Leeds Health & Care Partnership

NHS West Yorkshire Integrated Care Board

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

**Wednesday 13th March 2024, 13:15 – 16:30**
**(Private pre-meet for members 13:00, public meeting 13:15)**
**New Wortley Community Centre, 40 Tong Road, Leeds LS12 1LZ**

**AGENDA**

| No. | Item | Lead | Page | Time |
|---|---|---|---|---|
| **LC 66/23** | **Welcome, Introductions** | **Rebecca Charlwood**<br>Independent Chair | - | 13:15 |
| **LC 67/23** | **Apologies and Declarations of Interest**<br>- To note and record any apologies<br>- A register of interests of members can be found at mydeclarations.co.uk<br>- Those in attendance are asked to declare any specific interests presenting an actual/potential conflict of interest arising from matters under discussion | **Rebecca Charlwood**<br>Independent Chair | - | |
| **LC 68/23** | **Minutes of the Previous Meeting**<br>- To approve the minutes of the meeting held 13th December 2023 | **Rebecca Charlwood**<br>Independent Chair | 3 | |
| **LC 69/23** | **Matters Arising**<br>- To consider any outstanding matter arising from the minutes that is not covered elsewhere on the agenda | **Rebecca Charlwood**<br>Independent Chair | - | |
| **LC 70/23** | **Action Tracker**<br>- To receive the action tracker for review | **Rebecca Charlwood**<br>Independent Chair | 14 | |
| **LC 71/23** | **People's Voice**<br>- To receive the Healthwatch West Yorkshire Insight Report - People's experience of end-of-life care in West Yorkshire | **Jonathan Phillips**<br>Healthwatch Leeds | - | 13:20 |
| **LC 72/23** | **Questions from Members of the Public**<br>- To receive questions from members of the public in relation to items on the agenda | **Rebecca Charlwood**<br>Independent Chair | - | 13:35 |
| **LC 73/23** | **Population and Care Delivery Board Update**<br>- To receive a highlight update from the End of Life Population Board | **Helen Smith**<br>Head of Pathway Integration | - | 13:45 |
| **LC 74/23** | **Place Lead Update**<br>- To receive a verbal update from the Place Lead | **Tim Ryley**<br>Place Lead | - | 14:00 |
| **ROUTINE REPORTS** | | | | |
| **LC 75/23** | **Quality & People's Experience Sub-Committee Update *to follow***<br>- To receive an assurance report from the Chair of the sub-committee | **Rebecca Charlwood**<br>Independent Chair & Chair of the Quality and People's Experience Sub-Committee | - | 14:15 |

| No. | Item | Lead | Page | Time |
|---|---|---|---|---|
| LC 76/23 | **Delivery Sub-Committee Update**<br>- To receive an assurance report from the Chair of the sub-committee | **Yasmin Khan**<br>Independent Member & Chair of Delivery Sub-Committee | 16 | |
| LC 77/23 | **Finance & Best Value Sub-Committee Update**<br>- To receive an assurance report from the Chair of the sub-committee | **Cheryl Hobson**<br>Independent Member & Chair of Finance & Best Value Sub-Committee | 18 | |
| **BREAK 14:30 – 14:40** | | | | |
| **FINANCE** | | | | |
| LC 78/23 | **2023-24 Financial Position at Month 10**<br>- To receive the financial position update | **Visseh Pejhan-Sykes**<br>Place Finance Lead | 20 | 14:40 |
| LC 79/23 | **Finanical Plan 2024/25**<br>- To receive and approve the financial plan | **Tim Ryley**<br>Place Lead | 30 | 14:50 |
| **ITEMS FOR DECISION/ASSURANCE/STRATEGIC UPDATES** | | | | |
| LC 80/23 | **Proposal to merge Wetherby Surgery and Bramham Medical Centre and close Harewood Branch Practice**<br>- To receive and approve the proposal | **Gaynor Connor**<br>Director of Primary Care and Same Day Response | 61 | 15:50 |
| **RISK MANAGEMENT** | | | | |
| LC 81/23 | **Risk Management Report**<br>- To receive and consider the risk management information provided | **Tim Ryley**<br>Place Lead | 72 | 16:00 |
| **FORWARD PLANNING** | | | | |
| LC 82/23 | **Items for the Attention of the ICB Board**<br>- 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**<br>Independent Chair | - | 16:15 |
| LC 83/23 | **Forward Work Plan**<br>- To consider the forward work plan | **Rebecca Charlwood**<br>Independent Chair | 105 | |
| LC 84/23 | **Any Other Business**<br>- To discuss any other business | **Rebecca Charlwood**<br>Independent Chair | - | |
| LC 85/23 | **Date and Time of Next Meeting**<br>The next meeting of the Leeds Committee of the WY ICB will be held on 22nd May 2024 13:15 – 16:30 (private pre-meet for members 13:00, public meeting 13:15) | **Rebecca Charlwood**<br>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 |
|---|---|---|---|---|
| 87/23 | **Private Minutes of the Previous Meeting**<br>- To approve the private minutes of the meeting held 13th December 2023 | **Rebecca Charlwood**<br>Independent Chair | - | 16:25 |

# Draft Minutes

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

**Wednesday 13 December 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) | | ✓ |
| Andrea North (deputising for SP) | **AN** | Interim Executive Director of Operations, 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) | | ✓ |
| James Goodyear (deputising for PW) | **JG** | Director of Strategy, 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) | | ✓ |
| Victoria Eaton | **VE** | Director of Public Health, LCC | ✓ | |
| Pip Goff | **PG** | Chief Executive, Forum Central | ✓ | |
| Dr John Beal | **JB** | Chair, Healthwatch Leeds | | ✓ |
| Jonathan Phillips (deputising JB) | **JP** | Deputy Chair, Healthwatch Leeds | ✓ | |
| Dr Sarah Forbes | **SF** | Medical Director, ICB in Leeds | | ✓ |
| Jo Harding | **JH** | Director of Nursing and Quality, ICB in Leeds | ✓ | |
| **Additional Attendees** | | | | |
| Sam Ramsey | **SR** | Head of Corporate Governance & Risk, ICB in Leeds | ✓ | |

| Members | Initials | Role | Present | Apologies |
|---|---|---|---|---|
| Harriet Speight | **HS** | Corporate Governance Manager, ICB in Leeds | ✓ | |
| Lindsay McFarlane (Item 53/23) | **LM** | Head of Pathway Integration (Long Term Conditions), ICB in Leeds | ✓ | |
| David Wardman (Item 53/23) | **DW** | Clinical Lead for Long Term Conditions, ICB in Leeds | ✓ | |
| Eddie Devine (Item 58/23) | **ED** | Head of Pathway Integration (Mental Health and Learning Disabilities) | ✓ | |

**Members of public/staff observing – 3**

| No. | Agenda Item | Action |
|---|---|---|
| **45/23** | **Welcome and Introductions**<br><br>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. Jonathan Phillips (JP) advised that he would be the co-chair of Healthwatch Leeds from January 2024. The Chair welcomed Jonathan to the Committee. | |
| **46/23** | **Apologies and Declarations of Interest**<br><br>Apologies had been received from Dr John Beal, Dr Phil Wood, Sam Prince Caroline Baria, and Dr Sarah Forbes. Jonathan Phillips, James Goodyear and Andrea North were in attendance as deputies.<br><br>Members were asked to declare any interests presenting an actual or potential conflict of interest arising from matters under discussion. The Chair noted that she had recently started a new role at the Clinical Quality Commission supporting local authority assessments, which had been added to the register of interests. | |
| **47/23** | **Minutes of the Previous Meeting – 4 October 2023**<br><br>The public minutes were approved as an accurate record.<br><br>**<u>The Leeds Committee of the WY ICB:</u>**<br><br>a) **Approved** the minutes of the previous meeting held on 4 October 2023. | |
| **48/23** | **Matters Arising**<br><br>There were no matters raised on this occasion. | |
| **49/23** | **Action tracker**<br><br>The committee noted the completed actions set out in the action tracker. | |

| No. | Agenda Item | Action |
|---|---|---|
| 50/23 | **People's Voice**<br><br>Jonathan Phillips (JP) introduced Sophia's report from the 'How does it feel for me?' series, which included recommendations for partners around service improvement, recognising that some of Sophia's experiences throughout the system worsened her mental health and therefore required more support, clearly showing the link between effectiveness and best value. JP also highlighted the clear need for integrated service planning for mental health, as pressure on acute services intensifies if other parts of the system fail.<br><br>Pip Goff (PG) noted the link between health and employment highlighted by Sophia's experiences and the focus on wider determinants of health - including employment, housing, and education - within the recently revised Leeds Health and Wellbeing Strategy (2023 – 2030).<br><br>Yasmin Khan (YK) highlighted the importance of embedding the three c's (coordination, compassion, and communication) into mental health services, noting some good examples of where that worked well but also where services could be improved. JP suggested that a fourth 'c' – control – was also particularly relevant in Sophia's story, with some experiences where she felt empowered and others where she felt she had no control and the impact of this was significant.<br><br>The Chair noted that the Committee had listened to the powerful audio video from Sophia's series at a previous meeting and welcomed the final report and recommendations. The Chair thanked Healthwatch for the continued work to help people's voices be heard across the city.<br><br>***SM joined the meeting at 13:25 p.m. during discussion of this item.*** | |
| 51/23 | **Questions from Members of the Public**<br><br>Dr John Puntis (Leeds Keep Our NHS Public) submitted the following question:<br><br>'The forecast deficit for the Leeds Place at the start of 2024/5 is above £40m. The minutes of the last meeting note that Dr Winder asked to what extent communication with the people of Leeds took place about the implications of running out of money. He was told that a process for patient engagement regarding the financial strain on services had recently been developed. Could I ask what form this engagement takes, and what progress has been made since then in this area - and suggest that to exclude the public from the part of this meeting where financial planning is discussed represents a regrettable and increasing trend towards secrecy among ICS Boards and committees across the country that is conducive neither to public trust nor mobilising public pressure on government to increase NHS funding.'<br><br>Tim Ryley (TR) thanked Dr Puntis for his question and for recognising scale of the financial challenge faced by the NHS. In reference to the £40m deficit, TR advised that this figure related to the underlying position for 2023/24 and did not currently | |

| No. | Agenda Item | Action |
|---|---|---|
| | reflect a myriad of additional pressures, meaning that the actual figure was likely to be much higher. TR advised that through the Covid-19 pandemic, the previous CCG received additional funding from NHS England to manage the response which had since ceased, forcing the statutory NHS bodies in Leeds to return to the pre-Covid position, presenting considerable challenges. TR advised that a workshop had been arranged for late December to test communication avenues, which would continue to be revised through January, however noted that a joined-up approach across West Yorkshire would be key. TR confirmed that the confidential finance report to be considered in the meeting did not include any form of proposals to be agreed, but rather a set of principles and intended process for the Committee to provide a steer on. Once the proposals had been finalised, the communication and engagement process would be undertaken in advance of the final decision to be taken by the Committee in public at the meeting on 13 March 2024.<br><br>Dr Puntis noted that other ICBs across the country had been reported as using management consultants to support financial planning and expressed his concern about this occurring in Leeds. TR confirmed that management consultants had not been used in Leeds or West Yorkshire, and financial planning arrangements had been developed to date by NHS partners only.<br><br>**ACTION –** To provide a written response to the question submitted by Dr John Puntis. | **TR** |
| **52/23** | **Place Lead Update**<br><br>TR provided an overview of the report, firstly noting the upcoming retirement of Dr John Beal and thanked him for his leadership of Healthwatch Leeds over the years. TR also highlighted that the Care Quality Commission (CQC) had published its latest State of Care Report, and stated that issues identified last year, such as staffing levels, had continued to escalate, in conjunction with newer issues such as the cost-of-living crisis, highlighting the widening inequalities gap. TR also advised members that the recent bid for funding for an Elective Care Hub in Chapel Allerton had unfortunately been rejected and would undoubtedly impact ability to deliver some elective backlog improvements.<br><br>The Chair requested a verbal update on the progress of the HomeFirst programme ahead of the challenging winter period. TR, James Goodyear (JG) and Andrea North (AN) provided feedback from their respective experiences of the programme to date. Members were advised that there had been continued reduction in 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 'no reason to reside' patients, which in turn has had positive implications for individuals in terms of maximising the independence and reducing potential harm, and to date the financial benefits accruing from better care had shown to be ahead of trajectory. Members noted that replication of lessons learned from the success of the HomeFirst programme should be prioritised, particularly for service areas without the parity of investment, such as mental health. | |

| No. | Agenda Item | Action |
|---|---|---|
| | In reference to the recent CQC report findings on worsening inequality nationally, Victoria Eaton (VE) added that 1 in 4 people and 1 in 3 children in Leeds live in the 10% most deprived areas across the country. VE advised that public health colleagues track a number of health indicators that monitor health inequalities and this approach would inform the Marmot City work. VE advised that an update would be provided to the Leeds Committee in the summer.<br><br>TR noted that the ICB in Leeds would have a key role to play in the Marmot City outcomes in terms of primary and secondary prevention work to address inequalities. Related to this, Dr George Winder (GW) reported that widening health inequalities may be perpetuated by some national incentive schemes for GP practices as they are not awarded on a targeted basis using deprivation data. GW assured members that this tends not to be an issue in Leeds, however felt it pertinent to raise regionally and nationally. The Chair agreed that the matter would be escalated to the WY ICB via the AAA report.<br><br>**<u>The Leeds Committee of the WY ICB:</u>**<br><br>a) **Considered** and **noted** the contents of the report | |
| **53/23** | **Population and Care Delivery Board Update**<br><br>Lindsay McFarlane (LM) and David Wardman (DW) delivered a PowerPoint presentation, providing an overview of key areas of focus and some of the challenges experienced by the Long-Term Conditions (LTC) Population Board, including:<br><br>- Multi-morbidity is a growing priority in Leeds. 36,000 people live with 3 + Long Term Conditions and a mental health diagnosis in Leeds – this has been agreed as citywide priority linked to the Healthy Leeds Plan.<br>- Leeds is one of eight places in England to receive seed funding (£200,000) with Leeds University to co-produce a business case for a Systems Engineering Innovations Hub for Multiple Long-Term Conditions (SEISMIC) - provides opportunity to explore how we design interventions for people living with multi-morbidity in Leeds.<br>- Several successful schemes focused on early identification and intervention for diabetes, hypertension, adult asthma and cardiovascular disease, including targeted schemes to reduce health inequalities.<br>- Progress on Quality, Innovation, Productivity and Prevention (QIPP) projects, including savings identified through VAT removal and service reviews and redesigns.<br><br>James Goodyear (JG) thanked colleagues for the work undertaken, particularly around the SEISMIC project, however queried whether the scale of the work was sufficient and would be sustainable in supporting the large cohort in Leeds. VE also noted her support of the approach to multi-morbidity, advising members that the national Major Conditions Strategy would be published in March 2024 including a major challenge to the NHS in terms of preventing hospital admissions, requiring | |

| No. | Agenda Item | Action |
|---|---|---|
| | significant work to ensure that programmes are sustainable on a large scale. TR advised members that as part of the new operating model, a new team had been established to focus on data and insights for prevention work, to support prevention work across the city.<br><br>**<u>The Leeds Committee of the WY ICB:</u>**<br><br>a) **Received** the update. | |
| **54/23** | **Quality and People's Experience Sub-Committee Update**<br><br>The Chair provided a brief overview of the assurance report included in the agenda pack and highlighted the following key points:<br><br>- The sub-committee received the People's Experience report, which provided detail of current experiences of people living with complex mental health conditions – including an update on Sophia's story also presented as the People's Voice item (50/23)<br>- Following the addition of a new risk to the WY ICB corporate risk register, the West Yorkshire Quality Committee 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.<br>- 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. Overall, 70% of care homes had been rated 'good' and above, and discussions were focused on the approach to improve the number of high ratings.<br><br>**<u>The Leeds Committee of the WY ICB:</u>**<br><br>**a) Received** the update. | |
| **55/23** | **Delivery Sub-Committee Update**<br><br>Chair of the Sub-Committee, YK, provided a brief overview of the assurance report included in the agenda pack and highlighted the following key points:<br><br>- The sub-committee was advised of pressures faced by the third sector to temporarily fund some targeted maternity support services, following the end of nonrecurrent 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 | |

| No. | Agenda Item | Action |
|---|---|---|
| | the increased level of risk to continuing with targeted schemes that aim to reduce health inequalities, in the current financial climate.<br>- Related to the above, 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 and it was agreed that a discussion should take place outside of the meeting to how best to mitigate the risks as a partnership.<br>- 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.<br><br>**<u>The Leeds Committee of the WY ICB:</u>**<br><br>a) **Received** the update. | |
| **56/23** | **Finance and Best Value Sub-Committee Update**<br><br>The Chair of the Sub-Committee, Cheryl Hobson (CH), provided a brief overview of the assurance report included in the agenda pack and highlighted the following key points:<br><br>- 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 NHS Leeds Strategic Finance Executive Group to consider 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.<br>- 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 (LD) Pooled Budget in 2023/24. The sub-committee agreed that planning and forecasting would be key moving forward, including continued careful case management and regular review of packages. The sub-committee also 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. | |

| No. | Agenda Item | Action |
|---|---|---|
| | - The Chair noted that since the meeting and publication of the AAA report, there had been some further work to consolidate financial risks, with a directive that the financial risks currently held at place to become corporate risks, including capital funding risks.<br><br>PG wished for it to be noted for clarity that the SFEG membership includes statutory NHS partners only.<br><br>In reference to the deep dive into the Learning Disability Pooled Budget, Sara Munro (SM) advised that high-cost individuals would remain in the system, if not increase, and therefore assessment on future population of housing need based on current trajectories would be key to managing the budget in coming years. JP added that early intervention during childhood would also be crucial to future delivery of services.<br><br>**<u>The Leeds Committee of the WY ICB:</u>**<br><br>a) **Received** the update. | |
| **57/23** | **Finance Update at Month 7 (October) 2023-24**<br><br>Visseh Pejhan-Sykes (VPS) introduced the report and advised that at Month 7 and early analysis at Month 8, 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 in Leeds. Members were advised that pressures contributing to the projected deficit were associated with prescribing cost policies, the LD pooled budget, industrial action and subsequent agency costs (with an associated cost of £17-20m in Leeds), out of area placements, and waiting times – with several unknown factors likely to present before the end of the financial year.<br><br>GW queried whether structures exist within the system to allow ownership of the supply chain to alleviate cost pressures associated with prescribing and was advised of opportunities to tackle prescribing costs at a West Yorkshire level, along with the Anchor Institution commitment to the Leeds pound (£), however there were challenges with procurement collaboratives to consider, particularly around laws of competition.<br><br>**<u>The Leeds Committee of the WY ICB:</u>**<br><br>**a)** **Reviewed** and **commented** on the month 7 position.<br>**b)** **Reviewed** and **commented** on the QIPP delivery for 23-24 and beyond.<br><br>***The meeting adjourned for a comfort break at 3.00 p.m. until 3:15 p.m.*** | |
| **58/23** | **Transforming Community Mental Health in Leeds** | |

| No. | Agenda Item | Action |
|---|---|---|
| | Eddie Devine (ED) delivered a PowerPoint presentation, providing an overview of the new model of joined-up primary and community mental health to respond to local populations' needs and remove barriers to access. Members were advised of the timeline for implementation and were advised that the service had progressed from co-design to mobilisation phases, with early trials of joint-triaging underway. Members were also presented with the proportion of investment to date, including a significant proportion allocated to the third sector for community support, and the majority of funds allocated to LYPFT for workforce expansion across psychological therapy, advanced clinical practitioners, occupational therapy and pharmacy, plus programme resource.<br><br>Members were advised of a key challenge as the programme moves towards implementation and delivery from April when the NHS Service Development Funding (SDF) Programme ends. Therefore, ED noted that the programme resourcing must be maintained and built into financial plans to fully embed the new model to improve outcomes through cultural change, in addition to structural change.<br><br>The Chair welcomed the work undertaken to date as a vision for future services, noting the clear need for a joined-up response to mental health as shown by Sophia's story (Item 50/23), and queried whether a performance measure could be added to track the impact on acute bed days. JP also suggested a more explicit performance measure for quality of life to strengthen the focus on patient experience. ED advised that the performance measures and outcomes had been codesigned with people with lived experience.<br><br>Members recognised that the incremental approach taken to transformation would ensure the stability of current model, noting that rushing to transform models can increase risks.<br><br>**<u>The Leeds Committee of the WY ICB:</u>**<br><br>a) **Noted** and **considered** the report.<br>b) **Advised** on any further mitigations relating to risks and issues, as set out above.<br>**c) Noted support** for engagement and resourcing of this important and complex transformation. | |
| **59/23** | **Risk Management Report**<br><br>TR provided an overview of the report and advised that the WY Risk Management Operational Group had been asked by the WY ICB Audit Committee to undertake a review of all static risks and report back to the meeting taking place 29 January 2024. The team would be undertaking focused discussions with all risk owners with static risk scores, asking them to consider the articulation of risks, their mitigations, gaps and assurances, and the anticipated timeline for mitigation. TR also advised that a separate review of financial risks had been undertaken by finance colleagues across West Yorkshire, looking at where to consolidate common risks as corporate | |

| No. | Agenda Item | Action |
|---|---|---|
| | risks, including an action to remove the current prescribing costs risk (Risk no. 2158), as this would become a corporate risk. There was also some discussion regarding the management of financial risks at place and the role of the Leeds Committee in scrutinising financial risks moving forwards. It was agreed that further discussions would take place outside of the meeting to further determine how financial risks would be managed at Place.<br><br>**<u>The Leeds Committee of the WY ICB:</u>**<br><br>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;<br>b) **Received** and **noted** the risks directly aligned to the Leeds Committee of the ICB scoring 12 and above; and<br>**c) Noted** in respect of the effective management of the risks aligned to the Committee and the controls and assurances in place. | |
| **60/23** | **Items for the Attention of the ICB Board**<br><br>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:<br><br>- The significant financial pressures faced in Leeds in year and for 2024.25, and challenge around the approach taken to manage financial risk given place accountability.<br>- Concern around widening health inequalities in Leeds, including National incentive schemes for GP practices potential to widen health inequalities and ask around lobbying nationally.<br>- The anticipated directive from the national Major Conditions Strategy, to be published in March 2024, in terms of preventing hospital admissions, requiring significant work to ensure that multi-morbidity programmes are sustainable on a large scale.<br>- The progress of the new integrated model for Community Mental Health Services in Leeds, with focus on upstream preventative support model, and links to Sophia's 'how does it feel for me?' report discussed at the People's Voice item | |
| **61/23** | **Forward Work Plan**<br><br>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. | |
| **62/23** | **Any Other Business**<br><br>There were no items raised for discussion. | |

| No. | Agenda Item | Action |
|---|---|---|
| **63/23** | **Date and Time of Next Meeting**<br><br>The next meeting of the Leeds Committee of the WY ICB to be held at 1.15 pm on Wednesday 13th March 2024. | |
| | The Leeds Committee of the WY ICB resolved that representatives of the press and other members of the public be excluded from the remainder of the meeting, having regard to the confidential nature of the business to be transacted as set out in the criteria published on the ICB's website (Freedom of Information Act 2000, Section 43.2) and the public interest in maintaining the confidentiality outweighs the public interest in disclosing the information. | |

