needs.

3.3 NHS England published a 'Roadmap' for transformed community mental health services in 2022, with an updated version published in May 2023. This is included as appendix 1. The programme regularly self-assesses against this to identify key gaps and priority areas of work and resourcing.

4. Outcomes and measurement

4.1 We will know if we have 'transformed' the community mental health offer in Leeds if we achieve the following four key outcomes:

Outcome	We will know we have achieved it if…
Accessing high quality support	The community mental health system across West Yorkshire is transformed so people and their communities can access high quality community based mental health support.
Supporting care options	People and their communities understand the options for support and can access what they need, when they need it and services which will work with them to agree the best options.
Providing innovative, effective, and evidence-based care	People and their communities work in partnership with a responsive workforce that provides innovative, effective, and evidence-based care that places the individual at the centre of decision making.
Partnership working	All partners work in a seamless way to provide people and their communities with the personalised care they need as one health and care system.

4.2 An independent evaluation is being conducted across all West Yorkshire places, by an organisation called Niche, over the next 18 months.

4.3 The following two key performance indicators have been mandated by NHS England:

- Increase number people seen in 'transformed' community mental health services, including in dedicated focus areas (i.e. adults with an eating disorder; complex emotional needs associated with a diagnosis of personality disorder and people requiring community based rehabilitation and recovery services). The target set by NHS England is a 5% increase in the number of people accessing care by 31 March 2024.

- Maximum 28 day wait from receipt of referral to meaningful intervention offered. This means that within a 28-day period, a patient/service user should have: an assessment completed, baseline clinical outcome measure recorded; offered either a clinical intervention (e.g., an evidence based psychological therapy); a social intervention (e.g. employment support, a social prescribing intervention, etc) and/or co-produced a personalized care plan.

4.4 This will require work to ensure that clinical outcome measures are embedded as a therapeutic intervention in clinical practice and being systematically recorded. NHS England has just released guidance on what outcome measures should be used and so this work is now starting.

4.5 Additionally, we will need to ensure that testing this new hub model does not negatively impact on any existing key performance indicators within existing contracts, notably within Leeds Mental Wellbeing Service. In integrating the Primary Care Mental Health element of the service with Community Mental Health Teams to undertake joint triaging of referrals, we need to mitigate against any unintended consequences of a left shift of activity which negatively impacts on waiting times for a brief intervention approach. We have set this out in a detailed Quality Impact Assessment and a performance dashboard has been developed and currently going through sign off. We are establishing an integrated performance meeting structure, which will enable joint review of impacts in terms of activity and flow so we can understand impacts of any changes and take collaborative action in response.

4.6 Transforming community mental health is an iterative process as we continue to mobilise and implement an integrated hub model, and as we continue to expand interventions and services that are being developed. To allow us to track and measure impact and quality, we are developing a comprehensive set of metrics, informed by a completed Quality Impact Assessment and Equality Impact Assessment. Some will take longer to embed. This will need to be set out in the partnership framework agreement being developed. See appendix 2 for proposed measures and indicators.

5. Finance and resourcing

5.1 Community Mental Health Transformation comes with significant Service Development Funding (SDF) investment, aimed at growing the workforce and increasing provision of care and support in line with policy commitments.

5.2 Total committed funding in 2023/24 is £4,669k. £2,685k is committed to schemes delivered by Leeds & York Partnership NHS FT. This includes £1,769k made up of clinical roles and some programme delivery resource (some of which is fixed term) and £916k relates to the Emerge service that is now well established, and which provides care and support to young adults with complex emotional needs associated with personality disorder diagnosis. This is a key ambition and central mandate of NHS England, which requires systems and providers to prioritise improvement of care for this cohort of care, and which also requires a particular attention on a tailored offer for young adults. For this reason, there was an early decision by partners to channel a

proportion of the SDF money into embedding this service offer. Further information on Emerge is provided in section 6.40 on p.19.

5.3 Of the total 2023/24 investment, voluntary & Care Sector Enterprises are committed to receive £1,418k. This includes some new roles and schemes, and a continuation of some existing, previously non recurrently funded, schemes including the Touchstone Community Support Team, for which there was no other identified funding source. This equates to about 30% of the total investment. This appears to be slightly above national trends, based on an NHS England Board report from February 2023 which included analysis of 2022/23 SDF planning submissions which indicated that systems intended to spend an average of 22% of funding via VCSE organisations, with the largest proportion of planned spend being 48% in one system.[2] It is worth noting, of course, that this is a proportion of the additional SDF investment and doesn't take into account existing VCSE provision through, for example, the Leeds Mental Wellbeing Service partnership and indeed a number of roles which are sub-contracted through LYPFT to work with and into Community Mental Health Teams. So, in Leeds the actual proportion of overall VCSE investment is likely to be higher than 30%.

5.4 A significant amount of the unmet need can be met by non-clinical staff. VCSE providers are well placed within communities to provide support to meet the social needs of people with SMI, supporting people to manage their condition or move towards individualised recovery on their own terms in their local community. Furthermore, VCSE organisations, particularly grassroots organisations, have a key role to play in reaching previously underserved communities, thereby advancing equalities in access, experience and outcomes.

5.5 Other investment has included non-recurrent costs relating to comms and engagement, venue booking and training costs. Additionally, some investment has been used to fund an independent evaluation (as mentioned in section 4) and work to test a digital platform called 'Joy' which provides benefits around understanding of community assets, simpler social prescribing referral routes and a greater capture of activity and outcome data relating to social prescribing activities.

5.6 We expect the financial allocation to be in the baseline from April 2024 onwards, although there is, of course, some caution for the above, in the context of current NHS national financial pressures, and any potential changes

[2] https://www.england.nhs.uk/wp-content/uploads/2023/02/board-2-feb-23-item-6-cmh-role-of-vcse-v2.pdf

to Mental Health Investment Standard requirements that wouldn't provide the same safeguard for mental health funding being prioritised in the round.

5.7 It is important that transformation efforts and activities are viewed not only in the context of this new additional investment. We must also ensure that we optimise value and efficiency and outcomes through existing financial investment in Leeds, through existing contracts with all the services in scope of primary and community mental health services for adults and older people with SMI.

5.8 To date, we have used investment to:

- Grow our workforce across the NHS and third sector, including more psychological therapists, advance care practitioners, pharmacists, occupational therapists, peer support workers and mental health practitioners and new community wellbeing connector roles.

- Employ new recruit to train roles so we can develop, over time, the registered workforce pipeline we know we need with the right skills mix and specialisms (with the intended benefit of retaining them to work in the Leeds system post training).

- Expand community based, local support through a £500k grant funding scheme (specifically focusing on people with complex and ongoing mental health needs). More information is included in appendix 3.

- Fund involvement roles and infrastructure to support community engagement and service user and carer involvement as a key element of the work.

5.9 We have also had to use a sizeable amount of the investment (19%) to fund programme delivery roles across programme and project management, communications, workforce, business intelligence, involvement and engagement, digital and IT expertise and clinical time. This is because the programme has not been able to access this capacity and resource from any partner organisation business as usual functions. We will not be able to continue to fund all this resource from April 2024, as we need to prioritise spend on front line delivery roles. This poses a significant risk to the future stability of the programme, discussed further under section 8.

5.10 Please refer to appendix 4 for a full breakdown of investment to date, and for what intended purpose. We have gathered data against all funded initiatives, as part of the independent evaluation being conducted by Niche. These metrics will also be reviewed by the Delivery Oversight Group and the Programme Board on a quarterly basis.

6. Work to date and key impacts

Development of an integrated "core community model" for working age adults

6.1 In Leeds, we have been developing what we are currently calling 'integrated community mental health hubs'. To date, the work has largely focused on working age adult services and so the description in this section refers to that. Work has commenced on the older people's offer, and this is set out further in section 9.

6.2 The 'integrated community mental health hub' is a way to describe a multi-disciplinary, multi-agency team working together to best meet someone's psychological, physical and social needs. At this stage, we don't intend this to be a 'drop in' physical space.

6.3 Broadly, support offered to people referred to the integrated hubs in Leeds will include: recognition and assessment of mental health problems, provision of treatment (social, psychological and pharmacological); support with management of physical health problems; supporting carers; supporting with things that support good mental health like using community resources, stable housing, having enough money, obtaining and maintaining employment or education.

6.4 These teams will be made up of people and professional disciplines currently working in Community Mental Health Teams, mental health practitioners and support workers currently working in Primary Care Mental Health (part of Leeds Mental Wellbeing service), psychological therapists working across PCMH and CMHT, mental health social workers and a range of third sector roles with a focus on meeting people's needs in a holistic way.

6.5 The model has been co-designed working with staff, service users and carers, starting with the development of an initial model blueprint, then several design workshops during the latter part of 2022 and mobilisation task and finish working groups.

6.6 The model was signed off through Programme governance in December 2022, and taken through all partner's constituent governance functions for assurance and was endorsed across the health and care system.

6.7 The aim is to test the model in three ‘early implementer’ LCPs before scaling up to other parts of the city. These are: HATCH LCP, Leeds Student Medical Practice and the Light, and West Leeds.

6.8 The operational handbook, Quality Impact Assessment and Equality Impact Assessment and proposed team structures were finalised in August 2023. At this point, concerns were raised by some partners about the potential clinical and operational risks around integrated working without a clear contractual delivery framework around that. How will clinical and organisational risks be managed across different contracted services and providers, all of which have separate governance functions, and how will we ensure legally compliant processing of people’s data in the absence of a single lead provider (and associated data controller and accountable body)?

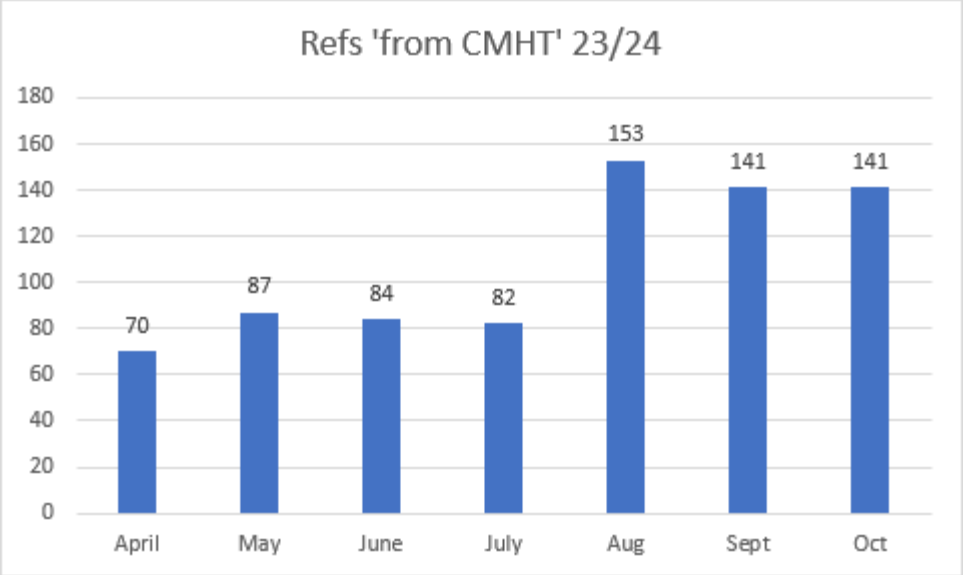
6.9 Work has been undertaken since then to map staffing structures, data access, proposed joint management arrangements and proposals for how operational and clinical governance can be managed. All risks and mitigations have been identified, with some further task and finish work planned between early December and end of February to agree the specific processes and systems to support testing of new ways in the early implementer sites. Concurrently, partner organisations, supported by the Pathway Integration team from the Leeds Office of the ICB are working together to develop a partnership agreement (Memorandum of Understanding) for the short term testing phase, and proposals are being developed to ensure compliance with Information Governance requirements around the processing of people’s personal data.

6.10 This has impacted on progress and pace of the programme and has delayed achievement of the intended ‘go live’ of the early implementer sites from October 2023. The task and finish work identified above, supported by the development of a partnership agreement/Memorandum of Understanding, are planned to be finalised by the end of February 2024 with the intention to have all these things in place ready to start tested the intended operating model from March 2024. This is subject to all partners signing off the partnership agreement.

6.11 To mitigate against the delays already incurred, the programme has made good progress in delivering work to start to build collaboration and reduce duplication across teams to build the foundations for the integrated hub model, and to prepare staff who will be working in the new teams. These positive developments are set out below.

6.12 Since mid-August, practitioners from PCMH and CMHT have been jointly reviewing and triaging referrals which are made into PCMH and CMHT

services with the aim of reducing duplication and directing service users to the "right bit of the system" for appropriate care and support sooner. There has been an increase of c. 60 referrals/month into PCMH from the joint triage (see chart below).



6.13 We can derive from this that 60 referrals were 'inappropriately' sent to CMHT, and the joint triage has meant they have then got to the "right service" without having to be first sent back to the GP and the person then having to wait for a further referral to the correct service. This does not necessarily mean 'new demand' on the PCMH service as these are people who would ultimately have been redirected to the service; this has reduced inefficiency and got people to the right place quicker.

