Leeds Health & Care Partnership

NHS West Yorkshire Integrated Care Board

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

Wednesday 27th November 2024, 13:15 – 16:00
(Private pre-meet for members 13:00, public meeting 13:15)
HEART: Headingley Enterprise & Arts Centre, Bennett Rd, Headingley, Leeds, LS6 3HN

AGENDA

No.	Item	Lead	Page	Time
LC 44/24	**Welcome, Introductions**	**Rebecca Charlwood** Independent Chair	-	13:15
LC 45/24	**Apologies and Declarations of Interest** - To note and record any apologies - A register of interests of members can be found at mydeclarations.co.uk. Once redirected to the portal, please select 'filter', and in the 'All decision making groups' field, select 'Leeds Committee of the WYICB' from the drop down box.	**Rebecca Charlwood** Independent Chair	-	-
LC 46/24	**Minutes of the Previous Meeting** - To approve the minutes of the meeting held 11th September 2024	**Rebecca Charlwood** Independent Chair	4	-
LC 47/24	**Matters Arising** - To consider any outstanding matter arising from the minutes that is not covered elsewhere on the agenda	**Rebecca Charlwood** Independent Chair	-	-
LC 48/24	**Action Tracker** - To note any outstanding actions	**Rebecca Charlwood** Independent Chair	13	-
LC 49/24	**People's Voice** - To receive the 'Communicating Changes' report from Healthwatch Leeds	**Healthwatch Leeds Co-Chair**	14	13:20
LC 50/24	**Questions from Members of the Public** - To receive questions from members of the public in relation to items on the agenda	**Rebecca Charlwood** Independent Chair	-	13:35
LC 51/24	**Population and Care Delivery Board Update** - To receive an update on recent work to redefine the role of the Population Boards	**Nick Earl** Interim Director of Strategy, Planning and Programmes	24	13:45
LC 52/24	**Place Lead Update** - To receive a report from the Place Lead	**Tim Ryley** Place Lead	36	14:00
ROUTINE REPORTS				
LC 53/24	**Quality & People's Experience Sub-Committee Update** - To receive an assurance report from the Chair of the sub-committee	**Rebecca Charlwood** Independent Chair & Chair of the Quality and People's Experience Sub-Committee	50	14:25
LC 54/24	**Delivery Sub-Committee Update** - To receive an assurance report from the Chair of the sub-committee	**Yasmin Khan** Independent Member & Chair of Delivery Sub-Committee	52	14:30

No.	Item	Lead	Page	Time
LC 55/24	**Finance & Best Value Sub-Committee Update** - To receive an assurance report from the Chair of the sub-committee	**Cheryl Hobson** Independent Member & Chair of Finance & Best Value Sub-Committee	54	14:35
BREAK 14:40 -14:50				
FINANCE				
LC 56/24	**Financial Update at Month 6** - To receive an update on the financial position	**Alex Crickmar** Director of Operational Finance	56	14:50
ITEMS FOR DECISION / ASSURANCE / STRATEGIC UPDATES				
LC 57/24	**Consolidating VCSE Mental Health Contracts - Provider Selection Regime Intentions** - To consider the report	**Eddie Devine** Head of Pathway Integration	72	15:10
GOVERNANCE / RISK MANAGEMENT				
LC 58/24	**Risk Management and Board Assurance Framework Report** - To receive and consider the risk management information provided	**Tim Ryley** Place Lead	81	15:25
LC 59/24	**Urgent Decision: Procurement Route for Short Term Community Beds** - To ratify the urgent decision taken on the procurement of Short Term Community Beds	**Rebecca Charlwood** Independent Chair	104	15:40
FORWARD PLANNING				
LC 60/24	**Items for the Attention of the ICB Board** - To identify items to which the ICB Board needs to be alerted, which it needs to be assured, which it needs to action and positive items to note	**Rebecca Charlwood** Independent Chair	-	15:50
LC 61/24	**Forward Work Plan** - To consider the forward work plan	**Rebecca Charlwood** Independent Chair	114	-
LC 62/24	**Any Other Business** - To discuss any other business	**Rebecca Charlwood** Independent Chair	-	-
LC 63/24	**Date and Time of Next Meeting** The next meeting of the Leeds Committee of the WY ICB will be held on 26th February 2025 13:15 – 16:30 (private pre-meet for members 13:00, public meeting 13:15)	**Rebecca Charlwood** Independent Chair	-	-
Additional papers for information: Working with the Third Sector - Annual Position Statement 2024 (Page 115)				

The Leeds Committee of the WY ICB is recommended to make the following resolution:

"That the press and public be excluded from the meeting during the consideration of the following item as it contains confidential information as set out in the criteria published on the ICB's website, and the public interest in maintaining the confidentiality outweighs the public interest in disclosing the information."