# Action Tracker

## Leeds Committee of the WY ICB

| Action No. | Meeting Date | Item Title | Actions agreed | Lead(s) | Accountable body / board / committee | Status | Update |
|---|---|---|---|---|---|---|---|
| **8** | **13/12/2023** | **Questions from members of the public** | To provide a written response to the question submitted by Dr John Puntis. | **Tim Ryley** | **LCICB** | | **Complete**<br>Response sent via email |
| **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**<br>Added to the forward work plan |
| **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**<br>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**<br>Invites sent to Director of Children Services |

| 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 2023. | **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 |

# 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>Delivery Performance Report</u>**<br><br>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 improved in several key areas, including A&E wait times, urgent community response, cancer patient treatment lists and annual health check performance for people with mental health conditions and learning disabilities. The sub-committee also noted assurance of the clear continued focus on addressing health inequalities and delivering on the Core20PLUS5 approach, however recognised that increasingly challenging circumstances pose a clear risk to this important work. Therefore, the sub-committee wished to alert the Leeds Committee to the impact of significant financial challenges, alongside seasonal pressure demand and anticipated industrial action, on the delivery of services and performance against national and local metrics. |
| **Advise:** |
| **<u>People's Voices</u>**<br><br>The sub-committee received the Healthwatch report 'People's experiences of end-of-life care in West Yorkshire' along with an audio video of family members and carers speaking about their experiences of services of end-of-life care in Leeds. Members welcomed the report and recommendations for partners and were encouraged to hear that 80% of respondents reported that care was well co-ordinated and staff were caring, compassionate and kind. However, members also discussed the importance of going further to capture the experiences of seldom heard groups in engagement work around end-of-life, particularly people with learning disabilities, dementia and BME communities, along with the experiences of |

staff working in those settings to provide insight into the challenges and enablers to providing the best possible care.

**Population and Care Delivery Board Reports**

The sub-committee received reports submitted by the Same Day Response, Frailty, and End-of-Life Population and Care Delivery Boards. The sub-committee noted assurance of clear progress aligned with each boards set priorities, and particularly noted the useful insight provided within the Chair's summaries of each report around the challenges experienced as a result of financial pressures, including the impact of the closure of third sector provision on services, such as the Leeds Bereavement Forum (closing 31st March 2024). During discussion of the End-of-Life Population Board report, a challenge was raised around the number of people who had an advanced care plan in place, specifying their preferences for their care as their illness progresses, particularly the low numbers for people with a learning disability. The sub-committee recommended that this be a key priority for the board moving forward, by formalising the requirement to do so in contracts with providers and working in partnership to ensure that an individualistic approach is taken to completing the plans with patients and family members, with the right staff member and at the right time.

**Assure:**

**Delivery Performance Report**

Members received a demonstration of the Leeds System Priorities dashboard tool, which presents performance metrics against national priorities, as well as the Healthy Leeds Plan and Population and Care Delivery Board priorities. Members agreed that the data analysis within the report itself summarised the data available comprehensively to provide meaningful assurance, and that, along with the option to access the online dashboard to seek further detail where required, this approach was deemed to be sufficient in place of an appended dated version of the dashboard previously received alongside the report. There was also some discussion around the breakdown of key metrics by health inequalities, such as IMD1 (Index of Multiple Deprivation – most deprived quartile), with suggestions to look further at opportunities to develop reporting.

**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. The sub-committee also noted assurance of the work undertaken to review all static risks held at place.

# Committee Escalation and Assurance Report – Alert, Advise, Assure

**Report from: Leeds Finance and Best Value Sub-Committee**

**Date of meeting: 21 February 2024**

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

**Date of meeting reported to: 13 March 2024**

**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 10 2023-24 and Financial Plan for 2024/25**<br><br>The sub-committee received the finance update and the latest iteration of the financial plans for 2024/25, to provide comment and recommendations ahead of formal consideration by the Leeds Committee on 13th March 2024. The Chair thanked colleagues for all of the work undertaken and noted that in a position where the alternative would be that 'turnaround directors' from NHS England would intervene and take out all discretionary budgets, the current position appeared to be a proportionate response and the sub-committee was assured by the thorough process undertaken to date. However, the sustainability of the third sector, specifically the unintended consequences of funding reductions on NHS services and the impact on health inequalities, was flagged as a key risk and it was requested that this be highlighted as such within the submission. The role of Leeds in supporting other places across West Yorkshire to achieve a balanced position was also discussed, and the sub-committee encouraged sharing of mechanisms used, particularly the approach taken to risk and focusing on interactions between schemes to ensure that potential impacts elsewhere within the system are mitigated. |
| **Advise:** |
| N/A |
| **Assure:** |
| **Risk Management Report**<br><br>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. The report advised that a new risk relating to the impact of the local authority financial position on NHS |

services would be added during risk cycle 6, following a directive from the WY finance team. The sub-committee was supportive of this addition. Members were also advised that the WYICB position for 23/24 set out a reduced risk to a score of 16 because overall, progress had been made in terms of utilising technical flexibilities to reach a balanced position, however Leeds had reported that a score of 20 remained appropriate at place level due to the challenging individual position. The sub-committee noted assurance in respect of the effective management of the risks and the controls and assurances in place.

| | |
|---|---|
| **Meeting name:** | Leeds Committee of the West Yorkshire Integrated Care Board (ICB) |
| **Agenda item no.** | LC 78/23 |
| **Meeting date:** | 13 March 2024 |
| **Report title:** | 2023-24 Financial Position at Month 10 |
| **Report presented by:** | Visseh Pejhan-Sykes, Finance Director, ICB in Leeds |
| **Report approved by:** | N/A |
| **Report prepared by:** | Visseh Pejhan-Sykes and Matthew Turner, 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 paper sets out the financial position of the Integrated Care Board (ICB) in Leeds and the wider Leeds System at the end of January (M10) 2023/24.

The ICB is forecasting a deficit variance to plan of £31.4m mainly due to pressures in LD pool, prescribing and increased independent sector activity. This is now the only variance across the Leeds system as the 3 NHS provider position are all forecast to balance. The £31.4m includes a £4m efficiency which the Leeds Place needs to identify as its share of the £10m gap across the WY ICS.

The financial plan for 2024-25 which started with a £207m gap is now reduced to £41.6m across the Leeds Place and further discussions are needed to reduce this further as well as managing the gap recurrently in the medium term.

**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 10 position.<br>2. **Review** and **Comment** on the QIPP delivery for 23-24 and to discuss what further actions Leeds as an ICB and as a system will be pursuing to improve the position and ensure that we are making inroads into closing the gap recurrently from 24-25 in the process. |
| **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) Running Costs Update |
| **Acronyms and Abbreviations explained** |
| 1. ICB – Integrated Care Board<br>2. LTHT – Leeds Teaching Hospitals NHS Trust<br>3. LCH - Leeds Community Healthcare NHS Trust<br>4. LYPFT – Leeds and York Partnership Foundation NHS Trust<br>5. SFEG – Leeds NHS Strategic Finance Executive Group |

**What are the implications for?**

| | |
|---|---|
| **Residents and Communities** | The paper sets out the efforts being made to minimise the impact on residents whilst operating within a reduced funding envelope. |
| **Quality and Safety** | The need to keep quality and safety at the heart of decision making is one of the key principles and noted as necessary to shape our decision making |
| **Equality, Diversity and Inclusion** | Notes requirement to complete Equality Impact Assessments |
| **Finances and Use of Resources** | The Paper describes the financial position for the Leeds system as we approach the end of the financial nature of a forecast opening £207m gap and the approach to closing this. |
| **Regulation and Legal Requirements** | The NHS has to deliver its statutory duty to live within its means whilst delivering a comprehensive health service free at the point of delivery. |
| **Conflicts of Interest** | All partners are impacted by the approach |
| **Data Protection** | None |

| | |
|---|---|
| **Transformation and Innovation** | The paper describes a number of areas of work that will need to continue or be started to address the gap |
| **Environmental and Climate Change** | None noted |
| **Future Decisions and Policy Making** | The Committee are advised that they will be asked to review the approve the NHS budget in March 2024. |
| **Citizen and Stakeholder Engagement** | The paper describes how the public are being involved. |

## 1. Main Report Detail

1.1. The purpose of this report is to provide an update on the Leeds ICB's financial position as at month 10 of 2023-24, as well as an update on QIPP delivery for 23-24 and our proposals for the longer term balanced financial plan for 2024-25.

1.2. 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

1.3. 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. Although our in year position over the past few months has worsened, the receipt of some central funding plus Elective Recovery Funds due to over delivery on target activity levels have helped close some of the gap in the system.

1.4. The reported position shown at month 10 for the ICB in Leeds now reflects the most likely scenario, although includes an additional £4m QIPP target for the Leeds Place to deliver whilst a significant level of NR support is being held at WY level which is yet to be played out to Places across the ICB. As at early February – no Places have yet been able to propose solutions towards the remaining £10m gap across WY. As a result a working group across WYAAT and all other NHS Providers reported back to the WY Finance Forum in January suggesting a number of technical adjustment options for review, consideration and agreement. A final decision will be made in March but there are a number of feasible albeit risky options to close the gap – non-recurrently only.

1.5. 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.

1.6. The Leeds wide position reported at **month 10:**

| | Final 23-24 Plan | QIPP | Month 10 Variance | Reported Forecast outturn |
|---|---|---|---|---|
| 2023-24 Plans | £m | £m | £m | £m |
| LTHT | (6.9) | 119.3 | 0.00 | 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 | £11.6m ICB plus £8.6m + £4m System | (36.2) | (31.4) |
| **Leeds Place TOTALS** | **(5.3)** | **160** | **(36.2)** | **(31.4)** |

1.7 From the perspective of the Leeds ICB we still have some further pressures around risks that may impact before the end of the financial year.

1.8 At month 10 the year to date and forecast outturn positions for the Leeds Place of the ICB are as follows:

| West Yorkshire ICB | Leeds |
|---|---|
| Finance Report 2023/24 | |
| Month 10 | |

| 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 | 697,814 | 701,254 | 3,440 | 836,976 | 842,928 | 5,952 | 5,952 | 7,552 | 5,952 |
| Mental Health Services | 184,568 | 195,929 | 11,361 | 221,482 | 234,493 | 13,011 | 13,011 | 15,811 | 13,011 |
| Community Health Services | 186,149 | 183,895 | -2,254 | 223,362 | 221,082 | -2,280 | -2,280 | 1,220 | -2,280 |
| Continuing Care Services | 57,954 | 63,006 | 5,052 | 69,545 | 75,281 | 5,736 | 5,736 | 7,736 | 5,736 |
| Prescribing and Primary Care Services | 137,000 | 142,613 | 5,613 | 164,292 | 171,140 | 6,847 | 6,847 | 6,847 | 6,847 |
| Primary Care Co-Commissioning | 136,588 | 136,627 | 39 | 158,408 | 158,408 | 0 | 0 | 1,700 | 0 |
| Other Services | 8,786 | 8,771 | -14 | 10,542 | 10,466 | -75 | -75 | -75 | -75 |
| Reserves | -11,287 | -4,891 | 6,397 | -13,549 | -9,964 | 3,585 | 8,359 | 6,559 | 3,585 |
| **Total Programme Services** | **1,397,572** | **1,427,205** | **29,633** | **1,671,057** | **1,703,835** | **32,778** | **37,552** | **47,352** | **32,778** |
| **Running costs** | **10,614** | **9,427** | **-1,187** | **12,737** | **11,359** | **-1,378** | **-1,378** | **0** | **-1,378** |
| Leeds Place Net Expenditure | 1,408,186 | 1,436,632 | 28,446 | 1,683,794 | 1,715,194 | 31,400 | 36,174 | 47,352 | 31,400 |
| In Year - Surplus/Deficit Plan & Suspense | 1,346 | 0 | -1,346 | 1,615 | 0 | -1,615 | | | |

1.9 The formal reported position for the Leeds Place of the ICB for month 10 now corresponds to the most likely scenario across the system but includes an additional £4m efficiency to find across the Place to meet the best case scenario. Given the pressures experienced in the first 10 months of the year, the more likely position is a deficit forecast of £36.2m (a £4m improvement in our position is expected by WY but that is across the Leeds Place and options have now been identified by WYAAT) after assuming that our QIPP of £11.6m will be delivered in 23-24. Should all anticipated risks crystallise in year, the worst case scenario – despite a partial achievement £11.6m QIPP for 23-24

would be a deficit of £47.4m. The financial gap we report in March 2024 for the 24-25 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.

1.10 The first main driver of our current deterioration is the adverse variance on the LD Pool budget – see Mental Health line in the table above. Drivers of the adverse variance include:

- Numbers - increases in community referrals to the LD pool – suspect some of it is linked to COVID and higher levels of distress/behaviour etc in recent years leading to carer breakdown.

- Complexity – some of this appears to be coming from the younger end of people through transitions and through earlier breakdown of care at home.

- Price inflation – we are discussing this bit at ICE tomorrow, as Tony Meadows' view is that we should not apply uplifts uniformly across contracts and where specific packages well above 'framework' have already been negotiated, especially if this is in the last few months, there should be no expectation of any automatic uplifts 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.

1.11 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. Leeds growth has reduced to less than 7% YTD which is not out of line to national growth. Our M9 position has likely worsen at M10 by £3.9m but that is because we have been holding our forecast since M7 and still includes a risk linked to winter months. For comparison we had assumed growth levels of 4% within our financial plan.

1.12 The third driver is the spend on acute Independent Sector providers. For M10 we are showing a pressure of £7.64m over planned levels. Whilst we had initially hoped there was a potential mitigation from our agreement with LTHT to redistribute Elective Recovery Funds (ERF) monies, this is now not the case. We will see savings from non-WY providers who are underachieving and now hope to receive additional ERF monies provided nationally but this has not yet been confirmed.

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

| 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 | 238 | 179 | 60 | 60 | 0 | 952 | 1,369 | 2,321 | 774 |
| Mental Health | 0 | 0 | 0 | 3,282 | 9,729 | 0 | 0 | 0 | 0 |
| Community | 0 | 0 | 0 | 0 | 0 | 0 | (1,140) | (1,140) | 0 |
| Continuing Care Services | 0 | 0 | 0 | 0 | 0 | 0 | 2,868 | 2,868 | 0 |
| Prescribing and Primary Care | 68 | 479 | 205 | 412 | 137 | 754 | 1,780 | 2,534 | 479 |
| Primary Care Co-Commissioning | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Other | (4) | (5) | (3) | (9) | (3) | (5) | (17) | (21) | (7) |
| Programme Reserves | 436 | 601 | 268 | 1,002 | 364 | 628 | 1,956 | 2,324 | 780 |
| | **737** | **1,253** | **529** | **4,747** | **10,228** | **2,329** | **6,816** | **8,886** | **2,026** |

| 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 | 238 | 179 | 60 | 60 | 0 | 952 | 1,369 | 2,321 | 774 |
| Mental Health | 0 | 0 | 0 | 3,282 | 9,729 | 0 | 0 | 0 | 0 |
| Community | 0 | 0 | 0 | 0 | 0 | 0 | (1,140) | (1,140) | 0 |
| Continuing Care Services | 0 | 0 | 0 | 0 | 0 | 0 | 2,868 | 2,868 | 0 |
| Prescribing and Primary Care | 68 | 479 | 205 | 412 | 137 | 754 | 1,780 | 2,534 | 479 |
| Primary Care Co-Commissioning | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Other | (4) | (5) | (3) | (9) | (3) | (5) | (17) | (21) | (7) |
| Programme Reserves | 187 | 258 | 115 | 430 | 156 | 269 | 839 | 997 | 334 |
| | **489** | **910** | **376** | **4,174** | **10,020** | **1,970** | **5,699** | **7,559** | **1,581** |

1.14 Despite the good progress on 2023-24 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. EMT has introduced tighter controls cross healthcare and non-pay spend from 14th August in addition to the vacancy control processes already in Place.

1.15 The next stages for the 24-25 QIPP delivery plan are being agreed with key dates around stakeholder assurance workshops (held on 19th December); informal scrutiny board planning discussions in December and January and planned scrutiny board reporting for February 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 were reviewed and

processed prior to the introduction of the new Provider Selection Regime in January 2024.

1.16 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.

1.17 The Running Costs table is provided in 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 we await moving to the New Operating Model from April 2024.Strategic Finance Executive Group and Financial Planning

## 2. Planning for 2024-25:

2.1 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.

2.2 As part of the review, generated by the partnership Executive Group, of how we work better in partnership, a Finance Governance Workstream was created during Quarter 3 of the financial year. 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.

2.3 SFEG has jointly produced a city wide NHS Financial Plan for 2024-25 using information already to hand and supported by WY to develop a set of planning assumptions as we await the national guidance. In scope are LTHT, LCH, LYPFT and the ICB In Leeds budgets that comprise the collective delegated Place based NHS Budgets.

2.4 SFEG has collated details of new Cost pressures in 24-25 and the underlying exit position for 23-24 (adverse gap to budget) to derive opening positions for the 4 Leeds-based partners in 24-25.

2.5 An initial stretch target of 5.5% efficiency has been applied across the 4 partners as to develop plans against. Any remaining gap will be assessed against transformation and disinvestment opportunities across Leeds to assess the risks and choices to be considered as we work towards submitting a balanced plan for 24-25.

2.6 The process is replicated in other places of the ICB and consistency checking, peer to peer reviews and benchmarking work are all contributing to sense checking our assumptions across the board in the next few weeks.

2.7 The SFEG is proposing a total of 5.5% savings to be identified by all partners including against the £600m Leeds ICB spends on healthcare services outside of its large NHS partners and work is underway to identify a combination of contract reductions, spending reviews and technical reclassifications of spend (e.g. MHIS) to achieve this.