6.14 Feedback from staff involved has been positive:

"Coming together has really helped our service users stop bouncing around and people are getting the right treatment at the right time instead of being passed from pillar to post. Relationships have really strengthened…both services sit physically together which allows for conversations to flow organically and confidence/knowledge of/trust in each other's services to grow. Where people do need stepping up or down, it feels much easier to facilitate by having open and honest conversations."

6.15 We are progressing realignment of working age adult CMHT staff around PCNs and LCPs and in line with the new model. Work is underway to transfer caseloads. We have worked with the programme's Involvement and Engagement Advisory Group to make sure this process is managed in an appropriate, person-centred way.

6.16 We have undertaken a comprehensive learning needs analysis (LNA) to support and develop staff who will be working in the new model. We are currently rolling out 3 pieces of key training: Trama Informed training for administrative staff; trauma and complexity training and formulation training. There have been 180 members of staff across transformation booked on and approximately 60 that have attended so far. The LNA will be reviewed in the new year and a joint CPD programme rolled out.

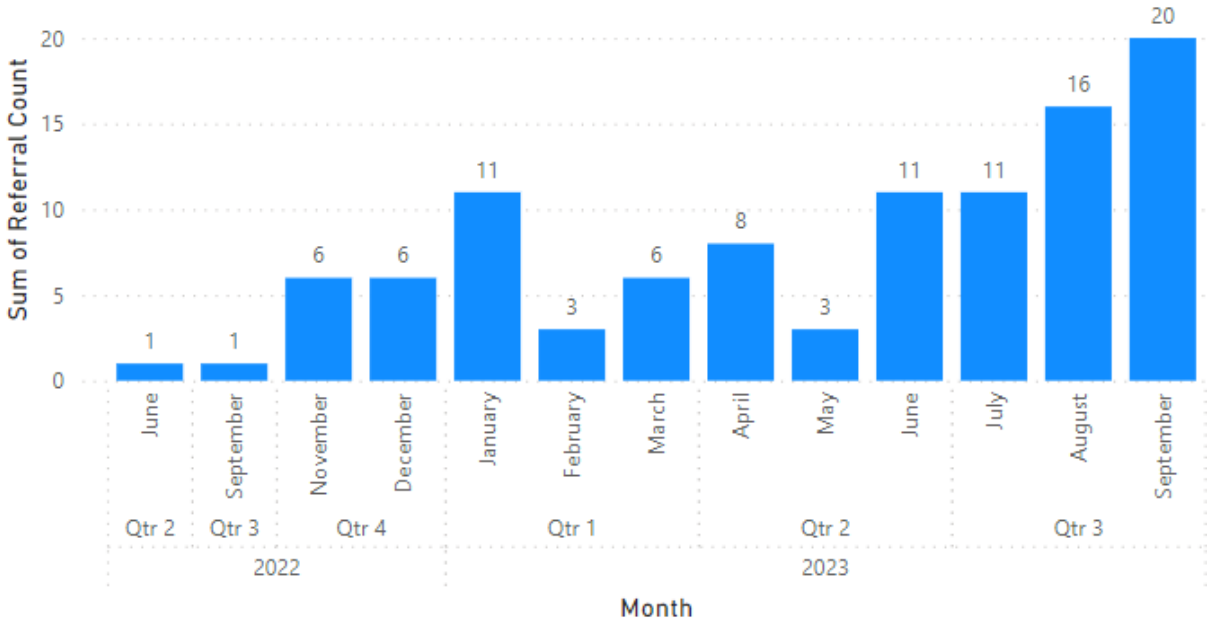
6.17 Introduction Days were held on the 20th and 21st November for all colleagues involved in the first early implementer LCPs, with additional invites to management and citywide colleagues. These sessions focused on work on Transformation to date, involvement and engagement with lived experience, new roles and how they work in a team, preparing for personal change and testing out different team scenarios. We have also put in place organisational development support in continuing to build integrated team cultures and to support people and teams through changes and new ways of working. Additionally, we are identifying shared estate for teams to work together.

Improving access to evidence based psychological therapies

6.18 A key requirement is to increase access to evidence based psychological therapies. To this end, we have used investment to expand the workforce, including recruit to train roles which allow us to ‘grow’ our own workforce rather than struggling to recruit or recruiting staff from other Leeds or West Yorkshire services. We have also introduced some new roles including mental wellbeing practitioners and group work facilitators to help expand psychological groups provision. This has included courses on Wellness Recovery Action Plans (WRAPs) in collaboration with the Recovery College (and open to people on the NHS Talking Therapies waiting list).

6.19 We have set up a new Primary Care Therapy Team, aimed at those people who traditionally fell through the gap between NHS Talking Therapies (previously known as “IAPT”) and CMHT (including people from minoritized and marginsalised groups whose needs may not be well met by the traditional service offer and including presentations like complex trauma). The team is not yet fully established as some of the team includes psychological training posts, and these people will fully join the team on completion of training.

Below we can see the number of people who have referred, accessed the service and have been discharged over time. Please review this in the context of the notes above re the team establishment.



6.20 The team provides assessment, consultation, brief interventions and therapy depending on need, therapeutic interventions, consultation and supervision to the PCMH team and training for colleagues. Referral criteria are intentionally broad and inclusive, and interventions provided include both 1:1 therapy and group work.

Enhancing community-based support

6.21 A large focus of the model is on supporting people to recover and to continue to live a fulfilling life in their own community, based on what matters to them. To this end, we have continued funding to support embedded Community Support Team practitioners within Community Mental Health Teams, employed new Community Wellbeing Connectors and expanded peer support provision. And we have invested £500k of funding in small to medium grass root organisations to test new forms of care and support for people with complex and ongoing mental health needs.

6.22 We have started to test new Community Wellbeing Connector roles across our first three early implementer LCPs, employed by Northpoint, Touchstone and Barca. These roles work with people to help them access a range of different types of support in communities, including attending appointments and accessing other services as needed. Community Wellbeing Connectors will work with people in a non-time limited way. There are currently 8 Community Wellbeing Connectors working across the three LCPs – 2 in each, with an additional 2 roles in LSMP and the Light employed as Advance Roles Reimbursement Scheme (ARRS roles).

6.23 From January 2022 to October 2023, there have been a total of 205 referrals into the Community Wellbeing Connectors. There has not been the full establishment of staff from that January date. Referrals increased from about September 2022, to be expected, as the service increased its capacity, embedded new workers, and continued to build awareness of the service. Anxiety and depression account for the largest presenting main condition for referrals, followed by support needed relating to trauma and emotional dysregulation.

6.24 We are in the process of scaling up these roles to cover the other LCPs. There are challenges we are working to overcome relating to challenge around access to clinical systems, and ensuring these roles are fully understood and embedded as part of a wider offer within a multi-agency multidisciplinary hub team.

6.25 We have expanded peer support provision across Leeds, delivered by a partnership of VCSE providers including Leeds Survivor Led Crisis Services, Yorkshire Mesmac and Health for All with Leeds Mind as lead provider. 7 peer support workers have been employed and 2 senior peer support workers. The service was mobilised in June 2023 and started taking on referrals, gradually building them up. 47 referrals were received from June 2023 to August 2023, with nearly all people receiving a contact within 10 days, and the vast majority within 5 days.

6.26 Positive client feedback includes:

"Gives me a reason to get up, washed and dressed"

"It has helped. Nice to be able to talk about me, Usually just listen to the other person talking"

"Feel supported and understood. Other person has lived experience of mental health problems which helps me feel less lonely"

6.27 As with the Community Wellbeing Connector roles, there have been challenges around system access and in optimising referrals and full use of these roles when we haven't yet been able to implement the full integrated hub model as intended. We are mitigating this by ensuring peer support workers are invited into PCN and CMHT multidisciplinary team (MDT) meetings, enabling hotdesking so teams get to know each other and using the two team 'introduction days' to spotlight new roles and offers.

6.28 The Transforming Community Health Grants scheme has been jointly led by Leeds Community Foundation and Forum Central and has available up to £500k to award in grants to small to medium community organisations to support people

with complex mental health problems. Eight projects were funded as part of the first round of grants, which mobilised during the summer of 2023. Further information about these schemes and how they will be evaluated is included as appendix 2.

6.29 Applications for round two of the Transforming Mental Health grants are live and was launched at an online event on the 30th of October with 98 people in attendance. Applications close on the 8th of December, with a cross sector panel at the end of January, awarding early February 2024 to deliver across the next financial year (24/25). This will split resource between a city-wide funding pot and a local responses pot. The city-wide fund will include (One grant of up to 50k to be awarded to resource five key priority areas supporting the health and wellbeing of: Black men, older people, young people transitioning into adult services, people with access needs & people disproportionately impacted by the cost-of-living crisis). The local responses project will fund a 10-20k project supporting people with complex MH needs (with a wide spec including supporting with the wider determinants of health).

Improving access to employment support

6.30 National access performance targets for employment support through the Individual Placement and Support Programme (IPS) for people with complex mental health needs are set by NHS England. Work has been undertaken in Leeds to improve the numbers of referrals made that are accepted onto the programme, and an increase in access performance was noted in the last quarter of 2022/23 (Q4, Jan-March 2023), where the service met 80% of the quarter's target. Embedding IPS as part of the new community mental health model will help to increase access performance further, by increasing integration of support and referrals from primary care.

Improving physical health

6.31 The life expectancy of someone with Serious Mental Illness (SMI) can be 15-20 years shorter than someone without a mental illness, with premature deaths increasing by 20% in the last five years. National data also indicates that more adult men with SMI die prematurely than adult women with SMI.

6.32 There is a national NHS Long Term Plan requirement to increase uptake of annual SMI physical health checks to help identify early intervention and preventative support to reduce health inequalities in people with SMI. This is an area in which Leeds continues to perform well. The latest data (quarter 2 2023/24) showed attainment of 67% of people on the SMI register in primary care

having received an annual physical health check in primary care (against a national target of 60%).

6.33 Additionally, we're looking at how we can improve uptake particularly for people who haven't been engaging in physical health checks but would benefit from these, and what targeted support we can put in place to help people access those checks and any follow up interventions identified as beneficial. Several initiatives have been funded to support with this work as part of physical health improvement pilots. These include introducing primary care based roles with a specific focus on improving SMI physical health in the following Primary Care Networks: Chapeltown, Burmantofts, Harehills and Richmond Hill, Leeds Student Medical Practice and the Light and Seacroft. These roles have helped deliver an increase in the uptake of physical health checks from 2021-22 to 2022-23. Also, new community wellbeing connector roles have been supporting people to attend physical health checks in Leeds Student Medical Practice and the Light.

6.34 The Physical Health SMI group is also looking at what onward support we can offer around physical health/health improvement to help people with SMI make informed decisions about healthy lifestyle choices and physical activity, given the stark data around poorer physical health outcomes for this group. It is worth noting that this is challenging given the changes in Leeds universal healthy living services and resulting impact on capacity within local services, and the wider funding constraints.

Embedding trauma informed and personalised care

6.35 Trauma informed care is a 'golden thread' that runs throughout this work. But we wanted that to be meaningful and observable and not just aspirational rhetoric, and we appointed Richard Barber, Director of the Visible Project to lead on this work.

6.36 As a result, we are currently rolling out trauma informed training for all staff working in the early implementer hubs, we have amended job descriptions to include reference to working in a trauma informed way, and we have made sure trauma informed principles are embedded in assessments, care plans, core competencies for all roles and in how meetings will be organised and run in the new community mental health hubs.

6.37 Richard Barber has also led on partnership innovations aimed at improving care for people who have experienced childhood sexual abuse. He has worked with Burmanthofts, Harehills and Richmond Hill PCN and the Continence, Urology & Colorectal Service (CUCS), staff from Leeds Community Healthcare NHS Trust to develop guidance for GPs, Nurses, Administrative and Reception Staff on working with and providing care to people who have experienced childhood sexual abuse; people, who may well may well have a range of medical symptoms and co-morbidities. These can include direct physical injury/issues as a result of

CSA, e.g. bladder, bowel and pelvic floor dysfunction (as seen very commonly at CUCS); but also, regularly reported issues such as hypermobility, chronic pain and fatigue, autoimmune disorders and so on.