No.	Item	Lead	Page	Time

64/24	**PRIVATE & CONFIDENTIAL** **Minutes of the Previous Meeting** - To approve the confidential minutes	**Rebecca Charlwood** Independent Chair	-	15:55

Draft Minutes

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

Wednesday 11 September 2024, 1.15pm – 4.30pm

St George's Centre, 60 Great George Street, Leeds, LS1 3DL

Members	Initials	Role	Present	Apologies
Rebecca Charlwood	**RC**	Independent Chair, Leeds Committee of the WY ICB	✓	
Caroline Baria	**CB**	Director of Adults and Health, Leeds City Council (LCC)		✓
Dr Jason Broch (deputising for SF)	**JB**	Chief Clinical Information Officer, ICB in Leeds	✓	
Alex Crickmar	**AC**	Director of Operational Finance	✓	
Hannah Davies (deputising for JM)	**HD**	Chief Executive, Healthwatch Leeds	✓	
Selina Douglas	**SD**	Chief Executive, Leeds Community Healthcare NHS Trust (LCH)	✓	
Victoria Eaton	**VE**	Director of Public Health, Leeds City Council	✓	
Dr Sarah Forbes	**SF**	Medical Director, ICB in Leeds		✓
James Goodyear (deputising for PW)	**JG**	Director of Strategy, Leeds Teaching Hospital NHS Trust (LTHT)		
Pip Goff	**PG**	Volition Director, Forum Central	✓	
Jo Harding	**JH**	Director of Nursing and Quality, ICB in Leeds	✓	
Cheryl Hobson	**CH**	Independent Member – Finance and Governance	✓	
Yasmin Khan	**YK**	Independent Member – Health Inequalities		✓
Shona McFarlane (deputising for CB)	**SMc**	Deputy Director, Adults and Health, LCC	✓	
Dr Sara Munro	**SMu**	Chief Executive, Leeds and York Partnership Foundation Trust (LYPFT)	✓	
Jane Mischenko	**JM**	Co- Chair, Healthwatch Leeds		✓
Tim Ryley	**TR**	Place Lead, ICB in Leeds	✓	
Dr George Winder	**GW**	Chair, Leeds GP Confederation	✓	
Prof. Phil Wood	**PW**	Chief Executive, LTHT		✓
Additional Attendees				
Sue Baxter	**SB**	Head of Partnership Governance, WYICB	✓	

Members	Initials	Role	Present	Apologies
Tim Fielding (Items 30/24 & 31/24)	**TF**	Deputy Director of Public Health	✓	
Harriet Speight	**HS**	Corporate Governance Manager, WYICB	✓	

Members of public/staff observing – 4

No.	Agenda Item	Action
22/24	**Welcome and Introductions** The Chair opened the meeting of the Leeds Committee of the West Yorkshire Integrated Care Board (WY ICB) and welcomed all attendees to the meeting. The Chair welcomed Alex Crickmar (AC) and Selina Douglas (SD) to their first meetings as members of the Committee.	
23/24	**Apologies and Declarations of Interest** Apologies were noted as set out above. Members were asked to declare any interests presenting an actual or potential conflict of interest arising from matters under discussion. No further interests were declared.	
24/24	**Minutes of the Previous Meeting – 22 May 2024** The public minutes were approved as an accurate record. **<u>The Leeds Committee of the WY ICB:</u>** a) **Approved** the minutes of the previous meeting held on 22 May 2024.	
25/24	**Matters Arising** No matters were raised.	
26/24	**Action Tracker** The committee noted the completed actions set out in the action tracker.	
27/24	**People's Voice** Hannah Davies (HD) introduced the summary report from the 'how does it feel for me?' series with Mercy from Chapeltown, coordinated by Healthwatch Leeds. It was noted that the Committee and its sub-committees had watched videos with Mercy during the last cycle of meetings, which generated an important discussion	