Summary of the position to date:

| | Underlying Closing Position 23-24 £m | New Cost Pressures 24-25 £m | Financial gap for 24-25 £m | Target Savings at 5.5% £m | Remaining Gap £m | Improvements in Starting Gap £m | Revised Remaining Gap £m | | MEMO ITEM Running Costs Savings in ICB Not factored in as Budgets have been reduced £m |
|---|---|---|---|---|---|---|---|---|---|
| Leeds and York Partnership NHS Foundation Trust | (7.1) | (11.7) | (18.8) | 13.5 | (5.3) | | (5.3) | | |
| Leeds Community Healthcare NHS Trust | (5.5) | (4.5) | (10.0) | 12.1 | 2.1 | | 2.1 | | |
| Leeds Teaching Hospitals NHS Trust | (40.9) | (56.9) | (97.8) | 100.4 | 2.6 | | 2.6 | | |
| Leeds ICB | (43.6) | (37.4) | (81.0) | 33.0 | (48.0) | 7.0 | (41.0) | | 4.8 |
| TOTAL | (97.1) | (110.5) | (207.6) | 159.0 | (48.6) | 7.0 | (41.6) | | |

## 3. Next Steps

3.1 The SFEG will now review Transformation and Disinvestment opportunities and their impacts as part of the next phase of the financial planning process

3.2 Planning guidance is likely to be issued as late as mid-March 2024, but some aspects of planning assumptions are starting to trickle through.

3.3 Final versions of Financial Plans are likely to be ready for submission towards the end of March.

## 4. Recommendations

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

1) Review and Comment on the month 10 position.
2) Review and Comment on the QIPP delivery for 23-24 and to discuss what further actions Leeds as an ICB and as a system will be pursuing to improve the position and ensure that we are making inroads into closing the gap recurrently from 24-25 in the process.

## 5. Appendices

1. Running Costs Update

## Appendix 1

| WY ICB - Leeds<br>Finance Report - Running Costs | 2023/24 | | | Year to Date | | | Full year | | |
|---|---|---|---|---|---|---|---|---|---|
| As at 31 January | 10 | | | | | | | | |
| 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 | 1,150 | 1,119 | -31 | 1,380 | 1,326 | -54 |
| Office of Data Analytics | 945564 | Leonardo Tantari/ Andre | 2 | 1,726 | 1,648 | -77 | 2,071 | 1,974 | -97 |
| Clinical Leadership | 945569 | Sarah Forbes | 1 | 169 | 204 | 36 | 203 | 243 | 40 |
| Primary Care Integration | 945570 | Gaynor Connor | 1 | 638 | 658 | 21 | 765 | 784 | 19 |
| Pathway Integration | 945571 | Helen Lewis | 1 | 1,231 | 1,261 | 31 | 1,477 | 1,503 | 27 |
| Insight, Communication & Involvement | 945572 | Sabrina Armstrong | 2 | 572 | 453 | -119 | 687 | 573 | -114 |
| Partner Relationship Management | 945574 | Visseh Pejhan-Sykes | 2 | 434 | 398 | -36 | 521 | 476 | -45 |
| Corporate Costs & Services | 945575 | Sabrina Armstrong | 2 | 38 | 25 | -13 | 45 | 33 | -12 |
| Corporate Governance & Risk | 945576 | Sabrina Armstrong | 2 | 170 | 147 | -23 | 204 | 174 | -30 |
| Organisation Development | 945577 | Sabrina Armstrong | 2 | 53 | 32 | -21 | 64 | 40 | -24 |
| NHS111/999 contract mgmt | 945578 | Visseh Pejhan-Sykes | 1 | 146 | 158 | 12 | 176 | 190 | 14 |
| Estates & Facilities | 945580 | Visseh Pejhan-Sykes | 2 | 351 | 270 | -80 | 421 | 374 | -47 |
| Finance | 945581 | Visseh Pejhan-Sykes | 2 | 949 | 757 | -192 | 1,139 | 906 | -233 |
| Admin Reserves | 945582 | Visseh Pejhan-Sykes | 3 | 171 | -211 | -383 | 206 | -257 | -463 |
| Equality and Diversity/HR | 945584 | Sabrina Armstrong | 2 | 71 | 60 | -11 | 85 | 72 | -13 |
| IT, IG & Digital | 945585 | Leonardo Tantari/ Andre | 2 | 373 | 305 | -69 | 448 | 373 | -75 |
| IT recharges/NHSE | 945586 | Leonardo Tantari/ Andre | 2 | 0 | -2 | -2 | 0 | -2 | -2 |
| National Data Lab Funding | 945587 | Leonardo Tantari/ Andrew Byrom | | 0 | 0 | 0 | 0 | 0 | 0 |
| Public & Patient Involvement - PPI | 945592 | Sabrina Armstrong | 2 | 107 | 4 | -103 | 129 | 20 | -109 |
| Population Health Planning | 945593 | Jenny Cooke/ Nick Grudg | 2 | 475 | 370 | -105 | 570 | 433 | -137 |
| Nursing and Quality Assurance | 945596 | Jo Harding | 1 | 590 | 620 | 30 | 708 | 735 | 27 |
| 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 | 152 | 105 | -47 | 182 | 126 | -57 |
| Investment fund | 945600 | Tim Ryley | 2 | 109 | 32 | -77 | 131 | 45 | -86 |
| Planning & Performance | 945601 | Jenny Cooke/ Nick Grudg | 1 | 48 | 52 | 4 | 57 | 63 | 5 |
| Leeds Place Committee | 945602 | Tim Ryley | 1 | 891 | 961 | 70 | 1,069 | 1,157 | 87 |
| RUNNING COSTS TOTAL | | | | 10,614 | 9,427 | - 1,187 | 12,737 | 11,359 | - 1,378 |

| | |
|---|---|
| **Meeting name:** | Leeds Committee of the West Yorkshire Integrated Care Board (ICB) |
| **Agenda item no.** | LC 79/23 |
| **Meeting date:** | 13 March 2024 |
| **Report title:** | NHS Leeds Financial Plan 2024-2025 |
| **Report presented by:** | Tim Ryley, Place Lead, ICB in Leeds |
| **Report approved by:** | ICB Executive Management Team (EMT) |
| **Report prepared by:** | Multiple authors |

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

**Previous considerations:**

Iterations of the financial plan have been considered continuously by the NHS Strategic Finance Executive Group (SFEG), and an earlier iteration of this report was considered by the Finance and Best Value Sub-Committee meeting held on 21st February 2024. Feedback provided has been incorporated into the plan presented.

**Executive summary and points for discussion:**

This report describes the current financial plan for the NHS in Leeds in 2024/25. It asks members to note the scale of the challenge, the progress to date and further reviews and other work proposed. It also describes the process of engagement and proposes the way forward for public involvement and communication.

The Committee is asked to consider next steps and approve some aspects of the plan that are being proposed.

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

☒ Improve healthcare outcomes for residents in their system

☒ Tackle inequalities in access, experience and outcomes

☒ Enhance productivity and value for money

☐ Support broader social and economic development

**Recommendation(s)**

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

1) ***Support***, in line with its delegated responsibilities, the overall approach taken to date to ensure the NHS in Leeds meets its individual and collective statutory duties to provide services within the available allocation.

2) ***Approve*** the areas where there has been some increase in funding to meet statutory duties (Section 4), The allocation of the Mental Health Investment Standard and Continued Investment in Community Mental Health Transformation (Section 5),The allocation of the Better Care and Discharge Funds (Section 5), The approach to General Practice funding and Core20Plus5 (Section 6), The small number of reviews proposed to date with a view to potentially disinvest, subject to public involvement and impact mitigation (Section 8) and The timetable for public communication and involvement (Section 10).

3) ***Note*** *and* ***consider*** the following:

What further areas to address the remaining deficit (Section 9)

The risks and approve the level of risk appetite (Section 11).

The proposal to bring back our approach to medium-term planning to the next committee (Section 12).

| **Does the report provide assurance or mitigate any of the strategic threats or significant risks on the Corporate Risk Register or Board Assurance Framework? If yes, please detail which:** |
|---|
| The report seeks to mitigate the financial risks held by Leeds Place. |
| **Appendices** |
| Appendix 1: Population Overview Impacts<br>Appendix 2: Timetable for Public Involvement |
| **Acronyms and Abbreviations explained** |
| 1. QEIA – Quality and Equality Impact Assessment<br>2. PCN – Primary Care Network<br>3. FYE - Fiscal Year End |

**What are the implications for?**

| | |
|---|---|
| **Residents and Communities** | The paper proposes the public engagement and involvement |
| **Quality and Safety** | The report notes the risks and mitigations associated with productivity challenges. |
| **Equality, Diversity and Inclusion** | Notes requirement to complete Equality Impact Assessments |
| **Finances and Use of Resources** | The Paper reports on the progress on reducing the £207m opening gap and developing a balanced plan for 2024-25. |
| **Regulation and Legal Requirements** | The NHS has to deliver its statutory duty to live within its means whilst delivering a comprehensive health service free at the point of delivery. |
| **Conflicts of Interest** | All partners are impacted by the approach |

| | |
|---|---|
| **Data Protection** | None |
| **Transformation and Innovation** | The paper describes a number of areas of work that will need to continue or others that may need development. |
| **Environmental and Climate Change** | None noted |
| **Future Decisions and Policy Making** | The report notes further action will be required and proposals to return with medium term financial planning. |
| **Citizen and Stakeholder Engagement** | The paper proposes the public engagement and involvement |

## NHS in Leeds Financial Plan for 2024-2025

## 1 Introduction

1.1 The Institute for Fiscal Studies (IFS) has noted that the NHS uplift for 2024-25 is below inflation to such a degree it equates to the largest real terms cut in spending since the 1970's. This is in a period of increased need for health services arising from ten plus years of large reductions in council spending impacting on prevention and social care, a cost-of-living crisis and associated inequality, and the long shadow of the Covid Pandemic.

1.2 In this context the NHS partners across Leeds were collectively forecasting a deficit of ***c£207m*** in their opening planning position for 2024-2025. This is based on an assumed c£2.9bn income. This paper describes the update on the work underway to close this gap and sets out a series of proposals for consideration and approval.

1.3 At this stage the NHS in Leeds, despite significant efficiencies, still has a remaining forecast deficit of **c£25m** (1% of budget) for next year. We anticipate by the 21st of March 2024 this will have reduced to nearer **£20m**. Even this has major delivery risks associated.

1.4 At the time of writing there has been no formal planning guidance issued and no date given for when this will be issued. This normally arrives prior to Christmas. However, NHS England has been circulating pieces of guidance since January and this continues, meaning ongoing adjustments.

1.5 The NHS is required to agree balanced plans for the following financial year by the end of March. The West Yorkshire ICB and each of the 10 NHS Providers in the West Yorkshire ICS have a statutory duty to agree these with NHS England. Failure to agree will result in various levels of regulatory intervention.

1.6 We were informed on the 12th of February that the ICS in West Yorkshire has to submit its first *Headline Plan* on the 29th of February. The paper before you is based on the Leeds element of that plan as of the 22nd of February. The next submission of plans will be the 21st of March.

*1.7* ***For these reasons, whilst there are a number of specific proposals the committee is asked to approve, members should note that this is not the final plan.***

## 2 Engagement in Development of the Plan

2.1 The ICB on behalf of the NHS in Leeds formally flagged to the system in early September 2023, the significant challenge that the NHS was facing in the current year and would face going into 2024-2025. A number of mechanisms were used including PEG, ICE, contract reviews, individual meetings, commissioning intentions letter and broader updates. This was on top of

ongoing concerns being raised throughout 2023-2024 and actions being taken within this year by all partners to control costs.

2.2 The Population Boards in Leeds each have a membership drawn from NHS partners, Leeds City Council, the Third Sector and General Practice. These boards have been asked to review all aspects of spending (as far as they are able) to identify both immediate cost savings and broader medium term transformation opportunities. This has been a new approach and not without challenges but has involved a wide range of parties in the conversations and is ongoing.

2.3 The information gathered through all these mechanisms, along with what national planning guidance is available and West Yorkshire assumptions, has informed the proposals to date.

2.4 Further information is set out in Section 10 on public involvement and the necessary impact assessments going forward.

## 3 Approach and outcome

3.1 NHS partners have worked together through a joint Strategic Finance Executive Group, (SFEG) which has met every other week. We agreed an underlying opening forecast for the 2024-2025 year of £207m across the NHS statutory partnership. The breakdown of this is set out in the table below.

| Organisation | Turnover £m | Revised Gap £m | Gap % |
|---|---|---|---|
| ICB in Leeds (exc Leeds NHS providers) | 600.0 | -81.0 | -13.5% |
| LCH | 219.5 | -10.0 | -4.6% |
| LTHT | 1,825.0 | -97.8 | -5.4% |
| LYPFT | 245.6 | -18.8 | -7.7% |
| **Total** | **2,890.1** | **-207.6** | **-7.2%** |

3.2 Each Chief Officer and each Finance Director have as a pair led a workstream which we have then pulled together to form an overall plan to address the gap:

- Organisational Stretch and Efficiency: Dr Sara Munro (LYPFT) and Simon Worthington (LTHT)
- Cost Pressures Management: Tim Ryley (ICB in Leeds), Bryan Machin/Andrea Osborne (LCH)
- Transformation: Sam Prince (LCH) and Visseh Pejhan-Sykes (ICB In Leeds)
- Disinvestment / Prioritisation: Dr Phil Wood (LTHT) and Dawn Hanwell (LYPFT)

3.3 Following this work the table below sets out the position as of the 22nd of February 2024.

| | Opening Position | | | | Position to Date | |
|---|---|---|---|---|---|---|
| | Turnover £m | Opening Gap as of Dec 23 | % | | Position as of 22.02 | % |
| | | | | | | |
| ICB In Leeds | 600 | -81 | -13.5 | | -20 | -3.3 |
| LCH | 219.5 | -10 | -4.6 | | -1.4 | -0.6 |
| LTHT | 1825 | -97.8 | -5.4 | | 0 | 0.0 |
| LYPFT | 245.6 | -18.8 | -7.7 | | -4 | -1.6 |
| **Total** | **2890.1** | **-207.6** | **7.2** | | **-25.4** | **-0.9** |

3.4 The Leeds Place forms part of the wider West Yorkshire ICS. The current NHS gap is about £160m across West Yorkshire, and work is underway in all places to reduce this gap further. Colleagues will note that the challenges are not unique to Leeds and also the effectiveness of the Leeds Health & Care Partnership in addressing our challenge collectively.

3.5 The rest of the paper will describe in more detail, how we are proposing to close our opening gap, and will make some specific recommendations.

3.6 In undertaking this work we have remained mindful not only of the immediate risks to safety, quality, and performance of services but to the medium-term ambitions for prevention and reducing inequalities, recognising that the NHS cannot address these latter issues alone.

3.7 We have also considered the risks to smaller organisations that make an essential and invaluable contribution, but are not statutory partners, namely General Practice and the Third Sector. The risks across all these areas are extremely difficult to fully mitigate in the current context.

3.8 In doing this we have taken an approach that looks to minimise the impact on the public with a strong emphasis on waste reduction, productivity, and cost control, ensuring we meet our statutory duties and delivery of services in the most efficient manner possible. This reduces spend with minimal loss of service. We then consider the benefit of joint transformation programmes, before finally looking at those areas which do impact the public either where we have had to not address known demands or where we are reviewing services with a view to disinvesting or reducing the level of service commissioned.

3.9 In summary, our approach is to work down this list:

- Meeting our statutory duties efficiently through waste reduction, cost control and productivity,
- The contribution of transformation,
- Not addressing known pressures, and

- Reduction in funding and decommissioning

## 4. Meeting our Statutory Duties Efficiently

4.1 The public rightly expect the NHS, as its first priority, to deliver good quality and safe services. Therefore, in looking at the proposals with our NHS partners in Leeds and other partners, whilst agreeing a significant efficiency requirement, (See Section 7 below) we have sought to ensure that we can continue to deliver non-discretionary core services safely and meet national requirements including reducing elective waiting times, improving A&E and cancer treatment waiting times along with requirements to improve community mental health services and primary care access. These are core non-discretionary expectations and NHS priorities.

4.2 There are a number of areas where we identified significant cost pressures through a combination of inflationary price increases and escalating demand. We have worked hard with partners in Leeds City Council, our local NHS organisations, and others to minimise the scale of these pressures whilst still meeting our statutory obligations.

4.3 The committee will be aware that Local Councils are under significant pressure, and this is driven by increasing costs of high-cost individualised packages of care, particularly for children but also adults. It is important that members of the committee are aware that similar pressures in terms of demand and cost are having to be met by the NHS as its statutory duty to provide personalised individual packages of care. Like the councils, this is now playing through in the underlying financial position.

4.4 ***The Committee is asked to note and approve*** the following areas where the financial plan for 2024-2025 has an increased allocation to meet these duties as described below.

4.5 ***Learning Disability:*** There is significant further growth in our spend for support to people with a Learning Disability linked to increased costs from providers and increased complexity, together with our continued commitment to minimise time in hospital for this cohort in line with national policy directives. Working with colleagues in Leeds City Council we have improved forecasting, planned for increased reviews, and identified other efficiencies thereby forecasting to deliver our legal responsibilities for an additional £5.4m rather than opening projections of c£8m. (**NB** Later proposal to further control costs Section 9.3)

4.6 ***Children and Young People:*** The increase in the needs and numbers of Children and Young people, especially those who are the most vulnerable including Looked After Children continues to present a considerable challenge. The NHS in Leeds is in the process of finalising an agreement with Leeds City Council to increase our contribution in these areas. The increase in spending on children is proposed to be c£3m of which £1.9m above this year's budget has been set aside for complex packages of care.

4.7 ***Continuing Health Care and Funded Nursing Care*:** We see increased costs of provision as well as increased demand year on year which we are seeking to mitigate wherever possible. Again, working with Leeds City Council Colleagues, we have set aside a funding increase of c£5.8m with about c£2.2m of efficiency built in.

*4.8* ***Weight Management:*** The NHS provides treatment for a number of people with obesity for whom less interventionist approaches have not worked. Since Leeds City councils' removal of Tier 1 and Tier 2 services, the NHS Tier 3 services have been overwhelmed with a very significant waiting list. Whilst we continue to treat individuals, we have had to close the list. We have made a small amount of funding available next year, c£500k, to continue to address the waiting list and to introduce Wegovy, a medical treatment, to those most in need. This is not at the scale that we would ideally want to invest (c£2.5m), given the long-term implications, but we are hopeful this should enable us to re-open the list in due course and introduce Wegovy to those who will most benefit. The benefits will fall mostly in our Core20plus5 most deprived populations.

4.9 ***Prescribing*:** The NHS Prescribing Budget is one of the most significant budgets, with a forecast spend in Leeds of c£148m in this financial year. We have planned for an underlying 5% increase in this budget in line with previous years and then applied a very high 5.5% efficiency of £9m to the uplifted position. This will be delivered through 35 plus individual schemes from waste reduction and ensuring appropriate use of off-patent medications through to stopping the prescribing of Gluten Free foods in line with the West Yorkshire policy.

## 5 Mental Health Investment Standard and Better Care Fund

5.1 ***The Committee are asked to approve*** the allocation of the Better Care Fund (BCF, Discharge Fund and Mental Health Investment Standard (MHIS)), and to approve the continued funding of the Community Mental Health Transformation programme.

5.2 ***BCF and Discharge Fund:*** The NHS is required to increase the Better Care Fund (BCF) each year. The BCF is a joint funding pool with the Local Authority. There is a Leeds City Council and an NHS element. We have also had additional Discharge Funding. The NHS is required to and has passed through as required £1.08m to Leeds City Council which forms part of the LCC proposals to support Adults and Health.

5.3 The NHS proportion is described in the table below and has generally been deployed as with other funds to ***protect existing pre-commitments and address cost pressures*** in the system. We have met a previous commitment to Leeds Community Health for community capacity offsetting a reduction in ad-hoc spot purchasing of beds in line with Home First.

5.4 We have included an allocation for digital to support integration given the challenges in multiple parts of the system to support integration including with third sector partners.

| Title | £m |
|---|---|
| Additional Community Capacity LCH | 1.5 |
| Falls Pick up Service (LCC) | 0.2 |
| Age UK Home Comfort | 0.3 |
| Capacity to support transformation (discharge/out of area) | 0.3 |
| Social workers to support Intermediate Care | 0.3 |
| **Total - Additional Discharge funding received 24/25** | **2.6** |

| Title | £m |
|---|---|
| Digital Virtual Ward | 0.4 |
| Enhanced Community Response | 0.4 |
| CCB Pharmacists | 0.3 |
| Joint Commissioning Posts | 0.1 |
| Newton Europe | 0.8 |
| Integrated Digital Systems | 0.8 |
| Passed through LCC as per requirement | 1.1 |
| **Total required uplift to BCF (no additional allocation)** | **3.9** |

5.5 ***Mental Health***: There have been growing demands for mental health mainstream services and specialist packages of care. Nationally, the NHS sets a requirement to increase spending on Mental Health (The Mental Health Investment Standard (MHIS)). The proposed budget delivers this requirement of an increase of £7.1m. Most of this will be addressing the growth in numbers and complexity of individual care packages and contribute towards addressing high levels of acute bed occupancy and out-of-area placements. There is a further £0.3m allocated from the discharge fund to support this aspect as well. The table below sets this out in more detail.

| Title | £m |
|---|---|
| Increased spend on occupancy growth | 1.7 |
| Section 117 tariff and growth | 2.5 |
| Section 117 FYE | 1.7 |
| Mental Health CHC | 0.7 |
| Mental Health Related Prescribing | 0.5 |
| **Total** | **7.1** |

5.6 In addition, the NHS has already invested £4.8m in community mental health services and we are in the middle of a major transformation programme which includes not just statutory providers but also many third sector partners. The proposed financial plan protects this investment and increases it to the originally planned £5.1m.