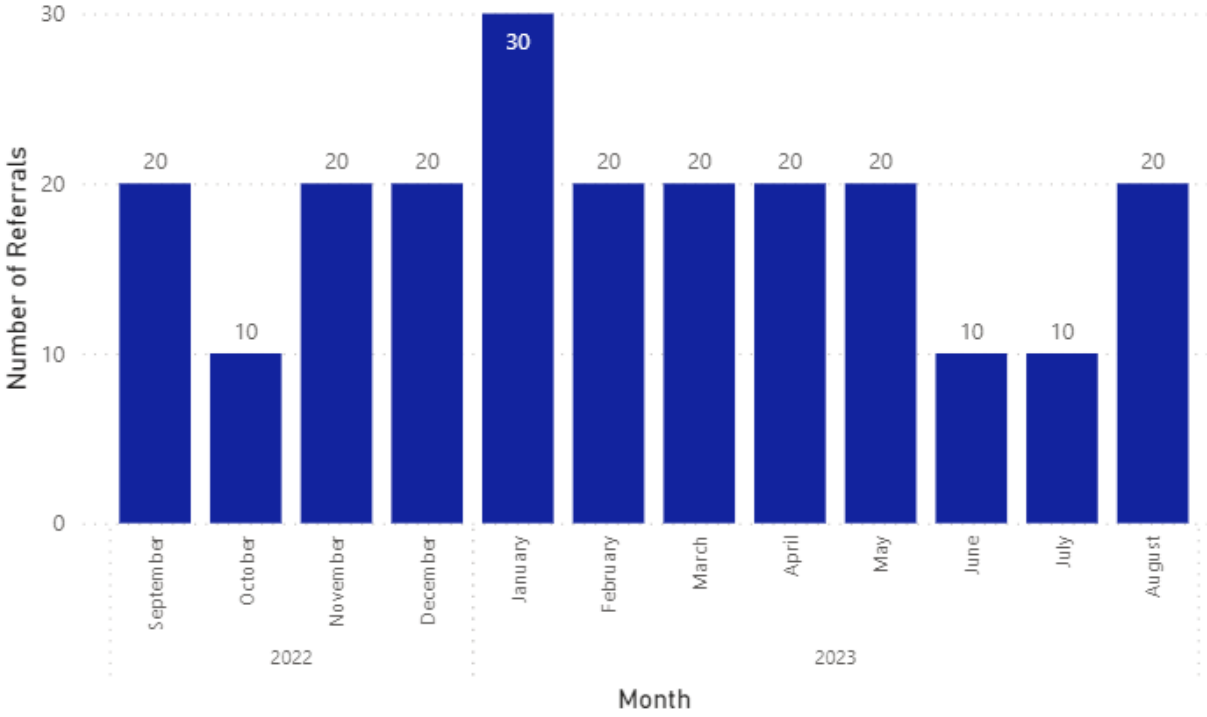
6.38 The guidance will support staff to have greater awareness and to provide compassionate, trauma informed care and treatment. This is a really good example of the power of embedding a trauma informed response throughout all our work and connects people's physical and mental health care needs in a simple way. This work will be tested and evaluated through the physical health SMI group with potential for scaling up across other PCNs and service areas.

6.39 Work continues within LYPFT on work to move away from the Care Programme Approach and to embed key principles around personalised care planning, moving away from generic care coordination to intervention-based care and from people having "care coordinators" to named key workers. We have embedded these ways of working throughout the integrated hub model, although challenges pertain relating to systems interoperability and how people's care plans follow them through the system.

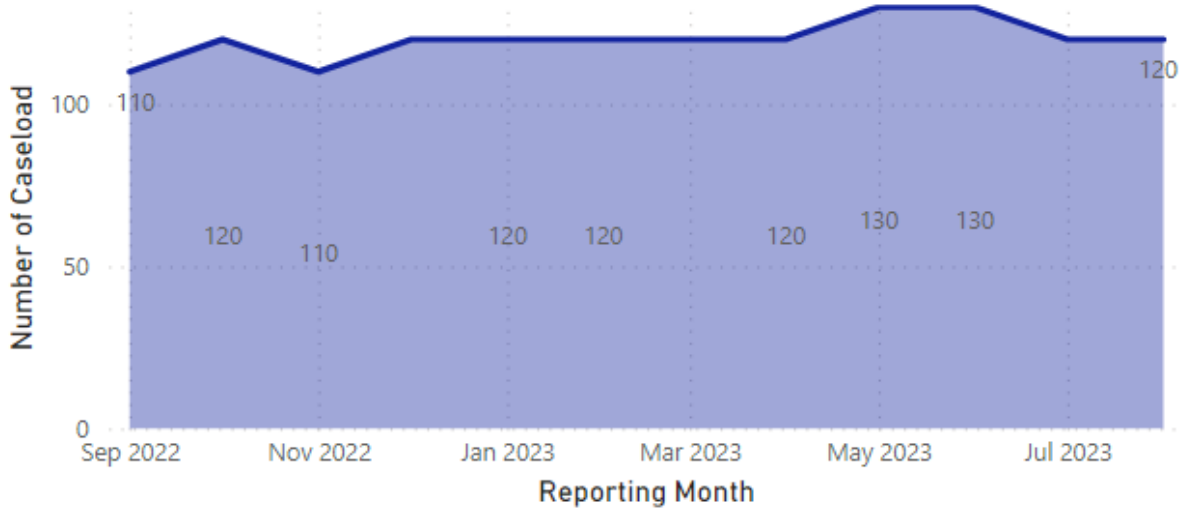
Improving access and care for people with an eating disorder, complex psychosis and complex emotional needs (personality disorder)

6.40 Work has continued on embedding the new 'Emerge' service which provides assessment and evidence-based care and support to young adults (aged 18-25) with complex emotional needs associated with a diagnosis of personality disorder. This includes 1:1 support, psychological group offers. The service also offers an assessment and guidance function to other services and has invested in enhancing the capacity of the wider system to work effectively with 'personality disorder/complex emotional needs' through the provision of co-produced training, supporting the development of a primary care e-learning training package (due for delivery in 2024) and setting up of consultation support.

Below is the number of referrals to the 'EMERGE' service for those aged 18-25 at the time of referral:



Below is the number of people on caseload, defined at 2 or more community contacts, over time:



6.41 We have Recruited an occupational therapy lead who will lead a team of complex psychosis & rehabilitation practitioner roles. New VCS roles are currently being recruited to and will be joined by existing assertive outreach nurses to focus on providing more preventative support to people with complex psychosis in primary and community care settings. Working closely with Hub colleagues in the provision of early and flexible intervention the pilot roles will scope population specific needs that can effectively support people to engage in meaningful and recovery focused activities preventing future losses associated with long term conditions where possible.

6.42 We have introduced a new Linked-ED service, which includes link practitioners working across Connect (specialist tertiary eating disorder service)

and CMHTs, to support CMHTs in working with people with an eating disorder/disordered eating, and who do not meet the criteria for Connect. In West Yorkshire, there is a gap in specialist eating disorder treatment for people who do not meet the criteria of the regional specialist service (Connect). Reducing this gap is a local priority and Link-ED represents a starting point to improve regional access to eating disorder services. There have been some challenges in bedding this role in due to vacancies and other pressures in teams.

6.43 There is more work we need to do to review and embed pathways for these three cohorts of people. A working group has been established, gaps identified and plans are being developed to inform the menu of interventions which should be developed to support these groups. This may bring challenges in implementation due to funding and resource requirements.

7. Enablers – involving and engaging or communities

7.1 We are committed to involving people with lived experience, including carers, in the design and delivery of services. We are also committed to ensuring that we double down on our efforts to understand those people whose voices are 'easy to ignore' so that we can design and deliver services that are responsive to the needs and characteristics of different groups and communities.

7.2 To this end, Leeds Involving People was commissioned to lead on involvement and engagement in the programme, and an Involvement Lead was appointed, along with four involvement workers hosted across Gipsil, Health for All, Carers Leeds and The Big Life Group, with a remit to ensure that people with lived experience, including service users and carers are involved in the design and delivery of services, and that we increase our efforts to hear from people who we know experience poorer outcomes in relation to mental health services.

7.3 Healthwatch Leeds have provided additional strategic oversight and support into this programme and have also been commissioned to undertake survey work in LCP areas to understand what matters to people in a transformed model of care and what barriers to access might exist. This insight has informed the development of grant funding priorities and criteria, workforce mapping across LCPs and also the learning needs analysis.

7.4 Regular insight reports are produced and reviewed by the programme team and workstream leads, and regular 'you said, we are doing…' reports will flow into the Programme's Involvement and Engagement Advisory Group, which acts as a critical assurance function to make sure the programme is listening to people and communities and acting on and responding to feedback and insight.

7.5 As we move from Community Mental Health Transformation as a programme, to a business-as-usual service delivery model, we need to agree how we embed this work into existing involvement and experience functions and infrastructure across the city. We are currently working closely with Healthwatch, Leeds Office of the West Yorkshire ICB and representatives of the People's Voices Partnership to plan for how we transition to a mainstreaming of involvement and engagement

work from April 2024 onwards. This is another area where we have no identified funding beyond March 2024.

7.6 We have also funded a third sector Involvement Lead, hosted in Forum Central, in recognition of the importance of having capacity to meaningfully engage with the diverse and large third sector in Leeds, and in supporting capacity building in the sector. This role has been critical to enabling us to do this work with integrity and comprehensively, which is a key learning for other transformation programmes.

7.7 A diverse range of over 100 community organisations of all sizes have fed insights into the development of the model, taken leadership roles in the process, and received regular updates on progress, through a mixture of forums and 1:1 meetings. We have received really positive feedback on the strength of partnership working and the cultural change that has been achieved through a co-design approach.

7.8 Next steps will include building on work to date in the building of a VCSE collaborative/alliance to deliver the VCSE component of Community Mental Health Transformation within a re-procured, consolidated simplified contract. This includes all contracts/roles developed through Community Mental Health Transformation and also those contained within a multitude of individual contracts and grants funding schemes held within the ICB.

8. Risks and issues

Programme resourcing

8.1 As noted previously, 19% of funding received from NHS England has been used to fund resource to support delivery of a large and complex transformation programme.

8.2 Many of the programme specific roles are fixed term until April 2024 with the intention to release that money back into front line investment. We will need to do this as we frontloaded the investment with a number of ‘recruit to train’ Advance Clinical Practitioner and psychological therapy roles, with the intent to build capacity into the workforce and ‘grow our own’ to aid retention. These posts’ full salary effects will hit during 2024/25 and we can only fund those roles by releasing spend on non-recurrent programme resource. Additionally, as we develop the older people’s offer, and as we test and scale up the model, we will need to develop the workforce to respond to any gaps in provision.

8.3 This was discussed at an extended Partnership Executive Group meeting in October 2023, where it was acknowledged that the programme remains a system priority and needs to be resourced adequately, in line with other system transformation programmes. The programme manager (Liz Hindmarsh) is developing a proposal, with input and support from the Programme Board and

members. It does need to be acknowledged, though, that there is no separate investment pot to continue to fund project management, comms and OD support, and as such resourcing will mean a collective assessment of any capacity, underspend and a prioritisation of this work. Without the right capacity and subject matter expertise in place this work will not be able to deliver and it also risks burn out for the very limited programme resource which will continue to be in place.

Achieving integrated service delivery models

8.4 As previously noted in section 6, challenges continue in developing the required frameworks which enable delivery of an integrated service delivery model which takes into account existing separate contracts, governance structures and in a way which is legally compliant in terms of data sharing. This work will continue and will inform learning for other integration priorities and programmes of work across the city.

Systems interoperability

8.5 Challenges persist relating to how we can join up clinical information and IT systems to really allow joined up care in practice. In practical terms, for this work, what we need is a system which allows us to: share (as required and proportionate) people's care plans and safety plans with the service users? and with the key people and agencies who are working with them; have digital solutions that enable people to hold their own care plans and safety plans and be owned by them; stop some workers having to input data onto multiple clinical systems which is inefficient and could free up time for people to care.

8.6 We have been working with Leeds Integrated Digital Service to help lead and identify solutions. We will not be able to fund this support beyond April 2024. We are attempting to mitigate against this by exploring what opportunities there are to jointly work with programmes like Home First on some joint enabling solutions. We are scoping this currently. There may continue to be some gaps where the solutions and work required are mental health specific and where lack of funding will therefore be problematic.

Estates

8.7 As there is an expansion of the workforce and the bringing together of integrated multidisciplinary multiagency teams there will be an impact on estates requirements, both for direct clinical activity and space big enough for teams to come together, build relationships and work together.

8.8 Finding sufficiently large space to bring teams together is challenging. For the three early implementer LCPs, Work has been undertaken to identify space for teams to come together and 'Hot Desk' At present this is within LYPFT Estates (Soley due to having available non -chargeable space).

8.9 In the next phase of work, we need to set up an estates workstream and a lead needs to be identified for this (which will be supported by the programme's mobilisation lead project manager and project support officer). This work will need to include further scoping of estates requirements, taking into account digital delivery solutions, as well as what estate exists in non-NHS community settings. We plan to report into the city-wide Estates Board. We have no identified budget for estates so our assumption is that this will need to be accommodate within existing available estate and/or any available capital budgets.

9. Next steps

9.1 Development of the partnership agreement and resolution of identified data controller to enable full mobilisation of the integrated community hub model are the critical next steps. Current anticipated timescales are that we are working towards having agreements in place by end of February 2024, ready to start testing the intended operating model in early implementer areas from March 2024. In the interim, we will continue with 'readiness' work and further collaboration including continuation of joint triage function, bringing teams together to build relationships and support a joined up model of care built around PCN and LCP populations.

9.2 Readiness and engagement work with 'wave 2' and 'wave 3' LCPs, including engagement meetings, Healthwatch survey work and expansion of the Community Wellbeing Connector roles across the city.

9.3 Ongoing model design for those elements of the NHS England Roadmap which continue to be gaps. Priorities include: eating disorder pathway; complex psychosis pathway; perinatal; older people and transition from children and young people's services into working age adult services (including embedding the recommendations of the previous improvement relational coordination work). All this work is resource intensive, requiring freeing up of clinical and operational leadership and input as well as project resource to support. This is difficult to progress within the current programme resource, and so this will be included in the resourcing case being developed in follow up to the extended PEG meeting in October.