No.	Agenda Item	Action
	around barriers to improving the balance of types of practitioners in primary care settings, which led to an alert in the AAA report to the WYICB on this issue and request that the WYICB continue to lobby NHS England for changes to the funding requirements to promote more flexibility and balance. Members noted the clear theme of digital exclusion in Mercy's story, and further risk associated with the shift nationally from analogue to digital data management for NHS services. It was noted that the upcoming WY digital strategy would address the risks associated with the digital transition. There was recognition from members that the communication around changes to audiology services had been challenging and there was some discussion around broadening the neighbourhood health model used at LCC to communicate changes with communities and the potential for the development of a shared equality impact assessment to ensure a coordinated approach across the partnership and better inform decision making. Members welcomed the comprehensive report and noted the actions set out. agreed the insights would also be used by relevant Population Boards to inform discussions and decisions. In addition, the reports would feed directly into the Leeds Health and Care Partnership, including the citywide Person-Centred Care Board and the Quality and People's Experiences Committee.	
28/24	**Questions from Members of the Public** No questions were submitted on this occasion.	
29/24	**Place Lead Update** TR provided an overview of the report, setting out the national context, including the new government and c commitment to stronger focus on preventative approaches, a welcome focus on determinants of health and reducing gap in healthy life expectancy, and a commitment to neighbourhood model of health and care which aligns well with the priorities of Leeds and Local Care Partnerships (as referenced in the Peoples Voice item, minute 27/24 refers.) TR also provide an update on the recent audit undertaken of neurodiversity services, which provided an assessment of capacity of 16 per month, with the demand at around 170, compared to around 20 when the service was established in 2011. The waiting list was reported at around 4,400 people. Members noted the particular challenges for those transitioning between children and adult services, and the shift in approach to providing support prior to diagnosis as opposed to requiring diagnosis to access support services. The Committee recommended that the ICB Board be advised of the gap between capacity to assess and the rise in demand on assessment for both adult and children's services. **<u>The Leeds Committee of the WY ICB:</u>**	

No.	Agenda Item	Action
	a) **Received** the update.	
30/24	**Fairer Healthier Leeds – a Marmot City** Tim Fielding (TF) introduced the report and provided an overview of the 'Fairer, Healthier Leeds' programme, intended to enable the city to better understand how to maximise opportunities to address health inequalities and the findings and recommendations following the whole system review. TR set out two priority workstreams for the programme – 0 – 5-year-olds and the link between housing and health, along with the governance of the schemes and timelines for completion of work. Whilst recognising the challenging financial context currently, members discussed the need for proportional financing of Local Care Partnerships (LCPs) in the most deprived areas of Leeds, to support the priorities and recommendations set out, and the need to utilise levers to influence national policy through the Leeds Hub to support this. A query was raised around the approaches taken to address racism discrimination as set out in the report, and TF advised that analysis had been undertaken to build on existing successful approaches in the city (e.g. Synergi-Leeds) to enable system leaders to have conversations about ethnicity, racism and discrimination through a health lens. The Committee accepted the recommendations noting that these would shape an action plan to be developed by November 2024. The Committee requested an update on the progress of the programme in 12 months' time. **ACTION** – To add 'Fairer Healthier Leeds – a Marmot City' update to the work programme for September 2025. **<u>The Leeds Committee of the WY ICB:</u>** a) **Noted** progress of the Fairer, Healthier Leeds programme. b) **Considered** the findings in the 'Fairer, Healthier Leeds – Reducing Health Inequalities' and commit to supporting delivery of the IHE recommendations.	**HS**
32/24	**Quality and People's Experience Sub-Committee Update** The Committee received the AAA report on behalf of the Chair, Rebecca Charlwood. **<u>The Leeds Committee of the WY ICB:</u>** **a) Noted** the update.	