## 6 General Practice and Core20Plus5

***The committee are asked to approve*** the proposed approach to the funding of General Practice and Core20Plus5:

6.1 Access to General Practice remains critical to the public and is of significant importance in addressing long-term health need, prevention, and inequality It has been the bedrock of the NHS since its inception. General Practice budgets have proportionately seen the lowest growth over the last five years of any sector in receipt of NHS funding. At the same time, they have seen sustained growth in demand and delivered increased activity.

6.2 There is a 3.2% increase in allocation for Primary Care, however GP contracts are only being increased by 2%, with the remainder being directed at PCN level. There is considerable concern, not just among GPs, given the rise in demand and the access expectations this will have a major impact on viability of general practice with immediate consequences.

6.3 In Leeds, in line with most places in England, we have over a number of years funded additional discretionary spend. The West Yorkshire planning assumption for this aspect has been a 2% uplift with a 1.2% efficiency factor meaning a 0.8% increase on this aspect of funding.

6.4 However, given the importance of health inequality and the major contribution General Practice makes to the Core20Plus5 ambition, and the contribution to viability that this more discretionary element makes it is proposed that in Leeds we pass through the full 2% to this aspect of primary care funding (£335k) but with a deliberate and specific focus on inequality as set out in Core20Plus5.

6.5 It should be noted that this is still a further productivity ask for general practice, and we are committed to minimising the bureaucracy associated and are proportionally reducing the ask associated with local schemes.

6.6 Much of this discretionary funding currently goes through a local Quality Improvement Scheme and few similar enhanced service type models. We are streamlining these as part of the reduction in administrative burden. At the same time, we are looking to repurpose this funding to strengthen the focus on inequality and earlier identification of disease in line with the Health & Wellbeing Strategy and the Healthy Leeds Plan. This will also contribute to us meeting our duties under the Core20Plus5 expectations.

6.7 The NHS requires that ICB's can demonstrate that a specific proportion of their core allocation is being used to address health inequalities. This is not additional funding, but rather seeking to ensure that the NHS does not lose sight of its duties in respect to health inequality. The framework used is called Core20PLUS5. In Leeds the minimum spend on this is to be £3.9m.

6.8 The framework identifies the 20% living in the most deprived communities plus 5 groups of the population (to be locally determined) that face particular issues of inequality of health outcome; for example, people living with an SMI or Young Black men, or the Gypsy Community. Within these cohorts the approach then identifies '5' focus ***clinical areas*** requiring accelerated improvement.

6.9 Leeds has a long history of investing in areas such as these. It is proposed that in the year ahead we review the overall approach in Leeds and identify all the funding that supports addressing inequality as defined. In the meantime, we propose delivery of the core expectation through the approach to General Practice funding set out here, plus the Weight Management and relevant aspects of the Children's investment described above and protecting a few key areas of discretionary spend. This is set out in the table below.

| **Core20Plus5** | **£** |
|---|---|
| GP Improvement Scheme (26%) | 2,381,000 |
| Weight Management | 328,000 |
| Children (Trauma, MH) | 585,000 |
| Increase in Translation Services | 322,000 |
| Protect Black Young Minds | 79,000 |
| Cancer Screening | 75,000 |
| Assorted | 130,000 |
| | **3,900,000** |

6.10 However, to sufficiently address the opening position and protect these and other core NHS Health services as described we are having to look very hard at other areas of both what we do and how we do things.

## 6 Waste Reduction, Efficiency and Cost Control

6.1 Each of the three NHS providers has committed to finding at least 5.5% of their contract value in efficiencies and waste reduction and to absorb known pressures. This is not through the decommissioning of services, but through things such as reducing agency spend, reducing administrative spend, reducing length of stay/out of area placements and redesign of how specific services are delivered within their organisation.

6.2 The Boards of each NHS provider are required to assure themselves, through their nursing and medical directors, that in reducing waste in these ways they are not making services unsafe. The quality sub-committee will seek the necessary assurance on behalf of the committee.

6.3 By working as a partnership, we are also looking to ensure, both between health care organisations and with Leeds City Council, that we are not shunting costs between providers through the decisions we make as individual organisations. The Strategic Finance Executive Group (SFEG) and Integrated Commissioning Executive Group (ICE) play an important role in this.

6.4 In asking NHS providers for at least 5.5% efficiency there was a recognition that given underlying and less visible cost pressures in other smaller providers including the Third Sector we were not in a position to ask for this level of efficiency. In general, therefore, except perhaps where a single person is employed for example or where there were prior reductions, we have applied a 3% reduction to contract values and grants. Given the overall opening gap in the health system of 7.2% and the 13.5% gap in the ICB element, and the discretionary nature of many of these arrangements, whilst far from ideal we believe this to be proportionate. We will continue to work with colleagues and fully understand that this may at times require an adjustment to the level of service offer.

6.5 In total these efficiency and waste reduction efforts have contributed £133m as set out in the table below.

| | **£,000's** | As % of Turnover |
|---|---|---|
| Leeds Teaching Hospitals Trust | -104,000 | 5.50% |
| Leeds and York Partnership Foundation Trust | -14,000 | 5.30% |
| Leeds Communinty Health Trust | -13,000 | 6.60% |
| Harrogate Foundation Trust | -1,500 | N/A |
| Third Sector* | -325 | 1.5-3% |
| **Total** | **-132,825** | |

## 7 Transformation

7.1 When using the word transformation in this paper we are describing fundamental redesign of services over and beyond changes to internal organisational processes. We are also describing changes that are at the very least maintaining existing safety and quality standards whilst reducing the cost to the system. Ideally, they improve outcomes, quality, and financial position.

7.2 The major transformation piece of work in the city currently running across Health and Care, is the Home First Intermediate Care redesign programme. There are in order of c£20m of benefits planned across Health and Social Care next year. These are already captured in the Leeds City Council Plans, the Leeds Teaching Hospital Plans (above) and within the ICB are anticipated to contribute to a c£4m financial benefit in 2024-2025.

7.3 One of the most significant cost pressures in the Leeds system is in Out of Area Placements for adult mental health patients and alongside the closely associated rise in expensive Section117 packages of care in the community.

This is also providing poor experience and less good outcomes for individuals and their families. The causes are multifactorial.

7.4 This is an area which we have agreed we need to address as a priority, and we are putting in place a joint programme of work in a similar vein to Home First. Our ambition in this financial year is to deliver c£7m benefit as well as significant improvements in care. The MHIS and BCF above have funding set aside to deliver these changes and the benefit is built into the LYPFT efficiency plans above.

7.5 We have identified a number of other areas that will contribute savings in the medium term, and which will contribute to revised medium term financial plans in a similar way to Home First, but at this stage these benefits are not included in the proposed financial plans for next year.

## 8 Service Reviews and Reduced Spending

8.1 The effort to date has been focussed on reducing the need to cut services by looking hard at efficiencies and controlling costs. However, we will need to go further, and set out below are a number of areas that it is proposed to review and which in-year we anticipate would collectively deliver £1.35m plus the £3m lack of investment in neurodiversity pathways (Section 8.5).

8.2 All of these will through the review process be subject to public involvement and impact assessments as set out in Section 10.

8.3 ***The committee are asked to approve*** the following proposals subject to appropriate public involvement and appropriate mitigation.

8.4 There are a number of areas that members will be aware of where there are pressures on services which result in excessive waiting times or even closed access to lists.

8.5 The main area where we have not set aside sufficient additional provision is in *Neurodiversity (including autism and ADHD).* There are significant waiting times for diagnosis for both adults and children. We have set aside a small additional amount to address potential risk of increasing numbers of people seeking private access, but this is not sufficient to address the backlogs. We estimate this would cost c£3m and it is doubtful we could recruit the workforce. However, there is both national and regional work underway to look at a completely different model to support earlier diagnosis which we are anticipating this coming year. Therefore, we believe it is prudent to not invest in an existing model until these reviews are complete.

8.6 The Community Ambulatory Paediatric Service (CAPS) was commissioned as a pilot with non-recurrent funding as a service for Children with Asthma. This has met a real need. We have not identified recurrent funding and will need to review how aspects of this service might be absorbed into other existing ambulatory services.

8.7 The Community Urgent Eye Service (CUES) was commissioned during Covid. The new Pharmacy First national model covers some aspects of the service, and some aspects of the service are not provided in other areas. However, there are a few conditions where we believe there is a remaining need for a service. We are therefore undertaking a review and are in conversations with the providers to develop a lower cost more targeted replacement from July.

8.8 We commission Linking Leeds to provide Social Prescribing. The contract ends in August, and we are currently reviewing the model with the providers. Given we are reviewing the end of the first contract for such a model we anticipate that the review will realise 10-15% efficiency without a significant reduction in the total service offer.

8.9 There is currently a review of Equipment Services underway across the city. As part of this we are undertaking a service review and quality impact assessment is planned in the first quarter of 2024-25 of the William Merritt specialist advice service for equipment and driving assessments to consider options.

8.10 We are proposing to provide bereavement support through an online portal which will ensure equity with the approach across West Yorkshire and in doing so will decommission Cruse Bereavements face-to-face provision.

8.11 We are also working with city partners to review all the joint funded programmes of work. This includes the Health Partnership Team, The Leeds Academic Health Partnership, The Leeds Workforce Academy, and The Leeds Care Partnership (LCP) team.

8.12 The ICB and Leeds City Council fund the core Forum Central contract, and this will continue. We will need to review the existing commitment to underwrite additional funding beyond September.

## 9 Further Reductions

9.1 The Committee are advised to ***note that these plans will still leave us with a c£20m deficit*** and thus ***not compliant with our statutory duties*** as the NHS in Leeds. Clearly given the ongoing conversations with treasury this position could change. We are therefore highly likely to need to find additional service reductions whilst of course continuing to review our efficiencies and cost control mechanisms.

9.2 ***The Committee are asked to consider the following:***

9.3 There is a national policy that individuals with significant neurodiverse needs should be moved back from specialist out of area services to the community and closer to family. This is entirely appropriate. However, at no point has NHS England made funding provision for the increased costs to the local NHS (and City council) of this policy direction. In the next year the costs of the

***known planned*** discharges are forecast to be c£1.7m. At the moment this is reflected in our deficit position. We could refuse to arrange the discharge without some form of parachute payment or similar in which case our forecast position might improve by a further £1.75m.

9.4 There are four broad areas where colleagues could look to make additional reductions and the committee are asked to consider the appropriate balance.

- Further increase the efficiency ask of NHS providers which could potentially impact on the quality of services and for example waiting times.
- Actively reduce services deemed discretionary which would have a further significant impact on smaller providers, potentially general practice and third sector viability as well as prevention, early identification, and inequalities.
- Decommission or significantly reduce whole areas of service provision which in reality would drive additional pressures into alternate areas or further increase waiting times.

## 10 Public Involvement and Communication.

10.1 We take seriously the duty we have to involve the public in service changes. We also need to ensure that we effectively communicate these changes.

10.2 ***The Committee is asked to note and approve*** the approach set out below.

10.3 Whilst there are only a small number of schemes that will result in a material cut to services, it is important that we effectively assess the impact on the people of Leeds. Therefore, we will initially be focusing on identifying the schemes that have the potential for the highest impact, particularly to those facing the greatest health inequalities. QEIAs are being completed for each scheme and overarching population. QEIAs are also being completed to give us as high-level view and to help us to identify where a particular group or groups of people may be more adversely affected by a number of schemes being put into action. EIAs will also be undertaken for those schemes where it is deemed necessary:

10.4 Schemes may be rated more high risk if they:

- have the highest impact on communities facing the greatest health inequalities,
- impact on a large number of people, mean a significant change to the way services are being provided,
- mean a significant change to the range of service that are being provided,
- have a high risk of controversy with partners and the public.

10.5 A summary of the schemes is included in Section 8 above.

10.6 Following the meeting we will begin to communicate at a high level to the public about the scale of the challenge facing us. Due to the pre-election period restrictions, proactive communications will need to finish before 26th of March.

10.7 We are not planning to begin direct involvement with the public until the pre-election period ends after the local elections at the beginning of May. We will use the time in between to continue to involve and communicate with our partner and provider organisations, including primary care, to understand the impact of the schemes on the people of Leeds, from their perspective, and to understand the impact the schemes will have on the organisations who provide health and care across the city.

10.8 We will also use this time to identify the insight we have already collected from people regarding the services affected by the schemes and undertake a gap analysis of our understanding. Many discussions regarding the schemes have already taken place using insight previously collected and in discussion with service providers who understand the potential impact on the people of Leeds.

10.9 We need to be very clear with this involvement about the level of influence people have on the decisions being made and the purpose of any involvement we have with the public. It is envisaged that the purpose of most of the involvement will be to understand, in more detail, the impact of the schemes and any mitigation that can be put in place to reduce that impact. Although, we will take seriously our obligation to review and understand this impact, particularly at a population level and for those groups facing the greatest health inequalities, and we will make changes to the schemes if necessary.

10.10 QEIAs and EIAs will continue to be updated throughout this Involvement and review period and these will be reviewed by the Quality and Delivery subcommittees.

10.11 We will seek assurance on our overall approach by running the second of our assurance workshops with public representatives and by running the approach past the Consultation Institute for feedback. This work will take place in March/April.

## 11 Risks

11.1 Comparison of Leeds progress with the levels of ambition across West Yorkshire as a whole underscores that there is considerable delivery risk across all our partners. Many of the internal efficiency schemes will require considerable attention throughout the year.

11.2 In addition, the current uncertainty regarding the planning guidance has led to a number of assumptions being made to achieve these ambitious

reductions. Small changes in planning guidance rules could move the position by millions in either direction. At this stage this is one factor in us holding a 1% deficit rather than taking further and more difficult decisions that could be reversed.

11.3 There is a risk that reductions will negatively impact on our plans to address health inequality and improve the quality and access to services for the people of Leeds. By focussing on efficiency rather than reductions, and by refocusing for example the GP Improvement Schemes we are trying to mitigate this.

11.4 There is a significant risk on third sector and smaller organisations that some of the existing proposals will be very difficult to absorb and that this is compounding other income challenges with knock on implications for example to recruitment and retain staff.

11.5 We have not made any provision for the expected change in practice in ADHD independent providers which is likely to increase the charges to the ICB for prescribing pathways (currently these providers do assessment only rather than also medication and shared care). We are working on a plan to mitigate this spend, but the cheaper option also does not have budget allocated at this stage.

11.6 We have allowed for £1.9m of growth in complex children's services, expecting most of this to flow to LCC for placements or for joint funded posts. We have also put in some provision for staff to support our other obligations around EHCP and CHC assessment and oversight and other statutory work. This may not be sufficient, depending on the results of ongoing audit work, increases in demand via EHCP and CHC and other pressures from individual young people whose needs cannot be met from within our joint core service offers.

11.7 No global uplift has been made to LYPFT or LCH equivalent to the uplift flowing to the Acute and Ambulance sector (0.6% in line with guidance). However, we are proposing targeted additional investments from MHIS and from BCF growth assumptions.

11.8 Prescribing costs have been volatile in 2023-24 so the outturn position remains unclear. We have assumed growth of 5% (down from initial assessments of 10%) for 2024/25. We are confident that a 5.5% efficiency (£9m) can be achieved on current assumptions although that may need to be reviewed once the final 2023-24 outturn is known.

11.9 The Plan does not yet include any further impacts on demand or occupancy due to pressures in LCC finances, but this represents a significant risk in coming months to system flow and therefore to our ability to flex capacity and maintain safety.

11.10 We are assuming that Strategic Development Funding will flow at least at the value in 2023-24 unless previously signalled as coming to an end.

11.11 Failure to make further progress to reducing the deficit increases the likelihood of external challenge and intervention.

## *12* Summary and Next Steps

*12.1* ***The committee are asked to note:***

12.2 The NHS in Leeds faces a considerable financial challenge next year and whilst good progress has been made towards delivering a balanced position this has not been without implications for the public. The focus of our effort to date has been minimising these as far as possible through efficiency, productivity, and transformation. However, there remains further work to do.

12.3 We continue to engage with and work alongside all our partners and local communities. And where we are required to will consult with the public.

12.4 Where any decommissioning or material reductions in services are proposed we will not only consult but are developing Equality and Quality impact assessments.

12.5 Over the next few weeks, we will continue to identify further options for reducing the deficit and manage emerging risks.

12.6 The timetable we are working to is:

- 13th of March Leeds Committee of the ICB
- 15th of March Public Communication as required and public involvement following local elections in May.
- 21st of March Final Detailed Planning submission to NHS England

12.7 At the next meeting of the Leeds Committee of the ICB in May 2024we will bring back an update and also our approach to medium term planning which we have just commenced working through.

## 13 Recommendations

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

1) ***Support***, in line with its delegated responsibilities, the overall approach taken to date to ensure the NHS in Leeds meets its individual and collective statutory duties to provide services within the available allocation.

2) ***Approve*** the areas where there has been some increase in funding to meet statutory duties (Section 4), The allocation of the Mental Health Investment Standard and Continued Investment in Community Mental Health Transformation (Section 5),The allocation of the Better Care and Discharge Funds (Section 5), The approach to General Practice funding and Core20Plus5 (Section 6), The small number of reviews proposed to date with a view to

potentially disinvest, subject to public involvement and impact mitigation (Section 8) and The timetable for public communication and involvement (Section 10).

***3) Note and consider*** the following:

What further areas to address the remaining deficit (Section 9)

The risks and approve the level of risk appetite (Section 11).

The proposal to bring back our approach to medium-term planning to the next committee (Section 12)

# Appendix 1: Population Level Review

Whilst in some cases not improving the service offer, the efficiencies described above do not generally reduce the NHS service offer. However, given the scale of the challenge there have been a number of changes in 2023-4 which will deliver a full year benefit/impact in 2024-5 and further proposed changes in 2024-5 where there are proposed reductions. Many of these are small in scope but, as described in Section 2, it is important we understand the cumulative effect of these. Therefore, below we look at each of these through a population lens.

The Leeds Health and Care Partnership segments its population into a variety of subpopulations, whose needs are overseen by Population Boards representing key system partners. We also have cross-cutting Boards for Planned Care, Same Day Response and Primary Care, and a major work plan for Medicines Optimisation and Prescribing, whose services overlap with some key populations, but also cover many medicines that are used by people across populations. We have provided a summary of the types of demand management, productivity, cost and spend reduction and disinvestment we are proposing for each of these population and care areas. We continue to risk assess these, alongside proposals from other providers, by population to ensure that we have not inadvertently created too much risk or harm by a series of individual decisions.

## Children's and Young People

The Children's and Young People's population is very significant in terms of the numbers of people and the wide range of service areas covered. Service improvements/efficiencies within NHS Trusts will be identified separately in those organisations and subject to appropriate risk assessments.

The key areas for redesign and demand management relate to the significant financial and patient experience risks related to neurodiversity. Colleagues will be aware of huge increases in demand for assessments for autism and ADHD and very significant waiting lists. There is both a WY and local piece of work on this. The WY work is aimed at creating a standard specification for non-NHS providers working in this area to ensure quality standards and a clear expectation of how these services will work with other providers. We are also looking to see if we can improve our clinical pathways to create more capacity and fewer waits for children and their families and more access to support and help. This redesign work will help us to mitigate the risks and improve outcomes. We are planning to continue with improvements on system flow for children, and in particular the children's virtual wards, which have helped to reduce time in hospital for children and their families.

There are a number of prescribing schemes that relate particularly to children (eg melatonin and baby milk formula) that are also part of our savings plans to ensure we prescribe optimally.

**3% reductions in VCSE spend.** We have asked our VCSE providers in all populations to take a 3% cost improvement and wherever possible to absorb this via productivity improvements. We are aware across all our service areas that this is against a backdrop of reduced VCSE income from fundraising and significant cost pressures linked to the Cost of Living.