9.4 Priority to clarify how resourcing will be continued beyond the official ‘end’ of the programme in April 2024.

10. Recommendations

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

a) **NOTE** and **CONSIDER** the report.
b) **ADVISE** on any further mitigations relating to risks and issues, not presented in this report.
c) **SUPPORT** with engagement and resourcing of this important and complex transformation programme.

11. Appendices

Appendix 1 – NHS England (2023) *Roadmap for Community Mental Health Transformation* (attached via the paperclip function due to large file size)

Appendix 2 - Proposed performance and quality metrics and indicators

Appendix 3 – Overview of Transforming Community Mental Health Grants

Appendix 4 - Summary of investment to date

Transformation metrics

Measure name	Measure description	Type of metric
Decrease the number of people visiting Primary Care for 10 + visits in a year for those on SMI Reg	Aim is decrease the number of people of the SMI population attending Practices more than 10 time in a year. Generally this could be a sign of people not accessing the services they require.	Local
Decrease the number of people on SMI Register with 0 visits in Primary Care	People on SMI register should be having yearly Physical health checks (1-6), unless in remission or on Secondary MH caseload. This is a sign of lack of engagement.	Local
Decrease the average number of Emergency Department visits for those on SMI Reg	We should stabilise more people so that we see a decrease in unplanned care	Local
Decrease the number of on SMI Reg attending A&E 3 or more times in a year	Attending 3 or more times at A&E in one year would imply more chaotic life styles.	Local
Number of referrals to MH Hubs	The number of referrals and unique people presenting at the "Hub" by any means - as a sign of demand.	Local
Increase the number of people seen in all community MH services - transformed and non-transformed	Based on NHS E detailed measure of what services are in scope for Transformation.	NHS E/ICB
Increase the number of people seen in all community MH services - in transformed services	Based on NHS E detailed measure of what services are in scope for Transformation. These will be the those service team types that are in the NHS Assurance Target query.	NHS E
Number of those referrals assessed	The number of referrals and unique people assessed by agreed contact method (presumably F2F, T, V). This would largely be those people with their helpful conversation at the start.	Local
Number of those referrals added to caseload	The number of referrals and unique people assessed and then taken on caseload - defined as open referrals and 2 happened contacts	Local
Number of people on caseload	Point in time reporting for caseload size	Local
Waiting Times - Referral and 2 community contacts - within 28 days	Phase 1 definition - August 2022	NHS E
Waiting Times - Referral and 2 community contacts - within 28 days - Assessment complete - PROM baseline recorded	Phase 2 definition - Q1 2023/24	NHS E
Waiting Times - Referral and of one of the following - Clinical intervention or social intervention or co-produced care plan completed - within 28 days As well as: - Assessment complete - PROM baseline recorded	Phase 3 definition	NHS E
Waiting Times - Referral and 2 community contacts - within 28 days - Assessment complete - PROM baseline recorded - due to change from mandatory to recommended - is this still valid? AND one of the following (Clinical Intervention started or Social Intervention Started or Personalised Care Plan completed)	Phase 3 definition - Q2 2023/24	NHS E
Waiting times - from referral received date where first contact is yet to take place	There are NHS E targets around this, but it would be useful to see the trend of waiting time from referral to first contact, which is likely to be helpful conversation first contact - for internal tracking	QIA/Local
Waiting Times - time from 1st contact to 2nd contact (F2F, Video, Tel?)	There are NHS E targets around this, but it would be useful to see the trend of how long it takes to the 2nd contact after the 1st contact - for internal tracking	Local
Increase number of people accessing evidence based psychological therapies	NHS E says in development what this means	NHS E
Improve the % of those on SMI Register receiving 1-6 physical health checks	National target - 60% - currently met from last 2 quarters	NHS E
Improve the % of those on SMI Register receiving 1-9 physical health checks	Local target is 30%	Local

Decrease re-referral rate to secondary MH in last 1 months and 1-3 months since discharge	Should be that we are treating people's needs better and after discharge	Local
Decrease the number of duplicate/inappropriate/incomplete referrals to MH Hubs (CMHT/PCMH)	Single front door should mean that less people get referred to PCMH, when it should be CMHT and vice versa.	Local
Increase the number of "successful" discharges from secondary care		Local
Decrease average LOS in Inpatient stays	Not sure whether to measure as could indicate good and bad to decrease LOS	Local
Decrease the % of BAME community entering MH services by either detained under MH Act or criminal justice system		Local
Increase the % of people who have been on caseload engaging with social prescribing/community services		Local
EIP - Access Standard 60%	At least 60% of people with first episode psychosis starting treatment with a NICE-recommended package of care with a specialist early intervention in psychosis (EIP) service do so within two weeks of referral	NHS E
EIP - Level 4 NICE 95%	95% of services will achieve Level 3 NICE concordance and current provision will be expanded to include care and support for all-ages (including 35+) and people experiencing At-Risk Mental State (ARMS).	NHS E
% of people discharged from Secondary MH IP care - followed up in 72 hours	National target is to achieve 80% F2F - this is about supporting people stepping down from IP care	Local
Number of SMI accessing IPS services	Number of SMI accessing IPS services	NHS E
No barriers to access	Referrals not based on a person - so removing referral criteria	NHS E - Dedicated focus - Adult ED
Early Intervention	Systems have an early intervention model (e.g. FREED) within their overall Eating Disorder model (or have plans to implement it within 2022/	NHS E - Dedicated focus - Adult ED
Medical Monitoring	Clear arrangements are in place for medical monitoring (in partnership with primary care where applicable) to manage the physical health needs of people with eating disorders (or plans to get these implemented within 2022/23)	NHS E - Dedicated focus - Adult ED
Addressing restrictive inpatient settings	Systems are implementing plans with clear milestones to reduce reliance on in patient care and to support people with complex needs in the least restrictive setting, including a focus on BAME groups and detention under the Mental Health Act	NHS E - Dedicated focus - MH Rehab
Fully linked to 'core' community mental health	Service is operating as an integrated team with 'core' CMH, primary care, VCSE and local authority services, providing accessible and timely recovery and rehabilitation interventions as well as improved advice and support to whole system to provide step down pathways out of rehab	NHS E - Dedicated focus - MH Rehab
Strong MDT approach	A strong MDT at place level is delivering meaningful, therapeutic interventions (including psychological therapies) and support including e.g. psychology, OT, social care, psychiatry, peer support, housing, MH nursing, MH pharmacy	NHS E - Dedicated focus - MH Rehab
Trauma informed	Services operating with clear trauma informed principles. Staff across all roles and levels of seniority within core, dedicated and primary care services have undertaken training (e.g. KUF or locally commissioned training) to embed trauma informed approaches.	NHS E - Dedicated focus - Adult PD
Paid lived experience	Paid lived experience roles are at varying levels of seniority within the MDT, with career pathways and supervision support for lived experience staff is in place.	NHS E - Dedicated focus - Adult PD
Monitor ethnicity split of the workforce	Workforce should reflect the general population. Monitor improvement over time.	EIA
Monitor staffing levels in the workforce	Monitor the number of in post WTE compared with the funded WTE	Local
Access for Neurodivergence and Learning Disability populations	Is the populations of these groups, defined by GP data, reflected evenly in access to transformed services?	EIA

Number of people accessing services that require an interpreter	Access to services for those requiring an interpreter	EIA
Access for people, more quickly and efficiently with less multiple assessments across all protected characteristics: § Waiting times § Access □ Referrals □ Caseload (2 + contacts) § Interventions offered and completed - so drop out rates § Clinical Outcomes (PROM's) □ DIALOGUE + □ GBO □ ReQuol	Protected characteristics: Can report these now: □ Age groups (can report yes) □ Gender □ Ethnicity Maybe - from Leeds Data Model: □ Pregnant/maternity leave We can report on where these people live as denominator - but limited data on the activity: □ Sexual orientation - ONS Census - available at LSOA □ Gender re-assignment - ONS Census - available at LSOA - Gender Identity - there is a field in MHSDS □ Religion or belief - ONS Census - available at LSOA □ Disability - ONS Census - available at LSOA and table in MHSDS (limited records) □ Relationship status - ONS Census - available at LSOA ("Legal Partnership Status") and data in MHSDS	EIA
Equitable access for communities with different levels of Deprivation	Deprivation should not be barrier to access and we should strive to have equitable access to services across the city	EIA
Monitoring acess for other groups: Rural communities Road distance to GP surgery? ONS ONS LA District level ie Leeds Asylum seekers Refugess Travellers	These are aspiration measures due to the problems identifying these cohorts.	EIA
Average number of days from referral to 1st contact/helpful conversation	Over time we aiming to have a target for the helpful conversation (5 days was previously mentioned) - so we need to track how long it takes for the first contact	QIA/Local
Number of Advice and Guidance requests		QIA/Local
Average number of days from Advice and Guidance request to given	Average number of working days from Advice and Guidance responses	QIA/Local
Number of Advice and Guidance responded to		QIA/Local
Number of Advice and Guidance responded split by psychiatry, pharmacy and psychological practitioners		QIA/Local
Decrease the number of inappropriate referrals to MH Hubs (CMHT/PCMH) that are sent back to Primary Care GP's	Single front door without criteria should mean that less people get referred from GP's and are rejected back to GP's.	QIA/Local
Number of re-referrals from 4 PCNs within the early implementer LCPs		QIA/Local
Reduction in redirected referrals	Reduction in redirected referrals - ie those referrals which are currently sent to CMHT via SPA and then redirected to PCMH)	QIA/Local
Referrals from wave 1 sites to NHS Talking Therapies	To track where people have ended up in the wrong service	QIA/Local
Number of people allocated a key worker	Each person in the hub should have a key worker allocated	QIA/Local
Number of people seeing a improvement in their clinical outcomes scores between when they started and at discharge (PROM)	This presumably looks at the first PROM score and then then at discharge to see if there is an improvement. Different PROM's have different criteria to understand whether there is an improvement or not, rather than just an improvement in the score.	QIA/Local
Number of people seeing a deterioration in their clinical outcomes scores between when they started and at discharge (PROM)	This presumably looks at the first PROM score and then then at discharge to see if there is an deterioration. Different PROM's have different criteria to understand whether there is an improvement or not, rather than just an deterioration in the score.	QIA/Local
Measure reason for discharge	Reason for discharge does indicate a form of dropping out of a service and a potential success of discharge	QIA/Local
Number of care plans initiated		QIA/Local
Number of compliments	Number of compliments received for those staff in the MH Hubs. Split by - Hub - Key worker - Moving to other services	QIA/Local

Number of complaints	Number of complaints received for those staff in the MH Hubs.	QIA/Local
Number of referrals receiving a more in depth assessment	If this is the "enhanced offer" - Caroline refers to then, it those people in CMHT or in scope specialised services. So can measure it that way.	QIA/Local
Referral to other services	Where referrals are "moved on" from the MH Hub. This could be to Talking Therapies, specialised services like ED, PD.	EIA
Number of Incidents	Number of Incidents in the MH Hubs.	Local
Number of people reporting a positive experience in a Patient Reported Experience Measure (PREM)		Local
Number of people reporting a negative experience in a Patient Reported Experience Measure (PREM)		Local
Waiting times - from referral received date to first contact (helpful conversation)	Time taken on average from referral to helpful conversation - telephone, but any other happened contact will count	QIA/Local
Referrals from PCMH/CMHT into NHS Talking Therapies		
Number of helpful conversations	This is the first contact for people referred to the Hubs which will be delivered in contacts called Helpful Conversations as per model design.	Local
Redirected referrals - ie those referrals which are currently sent to CMHT and then redirected to PCMH		Local
NHS Talking Therapies referrals to PCMH		Local
Workforce vacancy percentage rate		Local
Workforce retention percentage rate		Local
Talking Therapies - Access - PCMH Contribution	This is the Talking Therapies Access target, but the measure only covers the PCMH contribution to the Access Target, not the overall number.	ICB
Onward referrals from all community MH services to different services	Referrals to non-All Community Services in NHS E scope services	Local
Referrals in Wait time from referral to 1st F2F contact (Average number of days)	CMHT WAA measure	Local
Number of IG Incidents	Number of IG Incidents received for those staff in the MH Hubs.	Local
Talking Therapies - Recovery rate		ICB
Talking Therapies - Full access		ICB

Appendix 3 – Overview of Transforming Community Mental Health Grants

Grants awarded to date:

LCP	Grantholder	Scheme/project
HATCH	Black Health Initiative	Dr Delroy Hall, an experienced Mental Health Lead has been reruited to mitigate inequalities within the black community, with a focus on faith and religion, through their culturally informed counselling service based in Chapeltown. There have been delays in mobilising this due to the death of the CEO (which we report with great sadness).
HATCH	Shore up CIC	Will be running two occupational therapy groups in North Leeds. The12 week programme supports individuals to better understand the link between how they spend their time and how they feel. All individuals will develop an individual plan, focussed on what's important to them to try and change and have the opportunity to putit into action before coming back together as a group to reflect on the process.
HATCH	Mafwa Theatre	Will run weekly creative women's workshops for refugees and asylum seekers who face struggles with mental health issues, deprivation and social isolation from Lincoln Green.Workshops will run from September, and referrals are going through the HATCH Local Care Partnership
Leeds Student Medical Practice and the Light	Leeds Mindfulness Cooperative	Will deliver three eight - week mindfulness for stress courses for students, one of which they have already run. Courses will welcome students who are neurodiverse, and one will be specifically for LGBTQ+ students.
Leeds Student Medical Practice and the Light	Oblong	Will offer space and support for people with acute needs in Woodhouse, providing a drop - in service for advice, guidance and signposting with issues that are impacting negatively on mental health. They have considerable demand within the community, which

		they are focusing their energies on first, before taking referrals more widely.
West Leeds	Hollybush Conservation Centre	Provide a supportive bridge to a wide range of outdoor opportunities provided by TCV and by other local organisations in the West Leeds LCP. They offer one on one support to help people engage with an activity best suited to their personal needs. Hollybush runs around 30 sessions a week, including specialist mental health groups, but also several activities that appeal to a wide range of audiences, from gardening courses to practical conservation workdays, from Green Gym health groups to Whittling sessions and Wildlife Walks, Woodworking to Nature Crafts. If none of the opportunities at Hollybush match the requirements of an individual, they can also use this one-on-one support to help those accessing the new hubs through Hollybush to explore other opportunities within the Leeds Green Activity Providers Network, of which they are a founding member.
West Leeds	Humans Being	Will deliver their Hands, Heads and Hearts (HHH) programme, **a seven week course for women with complex mental health needs run in West Leeds** that brings participants an exciting **mix of spoken and practical tools.** The course will support them to break out of social isolation and explore their own mental wellbeing through the lens of gender, while also enjoying creating their own art and craft pieces to take home.
Across all three LCPs	Trust Leeds	Introducing Self-Reliant Groups as a new tool to transform mental health care for the benefit of people with complex mental health needs, their carers, and those who support them.