No.	Agenda Item	Action
33/24	**Finance and Best Value Sub-Committee Update** The Committee received the AAA report on behalf of the Chair, Cheryl Hobson (CH). **<u>The Leeds Committee of the WY ICB:</u>** a) **Noted** the update. ***The meeting adjourned for a comfort break at 2.45 p.m. until 2.55 p.m.***	
34/24	**Financial Update at Month 4** Alex Crickmar (AC) introduced the report, highlighting that the ICB in Leeds financial plan for 2024/25 reported a £12.3m deficit at month four, with additional pressures of pay award, impact of junior doctors' industrial action, potential risk for LTHT's achievement of elective recovery fund. Significant risks and potential pressures were reported, which would need to be managed to achieve a balanced position. This included delivery of a significant efficiency programme in 2024/25. Building on the PricewaterhouseCoopers's (PWC) independent review of finances of West Yorkshire Association of Acute Trusts (WYAAT), a further review of the ICB and other NHS partners had been agreed. In response to a query around funding for the NHS Agenda for Change pay uplift, members were advised that a national funding formula would determine the level of funding supplied to support the increases in pay, however it was noted that this would not reflect external provider contracts, leaving a shortfall for the ICB to cover. Members welcomed the proactive approach taken by WY to bring in external auditors to explore opportunities to improve financial management. Members queried the risk of Winter pressures worsening the financial position and potential for mandatory NHS England intervention. Members were advised that it was too early to predict at this stage, however the review would support fast and effective mitigations. **<u>The Leeds Committee of the WY ICB:</u>** **a)** **Reviewed** the 2024/25 financial position at Month 4 **b)** **Reviewed** the QIPP position for 24/25 at Month 4 **c)** **Noted** the national context and the extended WY review of finances building on from the West Yorkshire Association of Acute Trusts (WYAAT) commissioned review of acute trusts. **d)** **Discussed** next steps across the Leeds System as we continue to focus on achieving a financially balanced position across the Leeds system and for the ICB in Leeds	
31/24	**Director of Public Health Annual Report**	

No.	Agenda Item	Action
	Please note, this item was postponed until after item 34/24 due to technical difficulties. Victoria Eaton (VE) introduced the Director of Public Health Annual Report 2023 titled 'Ageing Well: Our Lives in Leeds' and provided an overview of the findings and recommendations. VE advised that the report explores how healthy people, places, and communities all contribute to living and ageing well in Leeds. A short film was played to members depicting Leeds residents sharing their experiences and outcomes of ageing. Key findings focussed on actions to create the conditions for healthy ageing and increasing the number of years spent in good health. Members noted that population trends show that the older population (50+) is growing in the most deprived areas and becoming more diverse, and referenced that the ongoing work to improve prevention through the Healthy Leeds Plan (goal 2) would be key in addressing this, along with national public health interventions such as smoking cessation and increased sugar tax. Members welcomed the report and supported the recommendations. **The Leeds Committee of the WY ICB:** a) **Noted** the findings and recommendations of the of the 2023 Director of Public Health Annual Report. b) **Noted** and **supported** the recommendations identified for Leeds Health & Care Partnership and Leeds NHS organisations.	
35/24	**Assurance and update on our plan for financial sustainability in 24/25** TR presented the report, highlighting that, in the context of an increasingly challenging financial forecast, the Committee agreed a financial plan for 2024/25 in March 2024. TR highlighted that the report provides an assurance update on the work undertaken to risk assess, assure and (in some instances) engage on efficiency schemes that sit outside of core provider contracts, along with an update on the schemes reviewed since. TR welcomed suggestions on how the process could be improved. Jason Broch (JB) declared for visibility that some of the efficiency schemes detailed in the report impacted him in his role as GP in Leeds. There was some concern raised around the process to determine efficiency schemes, as it was reported that feedback had been received that not all decisions had been taken through the Population and Care Delivery Boards, therefore highlighting inconsistent engagement. It was also suggested that the Health Inequalities Group (THIG) would also be helpful in this space. TR recognised that the process had not always been clear and that the Partnership Leadership Team (PLT) would be looking at the Population Board's roles moving forward to ensure	