**Service remodelling/contract reduction**. We are in the mobilisation phase for a new Community Emotional Mental Health provision, which has been procured within a lower envelope than the 3 previous existing providers. We are also reducing our spend on our Mental Health communications offer for Children and Young People, while maintaining the high quality and user led design that is so important

**Reduction in Contract Value >3%.** In addition to these schemes, we are looking at overlaps between some of our offers, and in particular around the crisis helpline offers where there is an overlap in timings between a Leeds facing and a WY offer already provided by a Leeds provider. We are also planning for a non-recurrent benefit due to a delay in starting some of the work planned in partnership with LCC and Early help, while we review the most cost-effective solutions and recruit to the revised service model. We are also flagging later in this paper the impact of the inability for us to continue to fund a non-recurrently funded Community Ambulatory Paediatric Service.

| Scheme Name | Scheme Description |
|---|---|
| Teen Connect | Reduction in duplication in cross over of crisis helpline opening times for 11–18year-olds. No reduction in service. Savings on costs of running two services at the same time. |
| Trauma budget | Anticipated non-recurrent slippage against a range of projects to support children with complex needs, based on likely recruitment timescales informed by uptake in previous years. Natural delays, not withholding services or stopping projects. |

## Healthy

This population covers people who are 'mostly healthy' and also oversees the needs of vulnerable groups within the City who are most at risk of health inequalities. We are not proposing any significant further demand management or cost reduction schemes, other than in relation to our city-wide social prescribing offer where the contract is due to end this year and we were already looking at the potential for improved productivity or greater targeting. (The vast majority of healthcare utilisation for these groups sits within our statutory providers and savings/productivity would be within their programmes).

**Service Redesign/disinvestment more than 3%**

| Scheme Name | Scheme Description |
|---|---|
| Review of Social Prescribing Contracts and change of model from 24/5 | Social Prescribing Contract Ends Aug 24 Use opportunity to update model and review cost envelope in light of the many system changes since the previous service spec was developed and seek greater targeting and productivity. Steering group convened, evaluation nearing dissemination, and service model redesign in hand. Support for step change from referral based model to cohort list / Staten Island type approach. |

## Cancer

Most of the work on Cancer in Leeds is led by the Cancer Alliance, a WY wide Alliance which has a very strict set of projects and targets defined for it by NHS England. Virtually all of the spend is within LTHT, so the projects identified to reduce costs sit within their waste reduction programme. (This includes projects such as improving the quality of photographs for people with skin cancer to reduce waste, and changes to follow up pathways to make them more cost-effective.)

People with Cancer are also often frail, use planned, intermediate and same day response services so are impacted upon by changes in those areas also.

Disinvestment/spend reduction. The main changes in service are that 24/25 sees a part year effect of non-recurrent funding on a Community Cancer Support Service which had support from Macmillan in previous years. Their funding has come to an end, and we have therefore ceased our spend in parallel. We have also proposed a small £25k cut in a small scheme to improve cancer screening in some targeted populations with low uptake rate. The current project is quite administratively complex, and we are looking at a similar scheme which still retains the same impact. This will be subject to a QEIA of the revised model.

**Disinvestment more than 3%**

| Scheme Name | Scheme Description |
|---|---|
| Primary Care Cancer Screening Champions | Review the current small scheme addressing low uptake on screening in practices with high levels of deprivation to consider ways of delivering this in a more cost effective model (at 25% less cost) |

## Long Term Conditions

This is a very diverse population, with the majority of healthcare utilisation in NHS Trusts, primary care and prescribing. There are overlapping services with frailty (Intermediate Care) which are shown in that section above. Most of the work of the ICB is in supporting partners in demand and cost reduction, as in facilitating improvements in our stroke pathways, reviewing our anti-coagulation pathways and in improved medication management for key conditions.

In line with a levelling off of demand for our Long Covid service, and a detailed service review of our model, we have also reduced our spend on our Long Covid model so that it is now within our allocation for this service. We continue to look at service improvements in this area and will be working on this further in 24/25 recognising there are commonalities with some other conditions and we may be able to provide an improved offer for people with other conditions using the learning from our excellent Long Covid model.

Most of the other savings work related to this population is within our significant (£9m overall) prescribing savings target or relates to Intermediate Care and is described below.

**Potential Contract Value Reduction >3%**

| Scheme Name | Scheme Description |
|---|---|
| William Merritt Disabled Living Centre | Risk assessment of the impact of fully removing NHS funding from this specialist advice service for equipment and driving assessments and whether this would simply shift demand to other service areas – linked to wider review our equipment provision as a Partnership |

## Frailty

The frailty population board also covers our work on Intermediate Care and on Continuing Healthcare although there is a crosscut with long-term conditions and End of Life populations in these areas.

A key area for cost reduction relates to our work on continuing care policies, and processes. We are looking at our local practice in line with other areas of West Yorkshire to review entitlements to full NHS funding and some additional allocations that were made historically but are not directly related to health needs. We are also improving our processes, with pre-payment cards that help patients and their families manage their Direct Payments, reduce running and audit costs, and allow more rapid changes in packages. We are also closely reviewing our expenditure on complex packages in care homes to see if we can better use technology instead of 1:1 care which is hard for care homes to provide and costly to fund. We are working closely with LCC around the uplifts for care homes and home care to ensure a fair payment to providers that is also affordable to the health and care system.

In terms of prescribing, we continue to work on the cost effectiveness of wound care and wound dressings, to reduce waste and streamline what is provided.

The other main area of cost reduction is around a reduction in NHS spend on home care and on temporary care home beds. Due to a significant investment in a transformation programme, we have increased the numbers of people able to go home with support and have more effective use of our existing service offers from LCC and LCH, and of our community care bed providers. We have therefore, further reduced our spend on 'spot' purchase beds and have reduced reliance on additional home care hours we had needed previously to support our neighbourhood nursing teams. In 24/25 given the improvements in length of stay in our community care beds, we will reduce by a further 30 beds, but have plans in place to mitigate in case there are spikes in demand or our improvement in length of stay does not remain at the expected level.

**3% reductions in VCSE spend.** We have asked our VCSE providers in all populations to take a 3% cost improvement and wherever possible to absorb this via productivity improvements. We are aware across all our service areas that this is against a backdrop of reduced VCSE income from fundraising and significant cost pressures linked to the Cost of Living.

**Potential Reduction in service offer.** We are currently risk assessing giving notice altogether to two small contracts, both of which relate to previous non-recurrent pots of money that have become recurrent and where the offer is not City-wide. These are currently subject to Quality and Equality Impact Assessments and would require 6 months' notice.

| Scheme Name | Scheme Description |
|---|---|
| Service review of Circles of Support (Mae Care) | Service review and quality impact assessment of potential decommissioning of standalone dementia project and incorporation of some elements into wider contract offer (only in one Neighbourhood network – looking to incorporate into wider offers.) |
| Service review of Touchstone BME dementia project | Service review and quality impact assessment of potential decommissioning of standalone dementia project and incorporation of Learning into mainstream dementia service offers across the city. (very small service working with very small numbers of people) |

**Contract Value Reduction >3%**

| Scheme Name | Scheme Description |
|---|---|
| Neighbourhood Team top up funding | Removing NHS additional funded hours provided during the last two years to top up neighbourhood team capacity, to support while patients transition to long term care (replaced by further investment in LCH community services, FYE of a previous investment decision) |

| | |
|---|---|
| Closure of 30 Community Care Beds | Closure of 30 community care beds, mitigated by the significant improvement in length of stay driven by the Home First Programme |

## End of Life

During 23/24 we carried out some work with our LCH partners to see if we could improve the way in which we provided night services to people at the end of life from within our NHS provider with less use of agency home care. This has been very successful in terms of quality and cost reduction and is contributing to our cost savings in 24/25 as it started part year.

During 23/24 we carried out some work with our LCH partners to see if we could improve the way in which we provided night services to people at the end of life from within our NHS provider with less use of agency home care. This has been very successful in terms of quality and cost reduction and is contributing to our cost savings in 24/25 as it started part year.

The end of life population also oversees our bereavement support offer. Sadly, Leeds Bereavement Forum decided it was not financially viable to continue as an organisation from April 24, so our (small) spend on that service will come to an end. We are proposing an option to reduce our access to a face to face counselling offer provided by CRUSE bereavement support, but this will still allow access for phone counselling provided as a national offer in line with the other parts of the WY ICB. We are looking at a very small saving around a designated Dying Matters campaign which we feel we could do in other ways, and are in discussion with our Palliative Care Network about a reduction in their funding. (This organisation provides a range of functions around education and service improvement for Palliative Care in Leeds, which is additional to the core offer of our hospice and NHS Trusts in direct care delivery.)

We are also proposing a further 1% reduction in our hospice contracts, which represents a 3% reduction over the last two years, as no uplift was paid in 23/4 or 24/5, and there was a 1% reduction in 23/24. Leeds remains at the high end of funding for hospice services, but we recognise that this is against a growing difficulty in fundraising in this sector and a growth in costs.

### Reduction in service offer

| Scheme Name | Scheme Description |
|---|---|
| Leeds Bereavement Forum service reviews | LBF is closing therefore contract will not be renewed. |

| | |
|---|---|
| Review continuation of CRUSE contract | Leeds commissions an enhanced local offer that gives 6 weeks face to face counselling . Alternative is a national offer by phone/on line but would provide savings |

**Contract Value reduction >3%**

| Scheme Name | Scheme Description |
|---|---|
| Palliative Care Network | Reduction in 15%. leadership and support for palliative care in Leeds |
| Dying Matters | Cut funding for an annual campaign (via LCC) £5k |

**Learning Disability and Neurodiversity**

The Learning Disability services in Leeds are overseen by a Joint Commissioning team with LCC. The work on cost reduction includes a review of day services and of individual packages, to ensure that they all remain appropriate to the needs of the client. We are also looking at cost efficiencies of the day services and total packages. The QEIA and tracking of these schemes is with LCC as the Lead commissioner. The NHS has contributed to a further clinical reviewer, in recognition that assessment capacity is otherwise always prioritised for people with the most complex needs who are most at risk of harm or subject to court proceedings. We are also working closely to ensure that we develop a range of provision, so that we can provide care closer to home at a lower cost where possible, and with the ability to be flexible to the varying and often significant needs of some of our clients.

Costs related to autism placements will be reviewed in the same way. We are also working across West Yorkshire as for the Children's population on a cost and quality framework for private providers of autism and ADHD assessments.

3% reductions in VCSE spend. We have asked our VCSE providers in all populations to take a 3% cost improvement and wherever possible to absorb this via productivity improvements. We are aware across all our service areas that this is against a backdrop of reduced VCSE income from fundraising and significant cost pressures linked to the Cost of Living. Where services are so small that this would require redundancy, we have discussed this on a case by case basis.

**Mental Health (Adults)**

**Demand management/Cost reduction.** As with Learning Disability, the NHS works closely with LCC on the management of community services for people with Mental Health problems and particularly for those eligible for after care under section 117 of the Mental Health Act. We will focus on reviewing those patients who have had long standing packages which may not have been reviewed during COVID, and on working with our providers to ensure that the funding of packages reflects costs and needs. LYPFT and LCH represent the other main spend in Mental Health

services, and they will be reviewing their own provision as part of their internal waste reduction work. We are also working closely with VCSE providers to see how they could work more closely together, where their services overlap, and whether we can reduce this overlap or think creatively about other models of service delivery, shared staffing or other areas of productivity.

**3% reductions in VCSE spend.** We have asked our VCSE providers in all populations to take a 3% cost improvement and wherever possible to absorb this via productivity improvements. We are aware across all our service areas that this is against a backdrop of reduced VCSE income from fundraising and significant cost pressures linked to the Cost of Living. Where services are so small that this would require redundancy, we have discussed this on a case by case basis. We have, for example, not taken a reduction from our small services for refugees and migrants. To help VCSE partners meet the efficiency requirement we are also working with our top 10 providers by size to see if we can support in data flows and data capture to reduce the administrative burdens of contract reporting while improving the data we all need to target our health care more effectively.

**Reduction in contracts/ contract values.** During 23/24 we reviewed a number of contracts, 4 of which were non-recurrently funded from previous years. We have reduced our funding to the Befriending element of Live Well Leeds, as it was not sufficiently focused on people with an SMI (£112k), not continued with an involvement worker project (£55k) and ceased to fund Relate, Calm and Centred, Inkwell Arts and a MIND family bereavement worker all of which were non-recurrently funded and the income was no longer available. (Total non recurrent contract value £179k)

**Service Redesign.** VCSE providers are working together to redesign the crisis alternatives pathways, and we are also expecting to respond to a WY wider review of Crisis Cafes. These proposals once finalised would be subject to QEIA and wider engagement, although we are naturally already engaging as part of the reviews and service redesign.

**Contract Value Reduction >3%**

| | **Scheme Description** | **Scheme comments** |
|---|---|---|
| Value review of current investment into building-based housing support pathway | Integrate the ICB supported accommodation contract with council with a single procurement and set of outcomes to improve value to improve value and reduce duplication for the provider. 10% reduction for ICB from July 24<br><br>Contract procurement model led by LCC and risk assessed by LCC | Transfer of Community Links contract to LCC via s256 at 90% of value for LCC to recommission (£152k saving) |

| | | |
|---|---|---|
| Transitional Housing Unit (LCC 3 flats for LYPFT use) | NHS funds 3 'crisis flats' from within the LCC offer | This is essentially a housing /social care offer only, so considering whether this is appropriate spend of NHS resources. 6 months notice required but need to risk assess as if the accommodation is then not available at all, may be counterproductive for flow and spend across the system. (In discussion with LCC about options) |

## Primary Care

Primary Care is centrally funded via a National Contract, but with a local scheme which is focused on the delivery of improvements in health outcomes and targeted for Health inequalities. No cuts are proposed to these schemes, but there is an element of slippage from primary care related budgets that has been put towards the savings targets for the Partnership. We will be risk assessing all other proposals for the materiality of their impact on primary care, recognising the importance of primary care access to the health and experience of the population.

## Prescribing

As described above in Long Term Conditions, there are large number of individual schemes related to prescribing, which range from brand switches, through prescribing guidance through to more major pieces of cross-system work to rationalise pathways where some products are differently priced in different settings. We continue to focus on reducing 'items of low clinical value' and those which are cheaper over the counter, and we have schemes in place in our more deprived communities to enable Over the Counter medicines use. Many of our schemes also have an environmental impact, in reducing numbers of inhalers, for example, as well as a financial benefit.

## Planned Care

Planned Care services cut across all of our populations. Most of our work on commissioning policies is led at a West Yorkshire level, but implementation of these policies remains a responsibility at place. Our providers are working hard to increase capacity through work on productivity which has been challenging during periods of COVID and ongoing industrial action.

Our cost reduction programme includes the following on risk/demand reduction areas:

**Risk/Demand Reduction**

| Scheme Name | Scheme Description |
|---|---|
| Cataract follow-up in line with current commissioning policies | Implement the cataract policy agreed pre - covid. |
| Ensure implementation of benign skin removal policy and other commissioning policies | |

We are also looking at cost reduction via changes in the national tariff for cataracts and have reviewed our local tariff for ear wax removal where the technology has changed dramatically since we first used a pricing structure linked to a hospital outpatient tariff. We are mindful of the significant waiting lists across many key services, and the national drive to increase activity, supported by the Elective Recovery Fund. We work closely with Independent Sector partners, and referrers as we want to make sure that the capacity is used to the best possible effect where this is clinically indicated in line with best practice.

**Same Day Response Services**

As with Planned Care, we have a group of services accessed by people of all ages and from all population groups that serve people with a need to be seen on the same day. Most of the same day response in the City is provided by Primary care, with additional services from our Urgent Treatment Centres, 111, and Emergency Departments.

We are proposing to reduce our spend on Urgent Eye care pathways, having had some national funding during Covid to establish a Covid Urgent Eye Care Service. We recognise that there is great benefit in using the skills of our local optometrists for some pathways but are looking to reduce the spend /contract value for those patients where they could be routed to self -care or pharmacy options. We are working with our Local Optical Committee to review this.

We have also had some non-recurrent funding over the past two years to create some additional capacity for people who are unable to be seen within their General Practice offers, and who might otherwise go to an Emergency Department. We have used this for CAPS (Childrens Ambulatory Paediatric Service) appointment slots for referral from 111 and General Practice and some similar slots for adults with respiratory conditions. We recognise that this has provided a valuable service particularly for parents of younger children and will be exploring whether there are any other options for reconfiguring other elements of our same day response and conducting a full QEIA on this proposal. However, no additional funding was made available to provide this service, and we are therefore not able to continue it without further adding to the system financial gap. The contract for this service was always non-recurrently funded, so we are not showing it as a potential ‘saving’ as its continuation would be a cost pressure.

## Contract Value Reduction >3%

| Scheme Name | Scheme Description |
|---|---|
| Value for money review of Covid Urgent Eye Service | Further focusing of spend on highest risk patients/replacement with optometry input. Risk assessment of impact on capacity in other partners required. Current spend projection for 24/25 £750k |

| **Timeline for Involvement and Communications** | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Comms or Involvement task/milestone | Purpose | w/c 4th March | w/c 11th March | w/c 18th March | w/c 25th March | w/c 1st April | w/c 8th April | w/c 15th April | w/c 22nd April | w/c 29th April | w/c 6th May | w/c 13th May | w/c 20th May | w/c 27th May | w/c 3rd June | w/c 10th June | w/c 17th June | w/c 24th June | w/c 1st July | w/c 8th July | w/c 15th July | w/c 22nd July | w/c 29th July |
| QEIA and population level QEIA - plus EIA (as required) working documents | Gain clear view of impact of individual schemes and at population level to understand mitigation needed - update on ongoing basis | | | | | | | | | | | | | | | | | | | | | | |
| Leeds Committee - schemes will become public | | | | | | | | | | | | | | | | | | | | | | | |
| Work to identify higher risk schemes and groups impacted, as identified through population QEIA | Purpose to understand impact on populations and potential mitigations | | | | | | | | | | | | | | | | | | | | | | |
| Work to identify higher risk schemes from the perspective of having a high risk of controversy | Purpose to understand comms support needed | | | | | | | | | | | | | | | | | | | | | | |
| Communications to public about financial situation - statement on website | Explain scale of challenge and that they may see services changing as a consequence of difficult decisions we need to make | | | | | | | | | | | | | | | | | | | | | | |
| Pre election period - no proactive communications/Involvement allowed | NHSE guidance during elections | | | | | | | | | | | | | | | | | | | | | | |
| Gap analysis of insight we have regarding the services and populations affected by the schemes | We start with the principle of using what the public have already told us. Then we can ensure that we concentrate our limited resources on involving people where we have gaps | | | | | | | | | | | | | | | | | | | | | | |
| Identify Involvement work that needs to be undertaken with people of Leeds | We don't have resource to involve on all schemes so must focus on highest risk | | | | | | | | | | | | | | | | | | | | | | |
| Involvement work continues with affected provide | Purpose to understand impact on populations and potential mitigations | | | | | | | | | | | | | | | | | | | | | | |
| Involvement work continues with partners (including primary care) | Purpose to understand impact on populations and potential mitigations | | | | | | | | | | | | | | | | | | | | | | |
| Follow up assurance workshop | To provide assurance on the process we are following for making these difficult decisions | | | | | | | | | | | | | | | | | | | | | | |
| Check approach with Consultation Institute | Gain further assurance on our approach, given the timeline we have | | | | | | | | | | | | | | | | | | | | | | |
| QEIAs and EIAs assured at Quality and Delivery sub committees | To gain further assurance that due process has been followed | | | | | | | 17th Delivery | 24th Finance | 1st May Quality | | | | | | | | | | | 17th Quality | 24th Delivery | 31st Finance |
| Involvement work takes place with the public to advise on changes for higher risk schemes and for populations as a whole. | Purpose is to understand impact on populations and potential mitigations. To ensure we have Involved and communicated with public. | | | | | | | | | | | | | | | | | | | | | | |
| LHCP website updated with information for public | To ensure we effectively communicate proposed changes to the public | | | | | | | | | | | | | | | | | | | | | | |
| Comms team provide support in communicating changes e.g drafting reactive messages in case of legal challenge | To ensure we effectively communicate proposed changes to the public | | | | | | | | | | | | | | | | | | | | | | |

| | |
|---|---|
| **Meeting name:** | Leeds Committee of the West Yorkshire Integrated Care Board |
| **Agenda item no.** | LC 80/23 |
| **Meeting date:** | 13th March 2024 |
| **Report title:** | Proposed merger of Wetherby Surgery and Bramham Medical Centre and the Closure of the Harewood Branch Site |
| **Report presented by:** | Gaynor Connor, Director of Primary Care and Same Day Response |
| **Report approved by:** | Gaynor Connor, Director of Primary Care and Same Day Response |
| **Report prepared by:** | Laura Dinsley and Lisa Kundi |

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

**Previous considerations:**

None at this committee

The paper was presented at the Primary Care Board on 2nd February 2024 with agreement to recommend the proposed merger to the Leeds Committee of the West Yorkshire ICB.