Evaluation:
To evaluate the Transforming Mental Health Grants, we are using a combination of qualitative and quantitative methods to capture learning and outcomes.

All Leeds Community Foundation Grants involve completing an End of Grant Report, which asks questions about what grantholders were able to achieve, what they have learned and how they have adapted, the outcomes for the people they supported and how their organisation may have been impacted by the funding. The Transforming Mental Health Grants use the outcomes Leeds Community Foundation use for all of their grants, which focus on areas like increased community cohesion, improved wellbeing and social networks, and increased participation, skills and aspirations. These are attached for information. Each grantholder is asked to pick one core outcome to evidence, and a maximum of four - the outcomes most key to this piece of work have been identified and communicated to all grantholders.

Rather than interim reporting, we wanted to focus on relational learning and qualitative insights. Forum Central are providing strategic support throughout the year, with an open offer for regular check-ins to support progress, give a space for grantholders to raise risks and issues, support integration with wider services and act as a critical friend. Grantholders can choose the frequency of these meetings, and the majority have chosen to meet fortnightly while mobilising, and monthly thereafter. Notes from these meetings will feed into the evaluation of the projects, providing another layer of insight. Forum Central are also running three learning events across the year, where grantholders get together for peer support and to do shared pieces of learning.

When designing the grant-making process, the Leeds Community Foundation outcomes were mapped to the evaluation framework for Community Mental Health Transformation as a whole, and any gaps LCF's framework didn't cover were identified and addressed through the content of check-ins, learning events and an additional survey which will go out towards the end of the grant around staff wellbeing.

Forum Central and Leeds Community Foundation will also meet quarterly with the ICB to provide an overview of the grantholders progress, map capacity and raise issues and risks.

OUTCOMES AND INDICATORS

Used in Leeds Community Foundation and GiveBradford interim and end of grant reporting forms

Outcomes	Indicators
Improved community cohesion	Number of people reporting an increased awareness and understanding of other cultures Number of people reporting that they feel able to have a say in the decisions that affect them Number of people reporting that they feel an increased sense of belonging in their community
Improved economic wellbeing	Number of people reporting a reduction in debt Number of people reporting improved access to food Number of people reporting increased income levels as a result of advice/support provided Number of people reporting increased understanding of money management Number of people reporting that they have an increased ability to heat their home and stay warm Number of people who became self-employed or gained employment
Improved mental health and wellbeing	Number of people reporting improved mental health or wellbeing Number of people reporting increased self-esteem and confidence Number of people reporting that they have improved self care and self-management
Improved natural environment	Area (hectares) of natural space maintained or improved Area (hectares) of natural space restored or created Number of people reporting appreciating nature and the environment more Number of people reporting increased awareness, understanding and support for conservation
Improved physical health and wellbeing	Number of people participating in sport, exercise and leisure activities Number of people reporting improved physical health or wellbeing Number of people reporting improvements in their diet to be more healthy and balanced Number of people reporting that they are more physically active
Increased participation in arts, culture and heritage	Number of people who attended arts and cultural events in the previous 12 months Number of people who visited an arts, cultural or heritage facility for the first time
Increased skills and aspirations	Number of people reporting an increase in personal aspirations and goals Number of people reporting increased interpersonal (social, communication and relationship) skills Number of people reporting increased literacy and/or numeracy skills Number of people reporting increased practical skills
Reduced levels of loneliness for individual people	Number of people reporting improved social networks Number of people reporting that they feel less lonely
Reduced offending/anti-social behaviour	Number of people reporting that they are less likely to commit anti-social behaviour Number of people reporting that they feel safer in their communities

Appendix 4 – Summary of investment to date

Investment	Investment to and value	Recurrent/Non recurrent	Purpose
Programme delivery resource			
Role/scheme	**Investment to and total**	**Recurrent/non-recurrent**	**Purpose**
1.0 Programme Manager	LYPFT (part of £2,684k committed spend)	Recurrent	Overall programme management
1.0 Involvement Lead, admin support and associated on costs (including service user payments and support offers)	Leeds Involving People £119k	Fixed term until 31.03.24	Lead on involvement and engagement of people with lived experience, including carers.
4.0 Involvement workers	Carers Leeds Gipsil Health for All The Big Life Group) £261k	Fixed term until Jan-March 2025	Dedicated expertise and capacity to work with communities and groups who have experienced the poorest outcomes/whose voices are not always heard.
1.0 Third Sector Involvement Lead	Forum Central £61k	Fixed term until 31.03.24 *we are trying to identify funding to continue this post to support ongoing work around development of an alliance contract*	Leads on development and running of community grants funding programme, involvement and engagement of large and diverse third sector in the work and capacity building in the sector, working towards the development of an integrated outcomes-based specification.
Clinical leadership backfill (0.3 Clinical Lead and 0.2 Psychiatry)	LYPFT (part of £2,684k committed spend)	Fixed term – TBC as depends on scale up (allocated	Dedicated clinical time to lead development and embedding of an evidence based clinical model, including engagement of

		through block contract)	colleagues across professional groups/disciplines. Leading on the embedding of mandated changes relating to moving away from the 'Care Programme Approach' in secondary care (including embedding of personalised care planning and clinical outcome measures).
0.5 Comms Lead	LYPFT (part of £2,684k committed spend)	Fixed term until July 2024	Leads on comms and engagement for all stakeholders
1.0 Mobilisation Lead	LYPFT (part of £2,684k committed spend)	Fixed term until July 2024 *(need to identify funding source for continuation)*	Dedicated project maanger to lead on mobilisation of new integrated community mental health hubs
1.0 Senior Analyst	Leeds Office of West Yorkshire ICB	Fixed term until January 2024 – under discussion to continue	Dedicated analyst to provide analysis and insight to inform a population health based approach to modelling of care delivery and resource allocation. Leads on development of strategic dashboard reporting and dedicated expertise to lead on evaluation activities.
0.6 Workforce Lead	LYPFT (part of £2,684k committed spend)	Fixed term – until February 2024. *Postholder left October 2023; replaced with b7 role – see below.*	Leads on all things workforce, including management of change, workforce planning, learning and development and culture
1.0 Strategic Resourcing,	LYPFT (part of £2,684k committed spend)	Fixed term – until September	Lead on recruitment activities. Skills mixed to take on a greater

Retention & Project Officer		2025 (*converted into a b7 workforce lead in response to resignation of workforce lead above).*	portfolio of work as per above with support from HR Business Partner colleagues within LYPFT.
Organisational Development	LYPFT (part of £2,684k committed spend)	Fixed term until April 2024*; trying to identify funding source to continue some OD support.*	Providing OD interventions and support, including team coaching, support with MDT working and relationship building; support in co-creating team based cultures, values to enable integrated working and support new ways of working.
Evaluation (Leeds contribution to West Yorkshire evaluation)	Niche Consulting Ltd £55k	Non recurrent until end of evaluation in 2025. Leeds funds a proportion along with other West Yorkshire places.	Evaluation of impacts of CMH Transformation including cost benefit analysis. Qualitative and quantitative methods. Formative reports are provided throughout the evaluation.
1.0 Digital Project Lead and 1.0 Solutions Architect	Leeds Integrated Digital Service (Leeds City Council) Upper limit of £136k (bill on actuals for time worked).	Fixed term until April 2024 *we need continued expertise but don't have sufficient available funding so we need some commitment from within the system to continue to support this work.*	Lead on the scoping, specification and development and implementation of solutions relating to digital, information and information sharing requirements and improvements across all areas of the work. This will include challenges around systems interoperability – such as how do we share care records across an integrated system in a way that is person

			centred and legally compliant with IG requirements.
Testing new community based schemes – Transforming Community Mental Health grants			
Grant funding	To Leeds Community Foundation and Forum Central (grants plus running, management, evaluation costs included) Total = £750k including £500k of two rounds of grant funding (and c £250k running and evaluation costs).	Grants are non-recurrent but we will need to model for sustainable/mainstream of funding of those schemes which evaluate well *as a starting position, we have nominally modelled for 50% mainstreaming with funding set aside for this*	Supporting ongoing recovery in people's own communities and addressing barriers to access and known health inequalities through testing delivery of 'grassroots' schemes aimed at supporting people with SMI and complex needs.
Workforce expansion/developing new offers			
Role/scheme	**Investment to and total**	**Recurrent/non-recurrent**	**Purpose**
1.0 Strategic Psychology post (Consultant Clinical Psychologist)	LYPFT (part of £2,684k committed spend)	Recurrent	City wide strategic psychology lead post to lead development of psychological therapy strategy and offers addressing gaps between primary and secondary care and gaps particularly around complex trauma. Focus on increasing access to evidence-based psychological therapies as per NHS E requirements.
1.0 Assistant Psychologist (Group work support)			Increasing access to psychological therapies through increased group work offer (part of primary care therapies team)

5.0 Advance Care Practitioners			New role. Responding to gaps in particular professional groups and providing increased clinical leadership and expertise. Will work with PCN colleagues to provide expertise to support patients with mental health needs. 2-year training post – year 1 is largely training focused with some clinical delivery in PCN; year 2 focus is on strengthening mental health pathways.
5.0 Mental Wellbeing Practitioners			This new role is designed to support collaborative care planning, alongside other members of the multi-disciplinary team. They will also deliver a set of brief wellbeing-focused psychologically informed interventions and will be a major part of the pipeline for the growth of psychological therapists within services.
1.0 b8A Psychologist			Part of new primary care therapies team. Increasing access to psychological therapies.
3.0 b7 Psychologists			Part of new primary care therapies team. Increasing access to psychological therapies.
2.0 Assistant Clinical Psychologists			Works as part of a psychological therapy team and supervision and training structure.

			Purpose is to increase access to psychological therapies, as per NHS E requirements. Additional capacity to provide group work.
9.0 recruit to train psychological therapy posts			Increasing access to psychological therapies. Training posts with the aim of boosting retention through 'growing our own'. Roles will work across a number of particular modalities and cohorts of need, boosting capacity to increase access to psychological therapies.
1.0 Specialist pharmacist			Additional resource to existing pharmacy team. Support patients with complex MH medication needs within the newly transformed community mental health services. This role will facilitate improved access to specialist mental health medication input across the primary and secondary care interface.
1.0 Senior Mental Health Recovery Practitioner Role (OT) and development lead for complex psychosis pathway	LYPFT (part of £2,684k committed spend)	Recurrent	Lead development of complex psychosis pathway and lead, including leading a team of recovery practitioners who will provide support to people with complex psychosis, aimed at preventing worsening of symptoms/condition through early intervention and joined

			up working, and providing a bridge across the integrated hub team and community based rehab and recovery services.
10.0 Community Wellbeing Connectors	6.0 currently funded through: Barca (2.0) Northpoint (2.0) Touchstone (2.0) Funding already committed for expansion to 10.0 during Q4 23/24 (due to start in post December 2023 and January 2024).	Recurrent funding source All VCSE contracts being reviewed in Q4 23/24 with the intention to develop a single outcomes based specification. This will include reviewing existing offers to identify any potential overlaps/duplications.	These roles work with people to help them access a range of different types of support in communities, including attending appointments and accessing other services as needed. This can include attending physical health checks, increasing confidence to engage with services as well as providing support to aid ongoing recovery. Referrals are via Primary Care Mental Health or Community Mental Health Teams.
Community Support Team – 2.0 workers	Part of total figure above Touchstone	Recurrent – this was to meet a funding gap. Will be part of the work above to develop a single outcomes based specification.	Intensive mental health support service using an assertive outreach approach. CST works with service users who have complex mental health needs and uses a strengths-based recovery approach with a focus on the individual and their strengths and interests. The aim of CST support is to enable service users to manage their own well-being and recovery and move towards

			greater social integration.
Peer Support • Team leader 0.27 • Senior peer support workers 1.62 • Peer support 4.82 • Admin 0.2	Lead provider through Leeds Mind)	Recurrent Will be part of the work above to develop a single outcomes based specification.	Providing emotional and relational support to people, including 1:1 and group work peer support. Work city wide to take referrals, and some workers have particular areas of specialism to work with particular communities. Will also link to particular integrated hubs as part of multidisciplinary team.
Recovery practitioner roles (“complex psychosis pathway) (procurement process underway) • 3.0 WTE recovery practitioner roles • 1.0 WTE senior recover practitioner role	Provider TBC – subcontracted through LYPFT and part of the LYPFT £2,264k committed spend)	Recurrent	Will work with the integrated hub team to support people with complex psychosis to have a more preventative offer of care and support, and to provide a more seamless pathway between the community hub model and rehab and recovery services.

Meeting name:	Leeds Committee of the West Yorkshire Integrated Care Board
Agenda item no.	LC 59/23
Meeting date:	13 December 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:	Harriet Speight, Corporate Governance 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 October 2023 (email)

Quality and People's Experience Sub-Committee – 15 November 2023

Delivery Sub-Committee – 22 November 2023

Finance and Best Value Sub-Committee – 29 November 2023

Executive summary and points for discussion:

This paper presents the ICB in Leeds High-Scoring Risk Report (risks scoring 15+) at the end of risk cycle 4. All risks have been reviewed by the Risk Owner, the allocated Senior Manager and by the EMT of the ICB in Leeds.

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

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

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

☒ Improve healthcare outcomes for residents in their system

☒ Tackle inequalities in access, experience and outcomes

☒ Enhance productivity and value for money

☒ Support broader social and economic development

Recommendation(s)

The Leeds Committee of the WY ICB is asked to **RECEIVE** and **NOTE** the High-Scoring Risk Report (scoring 15+) as a true reflection of the ICB's risk position in Leeds, following any recommendations from the relevant committees.

The Leeds Committee is also asked to **CONSIDER** whether it is assured in respect of the effective management of the risks aligned to the Committee and the controls and assurances in place.
Does the report provide assurance or mitigate any of the strategic threats or significant risks on the Corporate Risk Register or Board Assurance Framework? If yes, please detail which:
This report provides details of all high-scoring risks and risks aligned to the Leeds Committee on the Risk Register. The Risk Register supports and underpins the ICB Board Assurance Framework and relevant links are drawn between risks on each.
Appendices
Appendix 1: Risk Register extract (High Scoring risks and risks aligned to the Leeds Committee) Appendix 2: West Yorkshire ICB Risk Report Extract (Common Risks) submitted to the WYICB 21 November 2023 Appendix 3: Leeds Health and Care Partnership Partner Top Risks Appendix 4: Risk on a Page Report
Acronyms and Abbreviations explained
1. ICB – Integrated Care Board

What are the implications for?

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

1 Introduction

1.1 The report sets out the process for review of the Leeds Place risks at the end of risk cycle 4 which commenced on 20 September 2023 and ended after the West Yorkshire ICB Board meeting on 21 November 2023.

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

2 Leeds Place Risk Register

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

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

This report includes the high-scoring ICB in Leeds Place risks and 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. Please see pages 113 to 119 of the West Yorkshire ICB Risk Report 21 November 2023 for the Corporate Risk Register. An extract of this report is attached at Appendix 2 to provide visibility of 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 Finance, Investment & Performance Committee – 31 October 2023 (AM)
- West Yorkshire ICB Quality Committee – 31 October 2023 (PM)

- West Yorkshire Integrated Care Board – 21 November 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).

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

2.6 Partners are also consulted when populating and managing the Population and Care Board risk registers.

2.7 There are currently 21 risks on the Leeds Place Risk Register, with three risks that have been marked for closure since the last reporting cycle, leaving a total of 18 open risks.

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

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

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

Risk cycle 4 of 2023/24 was reported at the sub-committee meetings as follows:

a) All aligned quality risks were reviewed by the Quality and People's Experience Sub-Committee on 15 November 2023.

b) All aligned delivery risks were reviewed by the Delivery Sub-Committee on 22 November 2023

c) All aligned finance risks were reviewed by the Finance and Best Value Sub-Committee on 29 November 2023.

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

3 High Scoring Risks

3.1 The last report to the Leeds Committee of the WY ICB provided an update on the risk position during risk cycle 3 (2023/24). The following changes have taken place during 2023/24 risk cycle 4:

Risk	Cycle 2	Cycle 3	Cycle 4	Movement since previous risk cycles
2014 – Leeds System Financial Position	20	20	20	Static Risk – The financial plans for 2023-24 for the ICB in Leeds reflect a significant deficit position of C £25m with a similar gap reported at LTHT. 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.
2158 – Prescribing Costs	12	12	16	Risk Increasing – Rolling 12-month cost growth to the prescribing budget is continuing to increase. This is due to a wide range of factors but is predominately being driven by price inflation in addition to anticipated impacts of new high-cost drugs and continued high levels of price concessions. Leeds place remains in the best 20% performing places in the

Risk	Cycle 2	Cycle 3	Cycle 4	Movement since previous risk cycles
				country with YTD cost growth of 10.47% compared to the England average of 12.13% and the WY ICB average of 11.14% which shows this is a national issue and Leeds is not an outlier. However, the most likely forecasting scenario is now predicting an overspend of £4.7m Cost saving activities are continuing as much as possible but cost savings are not managing to keep up with this level of cost growth. In the next risk cycle, this will become a corporate risk for the whole of West Yorkshire, at which point the risk will be removed from the Leeds place risk register and managed as a Corporate risk and reported to the WY ICB.
2019 – Risk of Harm – System Flow	20	16	16	Static Risk - 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 2 have been made by process changes. However, 12-hour waits are still significantly higher than average.
2018 – Risk of Harm - Mental Health Access	16	16	16	Static Risk - The score remains unchanged. Rationale for this is significant pressures persist within the Mental Health system, evident in increasing numbers of out of area acute MH placements, and a deteriorating position with numbers of delayed transfers of care. Progress with the mobilisation of the community mental health transformation new model of care has also been slightly delayed until November.
2017 – Risk of Harm – Long Term Conditions / Frailty / Mental Health Conditions	15	15	N/A	Risk Closed – The LTC Population Board has agreed that the risk is certain and therefore this risk has been changed to an issue. The Board will continue to monitor. The Board's work programme has a number of mitigations which are being progressed and will continue to be monitored.

Risk	Cycle 2	Cycle 3	Cycle 4	Movement since previous risk cycles
2301 – Children and Young People Neurodiversity Waiting Times	15	15	15	Static Risk – The score remains static however it has been requested that the risk be reviewed in relation to the data flow and transformation funding recently agreed in principle.
2354 – Adults Neurodiversity Waiting Times	N/A	15	15	Static Risk – No further updates as the risk was added during the previous risk cycle.

3.2 Of these risks, 6 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.

3.3 During the reporting cycle to EMT, it was highlighted that a high number of risks had remained static for two or more cycles. These were reviewed and rationale provided for why these risks remain static during this cycle. The high number of static risks across West Yorkshire was also queried by WY Audit Committee, which has asked the Risk Management Operational Group to focus on static risks during the next risk cycle (cycle 5 2023/24), and to provide clear rationale for those risks that have remained static for several cycles. Target risk scores will also be reported on in future iterations of the risk report.

4 Risks Aligned to the Leeds Committee

There are four risks aligned directly to the Leeds Committee, which comprise 19% of total risks currently on the ICB Risk Register. Of these risks:

a) One risk is scored at 12;
b) and there are no other open risks scoring 12 or above.

Risk Number and Risk Title	Cycle 2	Cycle 3	Cycle 4	Movement since previous risk cycles
2024 – Deprivation of liberty legislation	12	12	12	Static Risk - A paper is being planned to consider commissioning advocacy to ensure continued availability to patients when it is required. The lack of financial resources has been acknowledged and a small increase to the legal budget has been approved for 24/25. Teams are also looking at how to work more closely with Bradford and Craven to administer these in a different and more effective way.

5 Next Steps

Subsequent to the Leeds Committee meeting, the risks will be carried forward to the next risk review cycle which commenced after the WY ICB Board meeting on 21 November 2023.

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

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

Appendices

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

Appendix 2: West Yorkshire ICB Risk Report Extract 21 November 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), November 2023

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+)															
2014	29/06/2022	Finance and Best Value Committee	20	(I4xL5)	6	(I4xL5)	Matthew Turner	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. A more stringent spend control process for all discretionary spend over £50k to be introduced from August 2023 for EMT to control in the same way as for ECFs (Vacancy Controls)	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 in previous years albeit only non-recurrently. This will not be the case in 23-24. We are starting the financial year with a £30 -£35m underlying deficit posted which is disproportionately the largest across the ICB. We have however made progress to achieve virtually all of our planned QIPP of £16m in 23-24 but have faced unexpected new cost pressures in the region of £14m relating to the Transferring Care Partnerships programme that commenced in 2016 with a large and highly complex cohort of cases transferring over the past 18 months from NHSE to locally funded care and prescribing costs and activity undertaken by the Independent Sector to cut elective waiting lists exceeding planned levels.	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 underachieved year on year on its recurrent target QIPP programme for the past several years. 2022-23 had the largest annual QIPP target of £18m of which a significant proportion relied on pathway changes that have not yet 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. The NHSE financial control regime was implemented in August 2023 across WY ICS where virtually all discretionay spend must now be reviewed weekly by EMT.	Static - 3 cycles
2158	13/10/2022	Finance and Best Value Committee	16	(I4xL4)	9	(I4xL4)	David Wardman	Gaynor Connor	There is a risk of increased prescribing costs due to inflation and supply disruption resulting in financial strain on the primary care prescribing budget.	Review prescribing budget and review all concession drugs and price changes on a monthly basis. If any actions can be undertaken to reduce the financial risk these are implemented. Messages are being shared with prescribers, pharmacies and patients to support cost-effective alternatives where possible. A prescribing QIPP plan is being implemented to offset prescribing growth We are working with primary care to improve the quality and number of structured medications reviews that can rationalise prescribing and improve cost effectiveness. We are implementing national recommendation on overprescribing to reduce unwarranted polypharmacy.	QIPP plans will take time to implement and may be offset with future price changes. Data on prescribing is released 3 months in arrears creating a lag in time to respond to any fluctuations in spend.	Review prescribing budget and review all concession drugs and price changes on a monthly basis with oversight from the Commissiong of Medicines Group. Any risks flagged with finance team as a cost pressure. QIPP plan implementation to be monitored weekly.	Monthly prescribing data	Data on prescribing is released 3 months in arrears	Increasing
2019	30/06/2022	Both Delivery and Quality and People's Experience	16	(I4xL4)	12	(I4xL4)	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.	strong surge plan in place as necessary (within LTHT) 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 Improvements have been seen over June & July and the current LTHT occupancy is 93% and 2 wards have been closed	Key controls in place responding to high levels of demand. Current controls are still not sufficient to reduce the risks when there is exceptionally high demand on the system or where outflow is constrained through Industrial Action or other absence While occupancy has improved, this isn't always correlated with a reduction in people spending a long time in ED - this needs further analysis.	Health & Social Care Command & Control Groups: System Resilience Operational Group (Bronze), System Coordination Group (Silver) and System Resilience and Reset Assurance Board (Gold) Integrated Commissioning Executive Partnership Executive Group Quality and Performance Committee New System Visibility Dashboard is in place to support assurance and decision making.	Weekly meeting in place for services to report on capacity /demand Reviewed Silver Action cards System Visibility dashboard in place and driving change Strong programme of Home First work in place Short Term Assessment pathway developed in the interim for winter to support the city's Home First ambition, while the Active Recovery service eligibility criteria is expanded. Improvements in the waiting times for pathway 3 have been made by process changes Current Occupancy in LTHT is 93% and we have seen a reduction in the 12h breaches over July.	OPEL reporting system under development for ASC but not yet finalised or shared. Recruitment and retention remain significantly challenging and limit the ability to create additional capacity, particularly in the Reablement service. (Mitigating over winter with Short Term Assessment Service). Still too many people over 6 and over 12 hours in ED which we know is linked to risk of harm.	Static - 1 cycle
2018	29/06/2022	Both Delivery and Quality and People's Experience	16	(I4xL4)	12	(I4xL4)	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 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	Review of MH crisis pathways to optimise value of investment- planned workshop with MH Population Board has been delayed until October 2023. Full Mobilisation of new model of integrated community mental health initially within 3 early implementer local care partnership/PCN sites. Mobilisation delayed until November 2023 in order to more robustly clarify clinical governance and refine partnership agreements.	Waiting and access times to services monitored through performance metrics, Healthy Leeds Plan, and Mental Health Board Outcomes Framework.	LYPFT MADE event took place on 2nd June - steering group established to oversee development and delivery of action plans informed by this Oasis evaluation completed, plans in development for rapid improvement work to further strengthen an integrated delivery model with LYPFT crisis services to maximise effectiveness and positive outcomes evidenced through evaluation Community Mental Health Transformation-mobilisation/phased roll out of the new model of care within integrated community mental health hubs progressing- delay of 8 weeks- phase one within early implementer Local Care Partnerships to now go-live November 2023. Access to Early Intervention in psychosis services in Leeds maintains performance above access target. 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 significant, with LYPFT reporting sustained OPEL 3E,-35 Acute Mental Health out of area placements as of 28.09.23: 30 adult acute, 4 PICU. Delayed transfers of care impacting acute MH capacity has deteriorated since last cycle - 21% DTOC for Adult MH acute reported by LYPFT as of 28.09.23. NHS talking therapies: average step 3/CBT waiting times remain at 14 months. IAPT: 2.4k people on the waiting list and average step 3 /CBT waiting times at 14 months	Static - 3 cycles