**Executive summary and points for discussion:**

The Partners of Bramham Medical Practice and Wetherby Surgery submitted a business case (Appendix 1) setting out a proposal to merge the two practices together under a single contract in August 2023. This followed a merger of the business' in July 2023 whereby the partners at Bramham also took on the contract for Wetherby Surgery. As part of this proposal, the new partnership is also seeking agreement to permanently close the branch site of Wetherby Surgery at Harewood.

The engagement commenced on the 16 November 2023 until the 31 December 2023 (6 weeks) and was supported by the Primary Care Team and Communications and Involvement Team at the ICB in Leeds.

This paper sets out the formal application from the practices, the key benefits of the merger to both practices and patients, the key themes and outcomes of the patient engagement and the recommendation to Leeds Committee of the WYICB.

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

☐ Improve healthcare outcomes for residents in their system.

☒ Tackle inequalities in access, experience, and outcomes

☒ Enhance productivity and value for money.

☐ Support broader social and economic development

**Recommendation(s)**

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

1. **Approve** the merger of Wetherby Surgery and Bramham Medical Centre from 1 April 2024.
2. **Approve** the permanent closure of the branch site of Harewood.

**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. Business Case from the practices
2. Engagement Report, prepared by the practice.
3. Map of Sites and Practice boundaries (All attached via the paperclip function)

**Acronyms and Abbreviations explained**

PCN- Primary Care Network

ICB- Integrated Care Board

FAQ- Frequently Asked Questions

**What are the implications for?**

| | |
|---|---|
| **Residents and Communities** | The proposal seeks to provide a stable and resilient service for the population of Bramham and Wetherby Surgery.<br>The report recommends the permanent closure of Harewood with the greatest impact felt by a small minority however there will be wider disappointment to the community to lose a much-valued asset. The report describes the complexity of the scenario which has led to the current unsustainable position. |
| **Quality and Safety** | The aim of the merger is to provide much needed resilience for both practices. As two small practices there is a risk to longer term viability.<br>As well as creating resilience, there is an opportunity to improve quality by bringing together a wider offer of services. The merged business has already seen the recruitment of permanent staff following a period of reliance on locums and temporary staff. |
| **Equality, Diversity and Inclusion** | None identified. |
| **Finances and Use of Resources** | Greater economies of scale through one larger combined list will support the practices both financially and in a reduction in workload and administration of delivering two contracts. |
| **Regulation and Legal Requirements** | The request to merge and to close a branch site has followed the process described in the Medical Policy and Guidance Book. |

| | |
|---|---|
| **Conflicts of Interest** | None identified. |
| **Data Protection** | None identified. |
| **Transformation and Innovation** | None identified. |
| **Environmental and Climate Change** | None identified. |
| **Future Decisions and Policy Making** | None identified. |
| **Citizen and Stakeholder Engagement** | The practices have engaged with Stakeholders during the engagement process |

## 1. SUMMARY OF PROPOSAL

1.1 In August 2023 the Partners of Wetherby Surgery (B86625) and Bramham Medical Centre (B86673) submitted a business case (Appendix 1) setting out a proposal to merge the 2 practices together under a single contract. The business case included the proposal to permanently close the Wetherby Surgery branch at Harewood which had been closed for some time under the outgoing provider. The decision to engage on the proposed merger and potential closure was approved by Primary Care Programme Board on 2 November 2023.

1.2 In July 2023 the partners from Bramham Medical Centre took over the partnership of Wetherby Surgery. The reason for the proposed merger of the contracts is to provide stability, resilience, and continuity of care across both practices due the smaller list size and financial viability of the practices in the current climate.

1.3 The merger will increase the resilience of both practices and offer opportunities to further develop the services available for patients. The practices will merge under the Bramham Medical centre contract (B86673) and the GMS contract will be varied to reflect the change.

1.4 The proposal for the merger is for all services to continue to operate from the 2 main sites. This is due to the second part of the proposal to close the Harewood Branch Site

1.5 To understand the current status of the Harewood branch it is important to outline the history of the site in recent years. Prior to July 2023, the contract was delivered by a different partnership who in 2019 applied and was successful in their request to cease providing a dispensary service from Harewood. Following the closure of this service and followed by the pandemic, the branch was open intermittingly and infrequently thereafter. The ICB were not aware of this until the partnership change discussions took place with the outgoing providers in 2023.

1.6 When the new partnership took on the contract in July 2023, they anticipated that the lease would be transferred over however, due to the legalities of this and complex outstanding issues around dilapidations this was not possible.

1.7 In November 2023, the lease between the landlord and outgoing provider ended and there is now no lease in place between the landlord and either contractor. The building requires works to ensure that it is suitable for modern healthcare standards and whilst these issues are outstanding it is not viable for the new partnership to enter into a new agreement.

1.8 There is limited available capital in the NHS and we are not aware of any offer from the landlord to complete any upgrades. There is no guarantee funding would be available or that this site would be the priority for investment should any funding become available. An assessment undertaken in 2021, identified a need for effective estates management particularly for compliance with Fire, Health and Safety and the Disability Discrimination Act.

1.9 The site has been closed to patients for more than 12 months and due to the unique set of circumstances that have transpired overtime it is not a currently viable for the contractor to sign a lease and enter a new contract.

1.10 As an alternative, the partnership has requested an additional clinical room at Wetherby which would ensure adequate estate for the continued delivery of services.

1.11 If the proposal was approved, the permanent closure of Harewood Surgery would be effective immediately and the contracts would be merged from 1 April 2024.

1.12 The proposal to merge should be considered in line with NHS England's Policy and Guidance Manual (PGM) (Part B, section 7.11). This sets out what commissioners should consider when deciding on contractual mergers, this includes;

- how patients would access a single service.
- what would the practice boundary be (inner and outer);
- assurances that all patients will access a single service with consistency across provision, i.e., home visits, booking appointments, essential and additional services, opening hours, extended hours, and so on, single IT and phone system;
- premises arrangements and accessibility of those premises to patients
- proposed arrangements for involving the patients about the proposed changes, communicating the change to patients, and ensuring patient choice throughout.
- the impact on patient choice; and
- how the proposed merger is intended to benefit patients.

1.13 The proposal to permanently close the branch site at Harewood Surgery should be considered in line with Section 8.15 of the policy book which sets out the following considerations for commissioners on such scenarios.

- financial viability;

- registered list size and patient demographics;
- condition, accessibility and compliance to required standards of the premises;
- accessibility of the main surgery premises including transport implications;
- the Commissioner's strategic plans for the area;
- other primary health care provision within the locality (including other providers and their current list provision, accessibility, dispensaries and rural issues);
- dispensing implications (if a dispensing practice);
- whether the contractor is currently in receipt of premises costs for the relevant premises;
- other payment amendments;
- possible co-location of services;
- rurality issues;
- patient feedback;
- any impact on groups protected by the Equality Act 2010 (for further detail see chapter 4 (General duties of NHS England);
- the impact on health and health inequalities; and
- any other relevant duties under Part 2 of the NHS Act (for further detail see chapter 4 (General duties of NHS England).

## 2 PRACTICE INFORMATION

2.1 Bramham Medical Centre and Wetherby Surgery are both part of the Wetherby PCN and the distance between the 2 main practice sites is 4.6 miles. Public transport is available between the sites however, buses are infrequent and are reported to be at times unreliable.

2.2 Bramham Medical Centre has a list size of 3125 and Wetherby Surgery is 4244 (January 2024 list size). The combined list size would be 7396.

2.3 The Harewood Surgery site is 6.8 miles from the Wetherby Surgery site. The site has not been used since November 2022 (last used by the previous partnership) and was not open full time in the 7 months prior to this date.

2.4 Bramham Medical Centre premises are owned. Wetherby Surgery are located within Wetherby Health Centre and hold a lease with CHP. The current partners do not hold a lease for the Harewood Surgery Site. This lease was held with the outgoing partners and expired in November 2023.

2.5 Bramham Medical Centre and Wetherby Surgery both hold a GMS contract. The proposal would see the Bramham Medical Centre contract varied to reflect the merger and the contract for Wetherby Surgery would end.

2.6 Both practices use SystmOne as their clinical system and use Red Centric as their telephony provider. Both practices use AccuRx for online consultation.

2.7 Bramham Medical Centre achieved a rating of ‘good’ on their last CQC inspection, there is currently no rating for Wetherby due to the change of partnership in July 2023

2.8 Bramham Medical Centre is a dispensing practice whereas Wetherby is not following the closure of the Harewood Surgery Dispensary in 2019. We are working with colleagues responsible for the commissioning of primary care pharmaceutical services and reviewing if the merger has any impact on the number of patients eligible for dispensing.

## 3. KEY BENEFITS

3.1 Key benefits of the merger, as outlined in the business case, include:

- **Expanded Services:** Merging two practices would lead to a broader range of medical services and specialties being available to patients. This means patients can access a more comprehensive set of healthcare offerings without having to visit multiple locations.
- **Improved Access to Care:** With a larger combined practice, there is the potential for patients to attend either site which may be quicker, more convenient and also will give more capacity for additional sessions.
- **Enhanced Technology and Resources**: Merging practices can pool resources and also find new ways of working that are more beneficial to patients.
- **Continuity of Care:** Merging practices can create a more stable and resilient healthcare environment, ensuring that patients receive continuous care even if one of the practices faces challenges.
- **Increased Collaboration:** A larger practice has a larger group of healthcare professionals, enabling better collaboration between healthcare professionals to deliver integrated and coordinated care.
- **Reduced Waiting Times:** By combining resources and staff, the merged practice can potentially reduce waiting times for appointments and procedures, leading to quicker access to medical care.
- **Better Staffing Levels:** The merger can address workforce shortages by combining the staff from both practices, allowing for a more efficient allocation of healthcare professionals and support staff.

- **Streamlined Administrative Processes:** Merged practices can achieve economies of scale and simplify administrative tasks, leading to a more efficient patient experience and reducing paperwork and bureaucracy.
- **Enhanced Patient Education and Support:** A larger practice may be better equipped to offer health education programs, support groups, and other resources to help patients manage their health more effectively.
- **Financial Sustainability**: Merging practices may improve financial stability, allowing for the longer-term viability of the practice.

## 4. PATIENT AND STAKEHOLDER ENGAGEMENT

4.1 The patient and stakeholder engagement process started on 16th November 2023 and ran until the 31 December 2023 (6 weeks) and included both the merger of the practices and the closure of the Harewood Branch Site

4.2 The practices led on the engagement and a variety of activities and methods were used to seek the views of registered patients across all 2 practices.

4.3 There was an initial meeting held with the PPGs to seek their views on how they should communicate the proposals and this feedback was fed into the agreed engagement process, this meeting included one of the local councillors for the area.

4.5 Practices printed copies of the survey and made these available at both surgeries to ensure those unable to access the survey online were still able to provide feedback.

4.6 A letter outlining the proposed changes was sent to all patients using AccuRx, patients could then also request a paper copy if they wished. The letter was also posted to all registered patients over the age of 70 and those of any age who lived within Harewood (1 per household) which included details of the survey, how to submit any questions and details of the 3 planned public events.

4.7 The practices organised and held 2 in person public events at Harewood Village Hall and Bramham Pavilion. They also offered a digital event but this was only taken up by one person so an individual conversation was held with this patient.

4.8 Additional text message reminders were sent out to all patients registered with a mobile phone halfway through the engagement period to encourage people to fill out the survey and make them aware of the events.

4.9 A total of 500 people actively engaged in the engagement process mainly by submitting the survey and a small number attended the in-person engagement sessions. It was a near equal split of responders from both practices

4.10 The engagement identified several key themes, including:

- The importance of:
  - Continuity of care with healthcare professionals
  - Having access to care close to home
  - Good telephone access to the surgery
- Concerns about appointment availability at preferred site
- Concerns about closing Bramham site in the future.
- Lack of public transport options from Harewood to Wetherby

4.11 An FAQ document was created prior to the engagement and was made available during the engagement process. A breakdown of the responses and assurances given to the concerns raised can be found in the full engagement report (Appendix 2). In addition, a stakeholder letter was sent out to wider partners including all local councillors. MPs and the Harewood Estate informing them of the proposal, the engagement process and timeline as well as detailing the associated governance process.

4.12 The Harewood Estate as landlord provided the following statement on their position: ‘Notwithstanding their position as Landlords of the premises, the family are disappointed to see the closure of the surgery as they see this as a loss of an important service for the local community. The family were keen to see the provision of this healthcare service, for village residents continue. It is regrettable that funding could not be sourced so that the building could be updated internally to meet modern healthcare standards and continue to be of service to the village.’

4.13 The engagement report details the engagement process and outcomes and includes a key themes table which outlines the practice response to some of the patient concerns (Appendix 2)

4.14 The engagement report, FAQs and the initial letter to patients are located on both practice websites for patients to view and read.

4.15 The response rate to the survey was the highest we have experienced for an engagement of this type which provides a level of assurance that patients were adequately informed. Additional care was taken to inform patients living in Harewood and/or any registered patients over the age of 70.

4.16 There were common concerns from patients regarding access to appointments which was anticipated. The practices are able to provide some assurance that there will be no loss of capacity as a result of this merger. The practices are also able to adopt a new system for answering the telephone should the merger go ahead. This would see calls answered by a more local team of staff who are more familiar with the service and local pathways which will undoubtedly improve patient experience.

4.17 A key concern was raised by a small number of residents in Harewood around how they would get to the main surgery sites should Harewood close. Buses are unreliable and for some older or more vulnerable residents this journey would not be possible. As with other changes of this nature we would recommend putting in place a transitional taxi budget for patients who might otherwise struggle to access services.

4.18 In summary, the engagement exercise yielded a high response rate with mixed views on the proposals. Most of the concerns around the merger can be addressed through reassurance from the practices which they will provide in their engagement report and subsequent follow up to patients. This may be partly due to the fact that the site has been closed for some time. The practices serve a rural and sparsely populated community who are already used to travelling to an appointment. The transitional budget would support those residents who need it, to access services.

## 5. FINANCIAL IMPLICATIONS AND RISK

5.1 There are implications for the WY ICB in terms of estates costs. The annual rent reimbursement of the Harewood site equated to £9,524 per annum. The cost of reimbursing an additional room a Wetherby Surgery is £18,050.40 plus VAT. This includes rent reimbursement and other reimbursable costs. The practice occupies the room on an informal basis with costs being picked up by WY ICB as void space. By adding the additional clinical room onto the practices lease, they will pick up the non-reimbursable costs incurred that the WY ICB is paying at this time. Whilst there may be increased costs against the delegated co-commissioning budgets, there should be an overall reduction in costs to the WY ICB.

5.3 It is recommended that as with previous changes of this nature involving a branch closure in a rural location, a budget is assigned to support the transition. This is for any patients requiring a taxi who do not meet the criteria of being housebound but would otherwise struggle to attend appointments or use public transport.

5.4 Finance colleagues will continue to be involved to provide future financial planning and analysis and to pick up any issues throughout the process.

## 6. NEXT STEPS

6.1 If the recommendation from Leeds committee of the West Yorkshire ICB is to approve the application. The Primary Care Team in Leeds will ensure the merger is enacted in line with NHS England's Policy and Guidance Manual (PGM) (Part B, section 7.11).

6.2 If the merger is approved, the practice will be asked to develop and implement their mobilisation plan. In addition, the Primary Care team will use the standard checklist for practice mergers to ensure all aspects of the merger are addressed. This covers formal patient and stakeholder communication, IT actions, and other operational aspects of the merger.

6.3 If the closure is approved, patients will be informed, and we will work with the practice to ensure that patients are supported through this transition.

6.4 The official notification letter to patients will be sent out once agreed with the practices along with the FAQs. Patients identified as requiring additional support will be contacted directly by the practice.

6.5 The proposed merger date is 1 April 2024. The closure of Harewopd Surgery would be effective immediately due to the current circumstances. The Primary Care Team at the ICB will support the practice through mobilisation meetings up to the date of the merger and the 3 months thereafter. We are planning to engage the Wetherby PCN on a Digital inclusion project alongside the 100% Digital Leeds team at Leeds City Council.

6.7 There will be ongoing support from the ICB with CHP to arrange the additional clinic room at the Wetherby Surgery.

## 1. Recommendations

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

1) Approve the recommendation to merge Wetherby Surgery and Bramham Medical Centre on 1st April 2024.
2) Approve the permanent closure of the Harewood Branch Site.

Not

| | |
|---|---|
| **Meeting name:** | Leeds Committee of the West Yorkshire Integrated Care Board |
| **Agenda item no.** | LC 81/23 |
| **Meeting date:** | 13 March 2024 |
| **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) – 5 February 2024 (email)

Finance and Best Value Sub-Committee – 21 February 2024

Delivery Sub-Committee – 28 February 2024

Quality and People's Experience Sub-Committee – 6 March 2024

**Executive summary and points for discussion:**

This paper presents the ICB in Leeds High-Scoring Risk Report (risks scoring 15+) during risk cycles 5 and 6. 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 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.

**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 16 January 2024

Appendix 3: Leeds Health and Care Partnership Partner Top Risks

Appendix 4: Risk on a Page Report

Appendix 5: Static Risk Review Summary

**Acronyms and Abbreviations explained**

1. ICB – Integrated Care Board
2. CMH – Community Mental Health
3. ND - Neurodiversity
4. PICU - Psychiatric Intensive Care Units
5. IG – Information Governance
6. LTHT – Leeds Teaching Hospitals NHS Trust
7. LCH – Leeds Community Healthcare NHS Trust
8. LYPFT – Leeds and York Partnership Foundation NHS Trust

**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** | |

| | |
|---|---|
| **Transformation and Innovation** | Any implications relating to individual risks are outlined in the Risk Register. |
| **Environmental and Climate Change** | |
| **Future Decisions and Policy Making** | |
| **Citizen and Stakeholder Engagement** | |

## 1 Introduction

1.1 The report sets out the process for review of the Leeds Place risks during risk cycle 6 which commenced on 16 January 2024 and will end after the ICB Board meeting on 19 March 2024. Due to the timing of the sub-committee meetings, risk cycle 5 was not reported on at the last meeting and therefore this report also provides an update on risk cycle 5 for completeness.

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 32 to 43 of the West Yorkshire ICB Risk Report 16 January 2024 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 Integrated Care Board – 16 January 2024
- West Yorkshire ICB Finance, Investment & Performance

Committee – 27 February 2024 (AM)
- West Yorkshire ICB Quality Committee – 27 February 2024 (PM)

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 demand for services, access to mental health and learning disability services, and workforce issues. The top risks identified by system partners are detailed at Appendix 3. Partners are also consulted when populating and managing the Population and Care Board risk registers.

2.6 The last reported position to the Leeds Committee set out a total of 18 open risks on the risk register. During risk cycle 5, 7 risks were closed following the static risk review (3.3 refers) and the WY financial risk review (3.4 refers). There are currently 11 risks on the Leeds Place Risk Register, with one risk that has been marked for closure since cycle 5, leaving a total of 10 open risks.

2.7 An overview of the Leeds Place risks exposure during the current risk cycle (risk cycle 6) is provided at Appendix 4, the Risk on a Page Report. Information that can be found includes:

- An overview of the risk profile, with details of the number of risks.
- A graph showing the changing number of risks on the register – over time, this can help to highlight the management of the ICB's risks.
- A graph showing the average score – again, this helps to demonstrate the risk profile, and help to alert if the overall risk score is increasing over time.

- Static risks – the graph will demonstrate over time how long risks have remained static for. A risk that remains static over a number of cycles, may be an indication that further work is needed to control the risk.

2.8 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 cycles 5 and 6 of 2023/24 were reported at the sub-committee meetings as follows:

a) All aligned finance risks were reviewed by the Finance and Best Value Sub-Committee on 21 February 2024.
b) All aligned delivery risks were reviewed by the Delivery Sub-Committee on 28 February 2024.
c) All aligned quality risks were reviewed by the Quality and People's Experience Sub-Committee on 6 March 2024.