2354	14/08/2023	Both Delivery and Quality and People's Experience	15 (I3xL5)	9 (I3xL5)	Philip Chan	Helen Lewis	There is a risk of unsustainable Neurodevelopmental assessment and treatment pathways (autism and ADHD) due to demand for services surpassing the capacity resulting in unmet need of patients, long waiting list and increased right to choose requests which will cause impact to patient outcomes and significant financial impact.	Established ND programme steering group to provide oversight of service development and transformation projects. Reporting to place Learning disability and ND population board Leeds Autism Diagnostic Service and Leeds ADHD service pathway service development Number of improvement pilots in development- supported through non-recurrent funding - ADHD primary care prescribing pathway pilot - Pre-diagnostic support - LYPFT Diagnostic Service Process improvement pilots, annual reviews, testing app for proactive information gathering from service users to improve capacity.	Lack of access to targeted funding to support service development and transformation projects. No explicit ADHD Strategy Gap in accessibility to information, resources and and personalised pre-diagnostic needs-led support through VCSE/social prescribing for Adults with ADHD	Autism and ADHD diagnostic waiting list times ADHD treatment waiting list times ADHD annual review waiting list times. ND service annual quality report. Oversight of Right to Choose ND diagnostic pathway referrals and spend Neurodiversity priorities agreed though Learning Disability and Neurodiversity Population Board Leeds Autism Strategy	Bi annual Population board report July 2023 Service annual quality board Draft pre valued proposition ND programme plan outlining key workstreams and work progressing	- Clear project and reporting structure for tracking progress against pilot/improvement in development through Adult ND steering group in development - Lack of targeted/identified recurrent funding streams provide ongoing challenge for sustainable improvement through non-recurrent mechanisms.	Static - 1 cycle
2301	16/05/2023	Both Delivery and Quality and People's Experience	15 (I3xL5)	6 (I3xL5)	Emily Carr	Helen Lewis	There is a risk of CYP being unable to access a timely diagnostic service for neurodevelopmental conditions (Autism and ADHD) due to rising demand for assessments and capacity of service to deliver this (ICAN for under 5, CAMHS for school age). Delays in access to timely diagnosis may impact upon children's outcomes, access to other support services across health, education and social care, and also compliance with NICE standards for assessment within 3 months from referral.	Development of "ND - thinking differently case" presented to PEG in March and outlining the need to think about a needs based approach to providing support to CYP who are neurodivergent Priority workstream for year 1 within SEND Inclusion plan Development of pre assessment support (MindMate ND hub, pilot delivering ND support with a cluster for 23/24) Links made to West Yorkshire ND programme of work particularly looking at how we as a WY ICB address the rising demand around the right to choose agenda and ensure a consistent method of delivery across the ICB. ND citywide development workshop undertaken on 19th July. Representatives from across health came together (including Education and parent/carer representation) to understand the current position and challenges facing us both locally, regionally and nationally. Forwards plan for working groups following this and a further education focussed time out in October. Links made to the West Yorkshire programme of work particularly in relation to responding to the ND choice financial pressure. Funding has moved to LCH to outsource assessments for our most vulnerable cohorts. Outsourcing to commence in September. Sam Prince and Stephanie Lawrence identified as SROs from LCH. ICB looking at local options to deliver 'Choice'	Development of ND governance under development to include working group to develop and set out strategy for plans over next year A similar ND citywide workshop (as detailed above) will be held in September with Education colleagues. No provider has yet been sourced to use the funding that has been identified to support outsourcing alongside LCH to provide assessments to identified vulnerable cohorts currenting awaiting assessment. A shared communication is being developed alongside LCH colleagues to share with all across the system (including general public). Continued shortfall in capacity for about 2600 assessments this financial year, at a cost of about £5m. Escalating increase in choice referrals due to this, costs projected for this year so far £1m (£700k greater than last year). No funding attached to transformation team and so dedicated resource not yet identified Available funding and workforce will make rapid improvements difficult.	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	None at this stage. To confirm outsourcing position for high risk cases post September.	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 Increasing public focus with request from Scrutiny to update Cllrs in September and increasing letters from MPs to service provider (LCH).	Static - 2 cycles
2017	29/06/2022	Both Delivery and Quality and People's Experience	15 (I3xL5)	9 (I3xL5)	Lindsay Mcfarlane	Helen Lewis	There is a risk of harm to patients with 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	Recovery to pre-pandemic levels of performance; i.e. Collaborative Care and Support Plan (CCSP) reviews in primary care and key waiting time trajectories Lack of funding to continue the 6 x LTC Health Inequalities projects Uncertainty regarding 24/5 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	Closed - The LTC Population Board were in agreement that the risk is certain and therefore this risk has been changed to an issue. The Board will continue to monitor. The Board's work programme has a number of mitigations which are being progressed and will continue to be monitored.
Risk Aligned to the Leeds Committee (12+)															

2024	30/06/2022	Leeds Committee of the WY ICB	12	(I4xL3)	1	(I4xL3)	Andrea Dobson	Penny McSorley	There is a risk of not meeting legislative responsibilities in relation to community deprivation of liberty for fully funded CHC cases; due to assessor capacity and availability of court of protection time; resulting in deprivation of liberty in breach of legislation. There is a significant additional risk that patients will not have the advocacy they need to go through the process due to a lack of commissioned resource. Family members can act as the RPR if they are objective, however in the majority of cases that is difficult.	Monthly meetings held with Health Case Management managers to monitor current position, plan LPS and maintain numbers. Prioritise cases based on complexity and risk of challenge Assessments are completed in line with the availability of court time to ensure they do not go out of date. However, delays to court proceedings have meant that a large number of cases have had to be redone as they became 'out of date' whilst awaiting a hearing. This has increased the workload of the HCM team. MCA Lead is working in collaboration with the health case management team and appointed solicitors to minimise delays and maximise performance. More case managers have received relevant training and experience to complete the assessments. Fast track reviewing moved to Continuing Care Service to free up HCM capacity	Please add actions in addition to the controls listed to reduce risk to target - with date for completion- see guidance p4. The following have been copied from Datix: Liberty Protection Safeguards LPS has been delayed in its implementation indefinitely. There is insufficient budget and resource at place to undertake preparatory work for all potential cases of DoL or to engage legal representation in order to progress all cases to the court of protection. The court has raised concerns on a number of occasions about the use of family members as appropriate rule 1.2 representatives, this requires additional legal support and HCM work.	LCH provide performance reports, highlighting the current position. The ICB Mental Capacity Act Lead meets with LCH quality Leads and Beachcroft solicitors quarterly to track progress and unpick any delays or performance issues	Regular meetings with the HCM Managers to ensure issue remains in focus. Mental Capacity Act Lead is working both at place and ICB level to monitor all associated risks. Adam (CHC System) being updated to record DoLS which will enable improved monitoring and recording.	No current gaps identified	Static - 2 cycles

Appendix 2 – Common Risk Mapping – Risk Cycle 4 of 2023/24 (as at 10 November 2023)

System Flow / Capacity and Demand Risks

Place	Risk	I	L	Score	Common Risk
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	2	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	4	16	
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	3	3	9	

	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)				
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	3	9	
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	
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	2	4	

	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.				

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

Place	Risk	I	L	Score	Proposed Action
Wakefield (2132)	There is a risk to the overall sustainability of the urgent care services within Wakefield due to the impending end of the lease for the King Street Walk In Centre. This service plays a vital role in the delivery of services at a place level	3	2	6 ↓	Common risk re: emergency departments demand
Kirklees (2331)	There is a risk that the system will continue to see an unprecedented volume of patients attending A&E and therefore will not deliver the NHS Constitution 4-hour A&E target of 76% due to pressures associated with unavoidable demand, patient choice, capacity and flow out – resulting in long waits, overcrowded ED, harm to patients and patient experience being compromised.	3	4	12	
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 ↑	
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	4	16	
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 2024/25 due to a significant number of the cases having no previous	4	3	12	Common risk re: gram negative blood

	health or social care interventions, resulting in failure to meet the requirements of the single oversight framework (should this measure be included).				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	Risk Operational Group flagged query on different impact scores.
Kirklees (2327)	There is a risk that reduced access to elective care services in both the surgical and medical divisions at CHFT and MYHT will result in: long waits, harm to patients, poor patient experience and non-delivery of patients' rights under the NHS Constitution.	3	3	9	Common risk re: failure to meet Constitutional standards
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	
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 higher demand and the legacy impact of COVID, resulting in poor patient experience/outcomes and non-compliance with the constitutional standards for waiting times.	4	3	12	
Kirklees (2330)	There is a risk that Kirklees Health and Care Partnership will fail to achieve national performance standards (set out in the NHS constitution), and in line with the Operational Recovery Plan for 2023/24 resulting in poor provider performance, poor organisational reputation and non-compliance with the constitutional standards for waiting times across the Kirklees system.	3	3	9	
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	SYSTEM PERFORMANCE AGAINST NATIONAL REQUIREMENTS	3	5	15	

(2168)	There is a risk that poor performance against national requirements (key constitutional standards, operational planning targets and recovery) will impact upon our place based contribution to the annual ICB performance assessment. This may lead to both financial and reputational impact alongside reduced patient care.				
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	1	3 ↓	Common risk re: adult ADHD assessment
Leeds (2354)	There is a risk of unsustainable Neurodevelopmental assessment and treatment pathways (autism and ADHD) due to demand for services surpassing the capacity resulting in unmet need of patients, long waiting list and increased right to choose requests which will cause impact to patient outcomes and significant financial impact	3	5	15	
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	5	15	
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	
Calderdale (2219)	There is a risk that the Posture and Mobility service will not achieve key performance indicators due to funding issues as a result of increasing equipment costs and increasing complexity of cases	3	5	15 ↑	

	resulting in the high likelihood that the 18-week Referral to treatment pathway will not be met for new referrals and a potential increase in complaints.				Common risk re: posture and mobility service
Kirklees (2218)	There is a risk that the Posture and Mobility service will not achieve key performance indicators due to funding issues as a result of increasing equipment costs and increasing complexity of cases resulting in the high likelihood that the 18-week Referral to treatment pathway will not be met for new referrals and a potential increase in complaints.	3	5	15	

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	Common risk re: continuing healthcare workforce challenges
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	3	9	
Wakefield (2181)	There is a risk of delayed response to changes in healthcare needs or discharge from hospital for children requiring Continuing Healthcare packages due to MYHT not having capacity to provide Children's Continuing Healthcare packages under the Block Contract resulting in the additional costs to the ICB associated with commissioning of external providers.	3	1	3	
Wakefield (2297)	Capacity and workforce pressures within the CHC contracting team could result in delays in commissioning patient care, dealing with provider issues and processing payments.	3	3	9	
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.
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	
Leeds (2272)	There is a risk to pregnant people of not achieving the preferred elements of care identified in individual personalised care plans, due to midwifery staffing issues (both recruitment and retention), resulting in a potential for poorer outcomes and experience of care	2	3	6	
Leeds (2269)	There is a risk of poor quality care to pregnant people and their families due to workforce short and long-term challenges (eg: industrial strike action across the maternity sector, recruitment challenges, sickness and absences, etc), resulting in poor patient experience, safety, and clinical effectiveness.	2	3	6	
Wakefield (2128)	Children and young people aged 0-19 years will be waiting for over 52 weeks for autism assessment due to availability of workforce to manage the volume of referrals. The time taken for a full diagnostic assessment for ASD for children and young people is continuing to increase due to the exceptionally and unpredicted number of referrals. The number of referrals remain much higher and above the	3	5	15	Common risk re: waits for CYP neurodiversity

	capacity planning which was part of the business case for investment. Because of the increased waiting times and pressure/publicity in neighbouring areas the numbers of Patient Choice referrals for assessment has risen in the last 3 months which increases financial pressure on the organisation.				Also seek corporate risk.
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	
Leeds (2301)	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.	3	5	15	
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	

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.	2	3	6	
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	

Quality and Safety Risks

Place	Risk	I	L	Score	Proposed Action
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.	4	4	16 ↑	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	4	16	