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 (15+)

3.1 The last report to the Leeds Committee of the WY ICB provided an update on the risk position during risk cycle 4 (2023/24). The following changes have taken place during 2023/24 risk cycle 5 and 6:

| Risk | Cycle 5 | Cycle 6 | Movement since previous risk cycles |
|---|---|---|---|
| 2014 – Leeds System Financial Position | 20 | 20 | Static Risk – Risk reviewed in line with instruction from WY Finance Team to ensure consistency of risk scoring at 20. Risk therefore remains static for Leeds. |
| 2158 – Prescribing Costs | N/A | N/A | Risk Closed - Risk has been removed and merged with existing risk on the WYICB corporate risk register, as directed by WY Finance Team. |
| 2019 – Risk of Harm – System Flow | 16 | 16 | Static Risk - Additional information added to the risk description to recognise the extreme pressure on LTHT during January 2024 which has meant patients have been placed in exceptional surge areas and there have been risks to patient safety within LTHT. Further consideration to be given to determine if the likelihood score can be reduced to 3. |

| Risk | Cycle 5 | Cycle 6 | Movement since previous risk cycles |
|---|---|---|---|
| 2018 – Risk of Harm - Mental Health Access | 16 | 16 | Static risk - Whilst there has been a slight improvement with a downward trend of total numbers of out of area acute and PICU placements, significant pressures persist within the Mental Health system with LYPFT consistently reporting OPEL 3E. Multiagency teams have commenced elements of collaborative working in the early implementer sites for the new model of community mental health care. However, a number of key IG and clinical governance risks have had to be worked through ahead of progressing to mobilise to fully testing the new core model - the work to fully mitigate these residual risks will be completed to enable full mobilisation at the beginning of March 2024. Target score reduced to 9. |
| 2301 – Children and Young People Neurodiversity Waiting Times | 15 | 15 | Static Risk – Some progress, but slow. Awaiting a formal proposal from LCH around the under 5 service. |
| 2354 – Adults Neurodiversity Waiting Times | 15 | 15 | Static Risk – A neurodiversity working group has been established as part of the CMH Transformation programme to improve access to mental health services for people who are neurodivergent. This will help people who are on diagnostic waiting lists to have their needs met - to 'wait well'. Working on improvement ND data in the Leeds Data Model to be able to work in a better population planning way. ND Programme steering group is reviewing the priorities and capacity. Timescales to be confirmed. |

3.2 Of these risks, all 5 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 The WY Risk Management Operational Group was asked by the West Yorkshire ICB Audit Committee to undertake a review of all static risks. During December 2023 and January 2024, the Corporate Governance Team contacted all risk owners with static risk scores, asking them to consider the articulation of risks, their mitigations, gaps and

assurances, and the anticipated timeline for mitigation. Risk owners were also, where relevant, asked whether the risk had reached its tolerance level, or had become an issue, and to consider whether it should be removed from the risk register. In total, 6 risks were closed due to becoming an issue, determined as a provider level risk or having reached tolerance, including one risk aligned to the Leeds Committee. A summary of the changes is provided at Appendix 5.

3.4 At the last meeting, a verbal update was provided on the recent review of financial risks undertaken across West Yorkshire to align and consolidate financial risks, with an instruction for the risks relating to prescribing costs and primary care costs to be removed as these would form part of an overarching corporate risk. There was some misunderstanding around whether the overarching financial risk for Leeds should be removed and held only as a corporate risk, however it was confirmed that WY places should maintain individual current year financial risks, with all risks consistently scored at 20. The Leeds risk was already scored at 20 and therefore no further changes have been required. The WY Finance Team also instructed all places to add a risk relating to the impact on NHS partners resulting from challenging Local Authority financial positions. This risk will be added and reported on during the next cycle to the Leeds Committee, with Tim Ryley as the senior risk owner.

## 4 Risks Aligned to the Leeds Committee

4.1 There are three risks aligned directly to the Leeds Committee, which comprise 27% of total risks currently on the ICB Risk Register. Of these risks:

a) One risk is scored at 12;
b) One risk was closed in cycle 5 following review.

4.2 **High Scoring Risks (12+)**

| Risk Number and Risk Title | Cycle 5 | Cycle 6 | Movement since previous risk cycles |
|---|---|---|---|
| 2024 – Deprivation of liberty legislation | 12 | 12 | Static Risk - There has been further discussion and clarification around the numbers of people awaiting assessment. Scoping work to be undertaken to consider a number of options. Both options would need a review of the existing services and a full consultation. |

4.3 **Closed Risks**

| Risk Number and Risk Title | Cycle 5 | Cycle 6 | Reason for closure |
|---|---|---|---|
| 2013 - Insufficient project and programme management resource | N/A | N/A | Closed Risk - This risk is now an issue due to the impact of the new Operating Model on project and programme management resource. |

## 5 Next Steps

5.1 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 19 March 2024.

5.2 Following a recent governance review, the WYICB governance cycle is set to change frequency from 1 April 2024 from a bi-monthly cycle to a quarterly cycle. This will result in the risk reporting cycle reducing from six to four cycles a year which aligns with the current Leeds Committee meeting cycle.

## 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 16 January 2024

Appendix 3: Leeds Health and Care Partnership Partner Top Risks

Appendix 4: Risk on a Page Report

Appendix 5: Static Risk Review Summary

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

| Risk ID | Date Created | Risk Type | Risk Rating | Risk Score Components | Target Risk Rating | Target Score Components | Risk Owner | Senior Manager | Principal Risk | Key Controls | Key Control Gaps | Assurance Controls | Positive Assurance | Assurance Gaps | Risk Status |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **High-scoring risks (15+)** | | | | | | | | | | | | | | | |
| 2014 | 29/06/2022 | Finance and Best Value Committee | 20 | (I4xL5) | 6 | (I3xL2) | 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<br>Audit of Procedures<br>fortnightly AO/CEO and FDs meetings<br>Weekly assessment and reporting to EMT<br>Bi-Weekly meetings with senior leads<br>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 was 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 did not take 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 discretionary spend must now be reviewed weekly by Leeds EMT this was enhanced further in October 2023 with reviews by WY EMT required | Static - 5 cycles |
| 2019 | 30/06/2022 | Both Delivery and Quality and People's Experience | 16 | (I4xL4) | 12 | (I3xL4) | Nicola Nicholson | Helen Lewis | There is a risk of harm to patients in the Leeds system due to people spending too long in Emergency Departments (ED) due to high demand for ED, the numbers, acuity and length of stay of inpatients and the time spent by people in hospital beds with no reason to reside, resulting in poor patient quality and experience, failed constitutional targets and reputational risk. In combination with the risk of harm to those people who remain in hospital when they no longer have a reason to reside from hospital-related harms and deconditioning while they wait for ongoing services, where their wait is longer than 72h. | Strong surge plan in place as necessary (within LTHT)<br><br>Transfer of Care hub completely staffed and working 7 days<br><br>Home First Programme refreshed and overseen by LTHT Chief Exec as System SRO<br><br>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<br><br>System Escalation Actions and Processes revised continuously<br><br>OPEL & System Pressures Reporting Regime - refreshed in view of the revised OPEL (Nov 23)<br><br>Communications work with Public to suggest alternatives to ED<br><br>Home First programme well underway - initial improvements have allowed the closure of 2 nR2R wards over the summer of 23. These were then available for seasonal surge<br><br>Investment in Home First services and in assessment capacity through Adult Social Care Discharge Fund<br><br>Improvements have been seen over 2023 and the LTHT occupancy dropped to 93% and 2 no Reason to Reside wards were closed.<br><br>Winter capacity plans in place to support discharge capacity<br><br>Improvements in pathways, processes and in hospital | Key controls in place responding to high levels of demand.<br><br>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<br><br>While occupancy has improved, this isnt always correlated with a reduction in people spending a long time in ED - this needs further analysis<br><br>Increase winter demand for acute care coupled with a increase demand for support on discharge has created longer waiting times and backlogs in hospital where capacity has been unable to meet the demand. | Health & Social Care Command & Control Groups:<br>System Resilience Operational Group (Bronze),<br>System Coordination Group (Silver) and System Resilience and Reset Assurance Board (Gold)<br>Integrated Commissioning Executive<br>Partnership Executive Group<br>Quality and Performance Committee<br><br>New System Visibility Dashboard is in place to support assurance and decision making | Weekly meeting in place for services to report on capacity /demand<br>Reviewed Silver Action cards<br>Revised System Resilience Structure<br>System Visibility dashboard in place and driving change<br>Strong programme of Home First work in place<br>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.<br>Improvements in the waiting times for pathway 3 have been made by process changes<br>Occupancy in LTHT was 93% over summer and we have seen a reduction in the 12h breaches. | OPEL reporting system under development for ASC but not yet finalised or shared.<br><br>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)<br><br>Still too many people over 6 and over 12 hours in ED which we know is linked to risk of harm<br><br>Additional winter demand acuity has outstripped the systems capacity in intermediate care and there are long waits in hospital for supported discharge and for admission from ED (Jan 2024).<br><br>Patients in LTHT have on occasions been placed in exceptional surge areas including corridors and in day rooms due to the lack of availability for inpatient beds (unsatisfactory environments have been mitigated as far as possible with the provision of call bells and other basic requirements) .<br><br>Long waits for admission in inappropriate ED environments for mental health beds have resulted in clinical incidents in Dec 2023.<br><br>Funding to maintain capacity within LTHT and to support Social care assessments is likely to become more difficult in coming months<br><br>SW capacity, recruitment and retention remain a key risk alongside groups such as therapists | Static - 3 cycles |
| 2018 | 29/06/2022 | Both Delivery and Quality and People's Experience | 16 | (I4xL4) | 9 | (I3xL3) | Eddie Devine | Helen Lewis | There is a risk of increased rates of avoidable deteriorations in mental health due to demand outstripping capacity to provide access to proactive community mental health intervention, hospital beds or to support wider social determinant needs , exacerbated by sustained workforce recruitment and retention challenges; resulting in increases in numbers and severity of acute /crisis presentations, with consequent increased lengths of stay and reduced system flow within LYPFT MH inpatient provision, resulting in increased utilisation of out of area placements for acute mental health beds that impacts quality, experience and service user outcomes. | Workstreams established and progressing in response to actions identified from LYPFT hosted MADE event focused on mapping to identify process improvements that enable system flow; internal process and quality improvement within LYPFT, development of system visibility dashboard and review of escalation governance for Mental Health, targeted VCSE support to expedite timely discharge from mental health inpatient wards, review of transitional accommodation pathways and transfer of care.<br><br>Systematic review of MH crisis pathways to optimize targeting of resources to meet the needs of population cohorts most at-risk through Mental Health Population Board in Leeds being progressed<br><br>Community Mental Health Transformation Programme:<br>-Phased implementation of new model of integrated community mental health care co-designed with Leeds Health and Care system partners ,including people with lived experience, carers and communities.<br><br>-Evaluation of phase I grants funding scheme to target bespoke intervention and support for population cohorts at increased risk of health inequalities, and launch of phase 2 led through Leeds Community Foundation (aligned to personalising new core model of integrated community mental health care to meet bespoke needs of local communities)<br><br>Crisis Transformation Programme<br>Review of range of crisis alternatives provision including MH helpline, crisis house, crisis cafes, crisis flats,<br>alongside redesign of model to simplify access to a | Review of MH crisis pathways to optimise value of investment- workshop to finalise areas of focus with MH Population Board planned for February 2024. Full Mobilisation of new model of integrated community mental health initially within 3 early implementer local care partnership/PCN sites. Work to address residual governance issues and establish clearer partnership agreements has progressed sufficiently to set an expected date for mobilisation within early implementer sites in February 2024 (realistic timescale for full completion of mitigation work). | Waiting and access times to services monitored through performance metrics, Healthy Leeds Plan, and Mental Health Board data dashboard and Outcomes Framework<br>Inpatient Flow Oversight Group within LYPFT | Actions from LYPFT MADE event feeding into Inpatient Flow Oversight Group programme plan<br><br>Review<br><br>Community Mental Health Transformation-mobilisation/phased roll out of the new model of care within integrated community mental health hubs progressing-early test of change through joint triage, and collaborative ways of working are anticipated to move to testing fully the new core model of care within 3 early implementer sites by early March 2024<br><br>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.<br><br>Internal review of LYPFT crisis assessment and Intensive Support delivery model underway to improve adherence to core fidelity standards progressing outputs of LYPFT MADE event - internal recovery action plan developed to support reducing out of area MH placements.<br><br>Number of key system-led workstreams now established: housing and accommodation; specialist placements including development of visible dashboard of availability/ waiting times; targeted 3rd sector support to facilitate and unblock barrier to discharge; housing and accommodation for MH mapping workshop planned which aims to identify key barriers to access and bottlenecks 01/12/2023.<br><br>Expansion of capacity through CMH transformation funding recruitment to new clinical roles, including advanced practice, psychological therapy practitioners, and specialist MH pharmacy- | Mental health pressures remain significant, with LYPFT reporting sustained OPEL 3E,-35 Acute Mental Health out of area placements as of 24/01/24: 30 adult acute, 5 PICU. This is an increase from the previous risk cycle<br><br>Delayed transfers of care impacting acute MH capacity has deteriorated since last cycle - 17% DTOC for Adult MH acute reported by LYPFT as of 24.01.24 NHS talking therapies: average step 3/CBT waiting times remain at 14 months- although service reporting positive increasing uptake of online step3 therapy offer through subcontracted provider that has stabilised numbers adding to the waiting list<br><br>Early Intervention in Psychosis Service- NCAP results (national quality audit) rated at 'Requires Improvement' across a number of areas for level 3 NICE compliance- the service has accepted offer from NHSE regional clinical lead/team for support to develop recovery plan. | Static - 5 cycles |

| | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2354 | 14/08/2023 | Both Delivery and Quality and People's Experience | 15 (I3xL5) | 9 (I3xL3) | 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<br><br>Leeds Autism Diagnostic Service and Leeds ADHD service pathway service development<br><br>Number of improvement pilots in development-supported through non-recurrent funding<br>- ADHD primary care prescribing pathway pilot<br>- Pre-diagnostic support to support 'waiting well' including to develop and curate the support offer from third sector organisations.<br>- LYPFT Diagnostic Service Process improvement pilots: annual review process, clinical prioritisation, waiting list validation, admin process improvements. Review quarterly.<br><br>A neurodiversity working group has been established as part of the CMH Transformation programme to improve access to mental health services for people who are neurodivergent. This will help people who are on diagnostic waiting lists to have their needs met to 'wait well'.<br><br>Working on improvement ND data in the Leeds Data Model to be able to work in a better population planning way.<br><br>ND Programme steering group is reviewing the priorities and capacity. Timescales to be confirmed. | ADHD service is currently in a state of business continuity impacting the capacity for development/transformation work. ADHD medication shortage is also requiring clinician capacity to mitigate risk to patients which is then further impacting on the ability to assess new patients.<br><br>Lack of access to targeted funding to support service development and transformation projects.<br><br>No explicit ADHD Strategy<br><br>Gap in accessibility to information, resources and personalised pre-diagnostic needs-led support through VCSE/social prescribing for Adults with ADHD | Autism and ADHD diagnostic waiting list times<br><br>ADHD treatment waiting list times<br><br>ADHD annual review waiting list times.<br><br>ND service annual quality report.<br><br>Oversight of Right to Choose ND diagnostic pathway referrals and spend<br><br>Neurodiversity priorities agreed though Learning Disability and Neurodiversity Population Board<br><br>Leeds Autism Strategy | Population board report July 2023<br><br>Service annual quality board<br><br>Draft pre valued proposition<br><br>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<br>- Lack of targeted/identified recurrent funding streams provide ongoing challenge for sustainable improvement through non-recurrent mechanisms. | Static - 3 cycles |
| 2301 | 16/05/2023 | Both Delivery and Quality and People's Experience | 15 (I3xL5) | 6 (I3xL2) | 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<br><br>Priority workstream for year 1 within SEND Inclusion plan<br><br>Development of pre assessment support (MindMate ND hub, pilot delivering ND support with a cluster for 23/24)<br><br>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.<br><br>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.<br><br>Links made to the West Yorkshire programme of work particularly in relation to responding to the ND choice financial pressure.<br><br>Funding has moved to LCH to outsource assessments for our most vulnerable cohorts. Outsourcing to commence in September. Provider has now been sourced (update from last cycle)<br><br>Sam Prince and Stephanie Lawrence identified as SROs from LCH. | Development of ND governance under development to include working group to develop and set out strategy for plans over next year<br><br>A similar ND citywide workshop (as detailed above) will be held in September with Education colleagues.<br><br>A shared communication is being developed alongside LCH colleagues to share with all across the system (including general public).<br><br>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).<br><br>No funding attached to transformation team and so dedicated resource not yet identified<br><br>Available funding and workforce will make rapid improvements difficult.<br><br>Vacancy in Under 5s assessment service in LCH has led to a pause in assessments. New postholder due to start in May 24 but gap will further increase waiting times and/or choice and has caused significant concern to local education colleagues. Staff availability with appropriate skills remains a key risk nationally and locally | Data from LCH on waiting times<br><br>Once working group established this will report regularly to SEND Partnership board and CYP population board<br><br>Meeting in place with ICB, LCH and LCC to determine development plan and shared position statement | Capacity in IS confirmed for highest risk cases<br><br>LCH workshop held in January to identify how /when to restart assessments and create alternative provision models<br><br>ICB establishing a clinical reference group to support model design | Mechanism for reporting on project progress not yet established (planned development for May-June)<br><br>Due to CAMHS cyber incident no regular data flowing on waiting times (Updated data due 6 February)<br><br>Increasing public focus with request from Scrutiny to update Cllrs in September and increasing letters from MPs to service provider (LCH). | Static - 4 cycles |
| **Risk Aligned to the Leeds Committee (12+)** | | | | | | | | | | | | | | |
| 2024 | 30/06/2022 | Leeds Committee of the WY ICB | 12 (I4xL3) | 1 (I1xL1) | 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.<br><br>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 Managemen managers to monitor current position, plan LPS and maintain numbers.<br><br>Prioritise cases based on complexity and risk of challenge<br><br>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.<br><br>MCA Lead is working in collaboration with the health case management team and appointed solicitors to minimise delays and maximise performance.<br><br>More case managers have received relevant training and experience to complete the assessments.<br><br>Fast track reviewing moved to Continuing Care Service to free up HCM capacity | Liberty Protection Safeguards LPS has been delayed in its implementation indefinitely.<br><br>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.<br><br>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.<br>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.<br><br>Mental Capacity Act Lead is working both at the place and ICB level to monitor all associated risks.<br><br>Adam (CHC System) has been updated to record DoLS, enabling improved monitoring and recording of DoLS | No current gaps identified | Static - 4 cycles |

## Mapping of risks – 5th risk cycle of 2023/24 (as at 4 January)

## COMMON RISKS

### 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 | 3 | 9 | |
| Leeds (2019) | There is a risk of harm to patients in the Leeds system due to people spending too long in Emergency Departments (ED) due to high demand for ED, the numbers, acuity and length of stay of inpatients and the time spent by people in hospital beds with no reason to reside, resulting in poor patient quality and experience, failed constitutional targets and reputational risk. | 4 | 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:-<br>a) increase in demand,<br>b) existing high waiting times and<br>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.<br>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).<br>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<br>Workforce remains a risk with vacancies across therapies which Provider are unable to recruit to (national picture) | | | | |
| Kirklees (2196) | There is a risk of delays for Kirklees' Children & Young people (CYP) requiring mental health services, including access to tier 4 CAMHS when in crisis, Community therapeutic placements.<br>Due to a significant increase in demand from pre pandemic levels & increased acuity.<br>Resulting in patient care and safety to be compromised & CYP being admitted inappropriately to acute wards or adult mental health beds and additional demands on ED. | 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<br>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 | |