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 Query raised re difference in scoring
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.	3	2	6	
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	
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.	5	4	20 ↑	Common risk re: prescribing costs
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	4	16 ↑	
Wakefield (2329)	There is a risk that the high level of risk within the collective ICS financial plan and more specifically the impact of that within the Wakefield Place will mean that transformation schemes and investment decisions will be severely limited.	4	4	16	Common risk re financial plan and financial control target
Leeds (2014)	There is a risk that the financial position across the Leeds system will not achieve financial balance due to the combination of undelivered QIPP and new cost pressures in 2023 – 24. This could result in the system as a whole not meeting the statutory duties.	5	4	20	
Kirklees (2306)	There is a risk that the Kirklees place as part of West Yorkshire will not achieve its financial control target due to financial pressures within the system of Kirklees and wider West Yorkshire system pressures, alongside having a large QIPP target to achieve financial balance. This risk is due to, in part, a number of elements - increased costs in all business areas - pressures due to inflation and pay - high QIPP target - under delivery of efficiency programmes The result of failure to deliver will be a risk to the achievement of the overall West Yorkshire ICS financial plan which could result in failure to deliver statutory duties, reputational damage and additional scrutiny from NHS England	4	4	16	

Kirklees (2328)	The risk is that Kirklees Place will fail to deliver our 2023/24 planned Recovery trajectory for the 23/24. This is due to the significant financial challenge & the inability to identify enough schemes that will deliver the required recurrent & non recurrent value for 2023/24 or plan for 2024/25. Failure to deliver the plan will result in a risk to the overall achievement of Kirklees place financial plan and financial statutory duties& have an impact on the overall west yorkshire recovery plan.	4	4	16	
Calderdale (2300)	The risk is that WYICB-Calderdale Place will fail to deliver the 2023/24 financial plan. This is due to 23/24 financial plan submitted to the WYICB including a number of pressures/risks which have been articulated in the plan development process.. These risks include activity pressures on independent sector acute contracts, prescribing and under-delivery of QIPP. The QIPP challenge for 23/24 is significant at around £5m as a minimum. This includes a £2.3m share of WYICB additional savings requirement. 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	3	12	
Calderdale (2299)	There is a risk that the Calderdale Cares Partnership part of the WYICS will not as a system deliver its planned financial position. This is due to in part to several key elements including : - the level of inflation, the scale of efficiency challenge, uncertainty around ERF income, pay award uplift, under delivery of efficiency programs, higher than planned agency costs and use of non recurrent resources. Strike related cost pressures continuing to add risk. The result of failure to deliver will be a risk to the achievement of the overall WYICS financial plan which could result in failure to deliver statutory duties, reputational damage and potential additional scrutiny from NHS England and a requirement to make good deficits in future years.	4	3	12	
BDC (2338)	IN-YEAR FINANCIAL PERFORMANCE There is a risk that we do not achieve the financial plan surplus target for 2023/24 due to shortfalls against savings plans, additional cost pressures and financial penalties relating to the Elective Recovery Fund scheme. Following the completion of the planning round for 2023/24, there is an additional savings requirement of £6.1m that needs to be met if financial plan targets are to be achieved.	5	4	20	
BDC (2337)	UNDERLYING FINANCIAL DEFICIT There is a risk that we do not address the underlying financial deficit and establish a financially sustainable position over the medium term. Following the completion of the planning round for 2023/24, the underlying financial deficit has increased further and therefore this remains a critical risk.	5	4	20	

Leeds Health & Care Partnership

NHS West Yorkshire Integrated Care Board

Appendix 3

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

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

		experience There is a risk to maintaining sufficient capacity to meet the needs of patients attending hospital and being admitted for planned/elective care and unplanned (acute) care caused by demand being greater than the available hospital capacity. Efficiency of patient flow and placement due to high occupancy across the health and care system impacts on patient safety, outcomes, and experience. There is also a risk to the delivery of constitutional standards, impacting on the Trust's delivery and efficiency ratings and reputation.		total and deliver the operational capital plan in 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. 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		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 stakeholder confidence and/or material breach of regulatory conditions of registration.

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

						may be required.
Leeds and York Partnership Foundation Trust		**System flow and Out of Area Placements** There is a risk to the quality of care of our service users as a result of ineffective patient flow within the system with an increasing use of Out of Area Placements, compounded by a lack of recurrent funding and a resulting financial cost to the system.		**Community Mental Health Services redesign** The Community Mental Health redesign and recovery plan will result in the need to do things differently across the city, and impact on the way partners provide their services. If this is not sufficiently addressed there is a risk to the overall quality of patient care and experience.		**Investment in Mental Health and Learning Disability Services** There is insufficient capacity to meet the level of demand of mental health needs within Leeds; this is manifested through the availability of core funding for our workforce and impacts on resource.
Leeds GP Confederation	↓	**Strategic**: There is a risk that both main aspects of the Confederation's purpose are compromised due to strategic decisions that are out with of our control. Voice & representation; if the funding for this is reduced or lost. Combined with PCNs taking Enhanced Access 'in-house' the combined affect will be a much-compromised Confederation infrastructure with limited ability to deliver purpose.	↓	**Financial**: Following an efficiency review we have mitigations for our 2024/25 deficit. Mitigations include increasing income through winning tenders but there is a risk that these contracts do not yield the level of income required. In addition, reducing running costs largely through changing the workforce profile. Whilst being closely monitored there is a risk that mitigations will not work and we will return to a risk of deficit.	New	**Operational**: Being agile for PCN requirements. Standing down services and standing up new services; all require workforce flexibility. Where workforce is limited, this may compromise the ability to flex services at the speed required.
Voluntary, Community and Social Enterprise (coordinated by Forum Central)		**Increased demand and complexity** Harm to patients, especially those with the greatest Health Inequalities (HIs), as third sector is increasingly unable to support		**Risk to financial position** Where reduction in TS services results in increased use of costly Preventable Unplanned Care services, including crisis services and associated additional bed		**Risk to current contracts and PHM/HLP approach and deliverability** Organisations unable to fulfil contracts and loss of third sector workforce and capacity

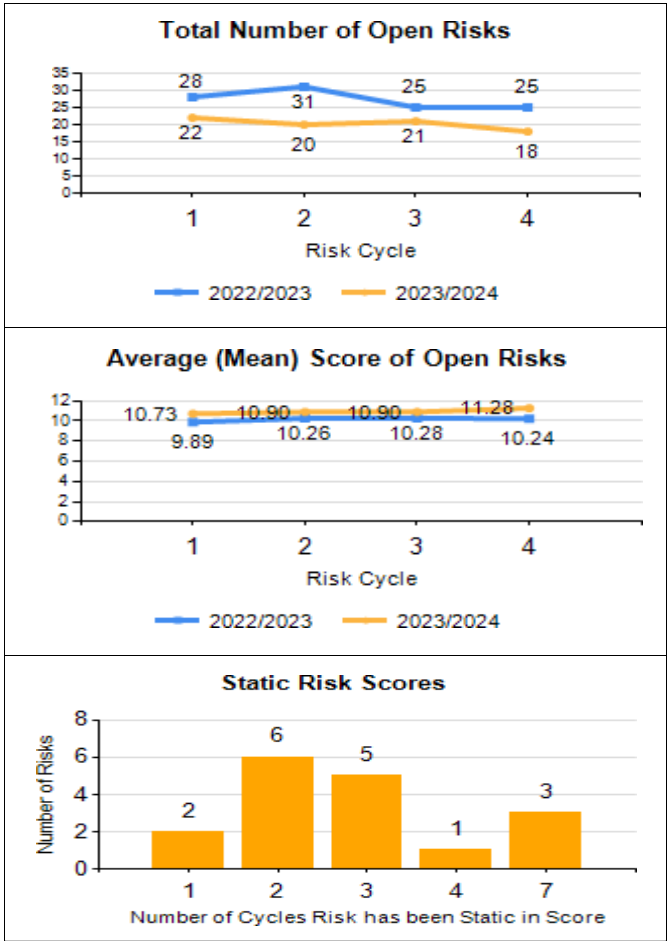
		existing as well as rising demand amongst the most vulnerable groups and communities. Forum Central has previously reported on the rise in people referred to third sector organisations with complex needs including SMI who are not in receipt of NHS or LCC support services. Cuts and restrictions on NHS/LCC services means TSOs are reporting demand from new users who cannot be safely or appropriately supported.		days, which will absorb resource for the two priority goals of the Healthy Leeds Plan (HLP).		tackling HIs and the HLP's two priority goals, particularly addressing root cause associated with the presenting problem captured in the Leeds Data Model (i.e. just as Leeds data model analysis gets to the point where it can identify the population groups to prioritise, we lose the staff, services and organisations that would be best placed to be a critical part of the solution).
Leeds City Council	New	**Increased demand and complexity** Increasing demand for services (health, care, children's, welfare and street support) 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	⇔	**Financial pressures** Ongoing impact of financial pressures on the local authority services leading to problems satisfying competing priorities 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.	⇔	**Recruitment and retention, workforce pressures and market sustainability** Worsening workforce pressures and market sustainability position. Problems in both Adults and Health and Children and Families directorates in recruiting and retaining care staff (in particular: social workers, professionals, educational psychologists, schools) leading to increased resource pressures and adverse impact on our ability to deliver a wider range of services. Risk that the

		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.				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.

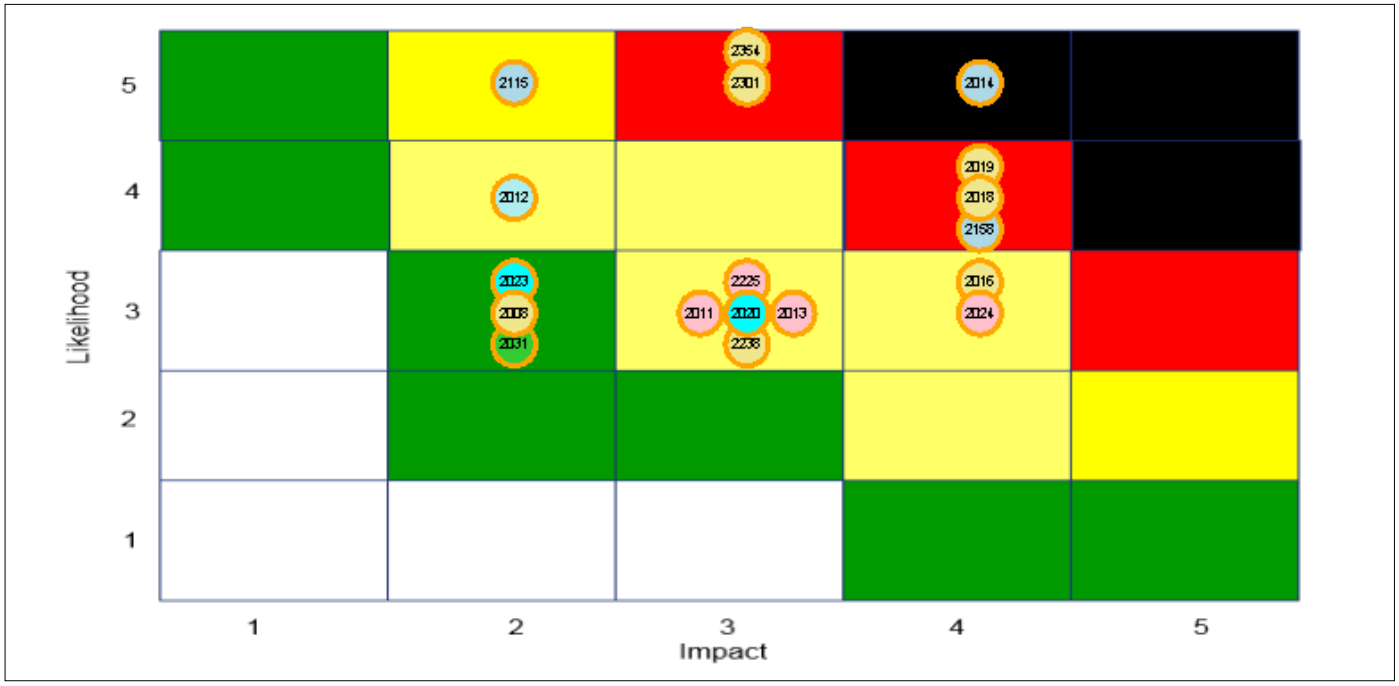
Appendix 4: Risk on a Page Report for the Leeds Committee of the West Yorkshire Integrated Care Board
Risk Cycle 4: Sept – November 2023

Total Risks	21
Delivery	1
QPEC	2
Delivery and QPEC	8
Finance & Best Value	3
Leeds Committee	4
EMT	3

Movement of Risks	
New	0
Marked for Closure	3
Risk score increasing	1
Risk score static (1 cycle)	2
Risk score static (2+ cycles)	15
Risk score decreasing	0



Risk Overview



Key

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

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

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	X	TR
Financial Position Update	X	X	X	X	VPS
ITEMS FOR DECISION					
Leeds Joint Working Agreement (JWA)		X			LM
GP Procurement / Merger of practices		X		X	KT
Healthy Leeds Plan / Joint Forward Plan	X				JC
STRATEGY & ASSURANCE					
Local Care Partnership (LCP) Update	X				TS
Financial Planning for 2024/25			X	X	TR/VPS
Marmot City Update				X	VE/ALL
The Director of Public Health Annual Report 2022		X			VE
Transforming Community Mental Health Update			X		HL
Tier 3 Weight Management Services Update				X	-