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

| Place | Risk | I | L | Score | Proposed Action |
|---|---|---|---|---|---|
| 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. | 2 | 3 | 6 ↓ | |
| 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 health or social care interventions, resulting in failure to meet the requirements of the single oversight framework (should this measure be included). | 3 | 3 | 9 ↓ | Common risk re: gram negative blood infections reduction target |
| Kirklees (2058) | There is a risk that the WY ICB Kirklees Place will not achieve the national ambition of reducing gram negative blood stream infections by 50% by 2024/25 due to the gaps identified in the key controls; resulting in a risk to population health and experience. | 3 | 3 | 9 | |
| 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 more complex cases and in some cases higher demand and significant capacity issues due to inability to recruit into key clinical roles, 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 (2168) | SYSTEM PERFORMANCE AGAINST NATIONAL REQUIREMENTS<br>There is a risk that poor performance against national requirements (key constitutional standards, operational planning targets and recovery) will impact upon our place based contribution to the annual ICB performance assessment. This may lead to both financial and reputational impact alongside reduced patient care. | 3 | 5 | 15 | |
| Wakefield (2146) | There is a risk that demand for adult ADHD assessment exceeds capacity due to increased referrals, resulting in more people exercising Choice and seeking private assessment which presents a financial risk. | 3 | 2 | 6 ↑ | 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. The gap between demand and | 3 | 5 | 15 | |

| | | | | | |
|---|---|---|---|---|---|
| | capacity within BDCFT BANDS continues to grow month on month and referrals increase and capacity remains static. There is inequitable access to services for those who do not exercise Right to Choose and request a referral to an independent sector provider. Concerns exist between differences in service quality and outcomes between NHS and IS providers of ADHD Assessment/Diagnosis services. | | | | |
| BDC (2266) | There is a risk of increased financial pressure in the annual projected costs for children's and adult ADHD and Autism assessments this financial year (circa in excess of £1,000000 all age cost) in the health system, due to increases in Right to Choose requests for both ADHD and Autism assessments (including dual assessments), which will result and lead to a significant unbudgeted cost to the ICB. Note: (GP's can refer to any provider that meets the Right to Choose criteria and the ICB will receive the invoice in retrospect). This will also result in a two tier system of assessments time frames, for those utilising Right to Choose and those utilising standard NHS providers. | 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).<br>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.<br>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 | 3 | 9 ↓ | 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.<br><br>*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 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 | 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 | ropo ed 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 | 3 | 9 ↑ | |
| Wakefield (2297) | There is a risk of potential delays in commissioning patient care, dealing with provider issues and processing payments due to capacity and workforce pressures within the CHC contracting team. | 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 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 | 4 | 4 | 16 ↑ | |

| | | | | | |
|---|---|---|---|---|---|
| | 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<br><br>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 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. | 3 | 5 | 15 | Common risk re: waits for CYP neurodiversity<br><br>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 | 3 | 4 | 12 | |

| | | | | | |
|---|---|---|---|---|---|
| | 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.<br>resulting in delays to timely diagnosis, may also impact upon access to other support services across Health, Education and Social Care and reputational damage. | | | | |
| 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<br>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. | 2 | 3 | 6 ↓ | |
| 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.<br>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 achievement of mandatory timescales Resulting in performance targets not being met and assessments being carried out late. Health needs may not be identified early enough to ensure that support is put in place promptly. | 3 | 3 | 9 ↓ | Common risk re: Looked After Children health assessments |
| Leeds (2257) | There is a risk of not meeting target for Initial Health Needs Assessment completion for CLA, lack of capacity within service responsible for delivering IHNAs, resulting in health plans not being available for the first multidisciplinary Child Care Review meeting, delay in identification of health issues and subsequent support. There is also a risk of potential breach of statutory duty. | 3 | 4 | 12 | |

## Finance and Contracting Risks

| Place | Risk | I | L | Score | Proposed Action |
|---|---|---|---|---|---|
| Kirklees (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. | 2 | 2 | 4 ↓ | Common risk re: CHFT business case funding<br><br>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. | 2 | 2 | 4 ↓ | |
| 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 | |
| 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. The ICB and in particular within Wakefield has significant cost pressures in Prescribing, Independent Sector Activity and Continuing Healthcare Packages and is therefore at risk from achieving its financial planning control total. | 4 | 5 | 20 | Common risk re financial plan and financial control target |

| | | | | |
|---|---|---|---|---|
| Wakefield (2397) | There is a that the WDHCP part of the WYICS will not as a system develop a financial strategy to deliver a break-even position in future years. This is due in part to the fact that the WYICB - Wakefield Place delegated budget has an underlying deficit going into 2024/25. In addition MYTT has a significant underlying deficit. The scale of these pressures will require a financial recovery plan to deliver a break-even position in future years. The result of failure to deliver longer term financial balance will be a risk to the achievement of the overall WYICS financial plan which could result in failure to deliver statutory duties, reputational damage and potential additional scrutiny from NHSE and a requirement to make good deficits in future years. | 4 | 5 | 20 |
| 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<br>- increased costs in all business areas<br>- pressures due to inflation and pay<br>- high QIPP target<br>- under delivery of efficiency programmes<br>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 | 5 | 20 ↑ |
| Kirklees (2328) | The risk is that Kirklees Place will fail to deliver our 2023/24 planned Recovery trajectory for the 23/24.<br>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.<br>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. | 3 | 3 | 9 ↓ |
| Kirklees (2393) | UNDERLYING FINANCIAL DEFICIT There is a risk that we do not maximise our opportunities to make effective use of our resources and achieve a sustainable recurrent financial position, due to the size of our underlying deficit, funding and cost pressures and competing aims around performance and quality. This may result in regulatory interventions, reputational damage and impacts on the range and quality of services and patient outcomes. | 5 | 4 | 20 |
| Calderdale (2300) | The risk is that WYICB-Calderdale Place will fail to deliver the 2023/24 financial plan.<br>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.. | 4 | 3 | 12 |

| | | | | | |
|---|---|---|---|---|---|
| | 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.<br>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. | | | | |
| 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.<br>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.<br>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<br>There is a risk that we do not maximise our opportunities to make effective use of our resources and achieve our financial targets for the year, due mainly to shortfalls against savings plans, unidentified CIP targets, additional cost pressures (e.g. prescribing, CHC, MH OAPs, industrial action, pay and non-pay inflation, etc) and potential financial penalties re Elective Recovery Schemes. This may result in regulatory interventions, reputational damage and impacts on the range and quality of services and patient outcomes. | 5 | 4 | 20 | |
| BDC (2337) | UNDERLYING FINANCIAL DEFICIT<br>There is a risk that we do not maximise our opportunities to make effective use of our resources and achieve a sustainable recurrent financial position, due to the size of our underlying deficit, funding and cost pressures and competing aims around performance and quality. This may result in regulatory interventions, reputational damage and impacts on the range and quality of services and patient outcomes. | 5 | 4 | 20 | |
| BDC (2173) | BMDC FINANCIAL POSITION There is a risk that the measures taken to control expenditure by BMDC and the Children's Trust will impact on other Place partners. This could adversely affect wider system finances, hospital discharges and the management of winter pressures. | 5 | 4 | 20 | |
| Kirklees (2394) | There is a risk that measures being taken to control expenditure in Kirklees District council will have an impact on other place partners. Due to the financial pressures being experienced by most councils across West Yorkshire and their statutory requirement not to overspend against budgets Leading to a potential impact on hospital discharges resulting in higher costs being retained within the Kirklees and WY NHS system (additional costs borne by NHS provider organisations for which there may not | 4 | 4 | 16 | |

| | | | | | |
|---|---|---|---|---|---|
| | be mitigations, thereby resulting in adverse variances to plan) and the management of winter pressures. | | | | |
| | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | **experience**<br>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:<br>Reducing the internal funding for the Trust's ambitious Five-Year Capital programme, including Building the Leeds Way.<br>Cash shortfall and risk to supplier payment.<br>Potential non-compliance with regulatory requirements, including new medical devices regulation (Regulation EU 2017/45).<br>Limiting the capital programme / not replacing equipment.<br>Increased clinical risk due to inability to replace capital assets within agreed replacement schedules.<br>Greater reliance on external sources of funding.<br>Potential to contribute to the Integrated Care System not meeting its overall control total.<br>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**<br><br>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**<br><br>Increasing demand for services (specific risks on the risk register relate to 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. | ⇔ | **Financial Position 2024/25**<br><br>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**<br>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**<br>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**<br>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. | ⇔ | **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**<br>Harm to people, especially those with the greatest Health Inequalities (HIs), as third sector is increasingly unable to support existing as well as rising demand amongst the most vulnerable | ↑ | **Risk to financial position**<br>Where reduction in third sector service capacity means these service users have no alternative but to present directly to NHS services such as A&E or crisis centres (increasing service demand) or are unable to return | ↑ | **Risk to current contracts, service sustainability and tackling Health Inequalities**<br>Organisations unable to fulfil contracts and loss of third sector workforce and capacity working with population groups to tackle HIs and associated |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | 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.<br><br>Cuts and restrictions on NHS/LCC services, in addition to rising poverty, mean Third Sector Organisations are reporting increased demand from new users who cannot be safely or appropriately supported by third sector providers: this represents an additional harm to people. | | home after a stay in hospital (reducing service efficiency).<br><br>Potential impact on actual vs budgeted ICB expenditure and plans to reduce spend. Includes disproportionate users of unplanned care services, so may have a disproportionate impact on unplanned expenditure.<br><br>**ICB funding for Forum Central representation and capacity linked to the ICB structures ends in Sept 2024:** Limits Forum Central's LHCP capacity to provide a strategic voice for the third sector for health & care, and manage third sector representation & engagement across the ICB/LHCP structures | | impact on the HLP's two priority goals. Includes provision not always visible to statutory organisations.<br><br>Loss of contracts and / or lack of full cost recovery leading to closure of local Third Sector organisations.<br><br>Reduced capability to address root cause associated with the presenting problem captured in the Leeds Data Model (i.e. just as Leeds Data Model analysis becomes able to identify the population groups to prioritise, we lose the staff and services best placed to be a critical part of the solution). |
| **Leeds City Council** | ⇔ | **Financial pressures (In-year budget)**<br>Council's financial position goes into significant deficit in the current year resulting in reserves (actual or projected) being less than the minimum specified by the council's risk-based reserves policy.<br><br><u>Sources:</u> Inflation and significant increases in the prices that local | ⇔ | **Workforce planning**<br>Workforce resource not in place to deliver the service to the required standard. 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, | New | **Major Cyber incident**<br>Risk to citizens, the council and city as a result of digital crime, process failure or people's actions in relation to a major cyber incident.<br><br><u>Sources:</u> Internal and external threats to cyber security e.g., human error, malware, ransomware and increasing sophistication of cyber-criminal |

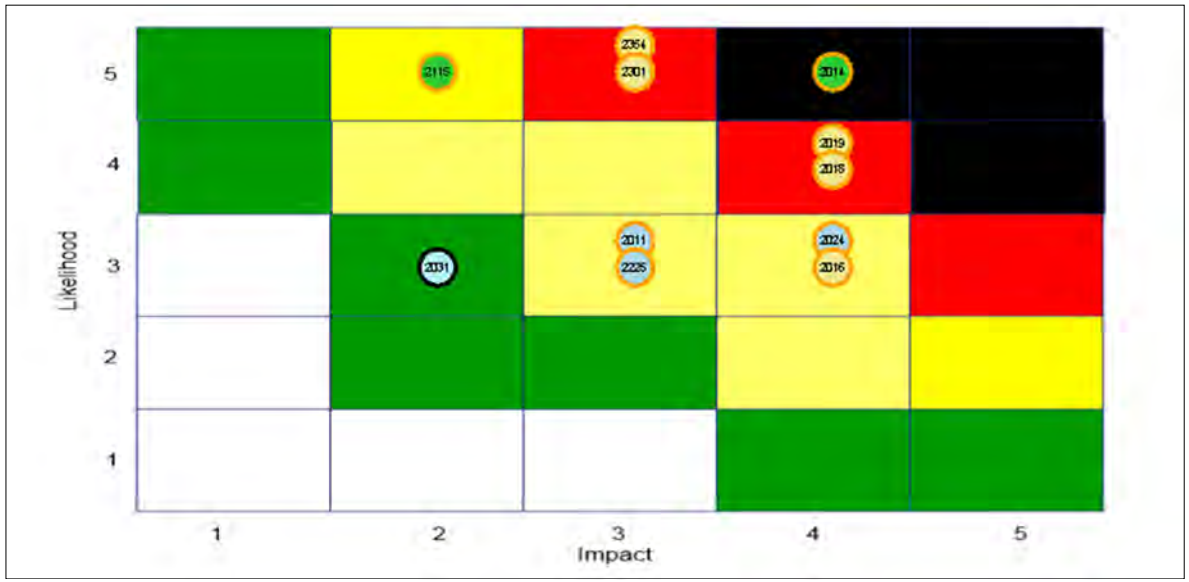
| | | | | | | |
|---|---|---|---|---|---|---|
| | | authorities pay for statutory, demand led health and social care services. Ongoing impact of over a decade of public sector austerity measures. | | schools) leading to increased resource pressures and adverse impact on our ability to deliver a wider range of services. Risk that the workforce capacity gap could worsen.<br><br><u>Sources:</u> 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. | | activity. Cyber disruption from world conflicts. |

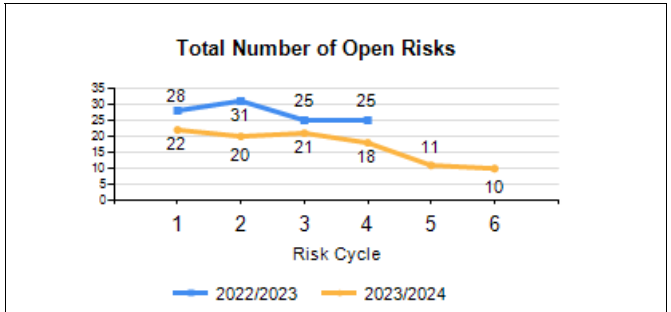
# Appendix 4: Risk on a Page Report for the Leeds Committee of the West Yorkshire Integrated Care Board
## Risk Cycle 6: January – March 2024

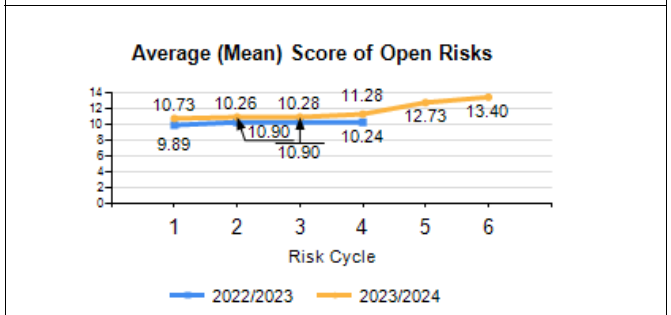
| Total Risks | 11 |
|---|---|
| Delivery | 0 |
| QPEC | 0 |
| Delivery and QPEC | 5 |
| Finance & Best Value | 2 |
| Leeds Committee | 3 |
| EMT | 1 |

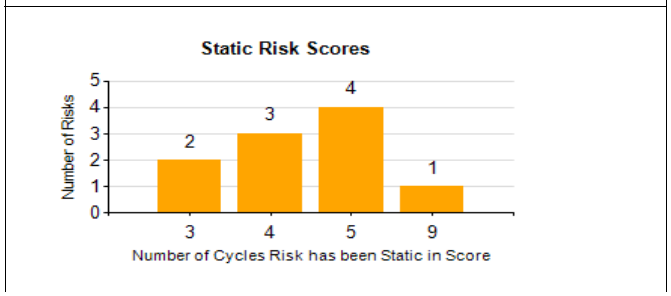
| Movement of Risks | |
|---|---|
| New | 0 |
| Marked for Closure | 1 |
| Risk score increasing | 0 |
| Risk score static (1 cycle) | 0 |
| Risk score static (2+ cycles) | 10 |
| Risk score decreasing | 0 |

### Risk Overview




### Key

- Finance and Best Value Committee
- Leeds Committee of the WY ICB
- EMT
- Both Delivery and Quality and People's Experience
- New Risk
- Closed Risk
- Risk Score Increasing
- Risk Score Decreasing
- Risk Score Static

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

Appendix 4

**Review of Static Risk Scores – as at 2nd February 2024**

**Summary of position:**

- All risks static for 2 or more cycles at the end of the last risk cycle reviewed through meetings between the Corporate Governance Team and risk owner for each risk.
- 16 risks reviewed
- Of these:
    - Risk score confirmed appropriate - 10
    - 5 risks closed, 1 risk marked for closure this cycle:
        - 2 risks reached tolerance
        - 1 risk closed as become issue
        - 3 risks to be managed at provider / other board level

| **Risks aligned to Committees/Subcommittees:** | |
|---|---|
| Finance & Best Value Subcommittee | EMT |
| Delivery and QPEC Subcommittee | Delivery Subcommittee |
| Leeds Committee of the WYICB | QPEC |

| Risk No. | No. of static cycles | Risk Owner | Senior Reviewer | Date of review | Before review | | After review | | Comments |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | Current score | Target score | Current score | Target score | |
| 2014 | 4 | Matt Turner | Visseh Pejhan-Sykes | 30.1.2024 | 20 (I4xL5) | 6 (I3xL2) | 20 (I4xL5) | 6 (I4xL5) | The risk has been reviewed in line with instruction from the WY Finance Team to ensure that risk scores for Place finance risks are scored at 20. |
| 2019 | 2 | Nicola Nicholson | Helen Lewis | 12.1.2024 | 16 (I4xL4) | 12 (I3xL4) | 16 (I4xL4) | 12 (I2xL4) | The risk has been reviewed and additional information added. |
| 2018 | 4 | Eddie Devine | Helen Lewis | 5.1.2024 | 16 (I4xL4) | 12 (I3xL4) | 16 (I4xL4) | 12 (I3xL4) | Risk score deemed appropriate following review. Further information added to key controls. |
| 2354 | 3 | Phil Chan | Helen Lewis | 11.1.2024 | 15 (I3xL5) | 9 (I3xL3) | 15 (I3xL5) | 9 (I3xL3) | Risk score deemed appropriate following review. Further information added to key controls and gaps identified. |
| 2301 | 4 | Emily Carr | Helen Lewis | Risk reviewed via email | 15 (I3xL5) | 6 (I3xL2) | 15 (I3xL5) | 6 (I3xL2) | Risk score deemed appropriate following review. Further work to be undertaken to determine timescales for reduction. |
| 2024 | 3 | Andrea Dobson | Penny McSorley | Risk reviewed via email | 12 (I4xL3) | 1 (I1xL1) | 12 (I2xL5) | 1 (I1xL1) | The risk has been reviewed and further information added. |

| Risk No. | No. of static cycles | Risk Owner | Senior Reviewer | Date of review | Before review | | After review | | Comments |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | Current Score | Target Score | Current Score | Target Score | |
| 2016 | 4 | Joanna Bayton-Smith | Helen Lewis | Risk reviewed via email | 12 (I4xL3) | 12 (I4xL3) | 12 (I4xL3) | 12 (I4xL3) | Further discussions to take place regarding scoring of this risk. |
| 2115 | 4 | Andrea Dobson | Penny McSorley | Risk reviewed via email | 10 (I2xL5) | 2 (I2xL1) | 10 (I2xL5) | 2 (I2xL1) | Target to close the risk next review cycle. |
| 2225 | 3 | Kate O'Connell | Tim Ryley | 11.1.2024 | 9 (I3xL3) | 6 (I2xL3) | 9 (I3xL3) | 6 (I2xL3) | Target to close the risk next review cycle as it has become an issue, to be managed by the Leeds Strategic Workforce Board and through the Leeds Place reporting to the WYICB via the recently finalised Board Assurance Framework (BAF). |
| 2011 | 8 | Gina Davy | Tim Ryley | Risk reviewed via email | 9 (I3xL3) | 6 (I3xL2) | 9 (I3xL3) | 6 (I3xL2) | Risk score deemed appropriate and timeline for reduction added. |
| 2020 | 3 | Paula Johnson-Laird | Gaynor Connor | 10.1.2024 | 9 (I3xL3) | 4 (I2xL2) | Closed | Closed | Risk closed following review. This risk will now be managed at provider level. |
| 2013 | 5 | James Hirst | Sabrina Armstrong | 10.1.2024 | 9 (I3xL3) | 6 (I2xL3) | Closed | Closed | This risk is now an issue and has been closed. |

| Risk No. | No. of static cycles | Risk Owner | Senior Reviewer | Date of review | Before review | | After review | | Comments |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | Current score | Target score | Current score | Target score | |
| 2012 | 2 | Kirsty Turner | Gaynor Connor | 9.1.2024 | 8 (I2xL4) | 6 (I2xL3) | Closed | Closed | Risk closed following review. This risk will now be managed by the Primary Care Board and is also covered by the corporate risk relating to capital (risk no. 2305) |
| 2031 | 8 | Mark Okun | Leonardo Tantari | Risk reviewed via email | 6 (I2xL3) | 6 (I2xL3) | Marked for closure | Marked for closure | Risk marked for closure in cycle 6 following review – tolerance reached. |
| 2008 | 2 | Kirsty Turner | Gaynor Connor | 9.1.2024 | 6 (I2xL3) | 4 (I2xL2) | Closed | Closed | Risk closed following review. This risk will now be managed by the Primary Care Board. |
| 2023 | 7 | Kirsty Turner | Gaynor Connor | 9.1.2024 | 6 (I2xL3) | 4 (I2xL2) | Closed | Closed | Risk closed following review. The risk has not materialised and has therefore reached tolerance; however it will continue to be monitored by the Primary Care Board. |

Leeds Health & Care Partnership

NHS West Yorkshire Integrated Care Board

**LEEDS COMMITTEE OF THE WEST YORKSHIRE INTEGRATED CARE BOARD**
**WORK PROGRAMME 2024-25**

| ITEM | May 24 | Sept 24 | Nov 24 | Feb 25 | 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 |
| Terms of Reference Review | X | | | | Chair |
| Sub-Committee Annual Reports | X | | | | Chairs |
| **ITEMS FOR DECISION** | | | | | |
| GP Procurement / Merger of practices | X | | | | GC |
| Financial Plan 2025/26 | | | | X | TR/VPS |
| **STRATEGY & ASSURANCE** | | | | | |
| Marmot City Update | X | | | | VE/ALL |
| Medium Term Plan | X | | X | | TR |