No.	Agenda Item	Action
	consistency and would also consider the role of THIG moving forward. TR also advised that all Quality and Equality Impact Assessments (QEIAs) would be published on the Leeds Health and Care Partnership website in due course for visibility. Jo Harding (JH) and CH, as QEIA Panel members, whilst recognising that the process was developed at pace, they felt that the process undertaken had been robust and challenging. Members requested that a further update be provided at the Committee meeting in February 2025. **ACTION –** To add a further efficiency scheme assessment process update to the work programme for February 2025. **<u>The Leeds Committee of the WY ICB:</u>** **a)** **Noted** and **suggested** further improvements on the processes used to meet duties to involve and to consider impacts on quality and inequality. **b)** **Noted** progress towards assessing overall impact in light of the balance of protected, new additional, and reduced funding to address health inequality recognising challenges this presents. **c)** **Noted** and **ratified** the outcomes of the processes on those areas that were designated for review (where applicable) in the annual Financial Plan approved by the Committee in March 2024. **d)** **Noted** the current level of risk within the health system, and the potential impact not taking these decisions may have on the financial stability and performance of the Leeds Health and Care System implications of the outcomes on the financial plan as submitted and the remedial action.	**HS**
36/24	**Leeds Joint Working Agreement (JWA) with Astra Zeneca for the Leeds MART Project Phase 2** JB introduced the report, highlighting that the Leeds Committee approved the approved the phase 1 Joint Working Agreement in December 2022, and that this report related to the next stage of the work. **<u>The Leeds Committee of the WY ICB:</u>** a) Approved the recommendation that the Leeds Place enters into a second Joint Working Agreement (JWA) with AstraZeneca for phase 2 of the Leeds MART Project.	
37/24	**Risk Management and Board Assurance Framework (BAF) Report** TR provided an overview of the report and provided an update on the request at the last meeting to undertake an in-depth review of the risk register. TR advised that the Director's had agreed that work to fully review the risk register should be slowed until the outputs of wider work is undertaken, including work to develop the BAF	

No.	Agenda Item	Action
	and ongoing discussions taking place amongst the Director of Operational Finance at each Place in WY around consistency of angle, articulation and scoring of financial risks. **<u>The Leeds Committee of the WY ICB:</u>** a) **Received** and **noted** the High-Scoring Risk Report (scoring 15+) as a true reflection of the ICB's risk position in Leeds, following any recommendations from the relevant committees; b) **Received** and **noted** the risks directly aligned to the Leeds Committee of the ICB scoring 12 and above; and c) **Noted** in respect of the effective management of the risks aligned to the Committee and the controls and assurances in place.	
38/24	**Urgent Decision: Direct award of new contract for Social Prescribing Service in Leeds** The Chair advised that the report provided detail on the recent decision taken by herself and the Place Lead on 17 July 2024 due to timescales, in line with the terms of reference, in respect of the new contract for the Social Prescribing Service in Leeds. The Chair advised that the report was circulated to members for comment in advance of the decision being taken. Additional information requested (from Healthwatch) in relation to the quality impacts of the proposal had been included in the main report for additional assurance. **<u>The Leeds Committee of the WY ICB:</u>** a) **Ratified** the decision taken on 17 July 2024 to approve the Provider Selection Regime (PSR) route for the Social Prescribing service: Direct Award C.	
39/24	**Items for the Attention of the ICB Board** The Chair outlined that the Committee would submit a report to the West Yorkshire ICB on items to be alerted on, assured on, action to be taken and any positive items to note. The key areas to highlight were set out as follows: - An alert to the impact of considerable financial challenge on people's experiences and specifically health inequalities. - The challenges experienced by neurodiversity services to meet the demand for assessments for both children and adults - Reflections on the People's Voice around communication and coordination - Positive work ongoing through the Fairer, Healthier Leeds' programme and the Director of Public Health Annual Report	
40/24	**Forward Work Plan**	

No.	Agenda Item	Action
	The forward work plan was presented for review and comment, noting that it continued to develop and would be an iterative document. Members of the Committee were invited to consider and add agenda items.	
41/24	**Any Other Business** There were no matters raised on this occasion.	
42/24	**Date and Time of Next Meeting** The next meeting of the Leeds Committee of the WY ICB to be held at 1.15 pm on Wednesday 27th November 2024.	

Action Tracker

Leeds Committee of the WY ICB

Action No.	Meeting Date	Item Title	Actions agreed	Lead(s)	Accountable body / board / committee	Status	Update
30/24	**11 September 2024**	**Fairer Healthier Leeds – a Marmot City**	To add 'Fairer Healthier Leeds – a Marmot City' update to the work programme for September 2025.	**HS**	**LCICB**		Added to the workplan.
35/24	**11 September 2024**	**Assurance and update on our plan for financial sustainability in 24/25**	To add a further efficiency scheme assessment process update to the work programme for February 2025.	**HS**	**LCICB**		Added to the workplan.
Completed Actions							
09/24	**22 May 2024**	**Place Lead Update**	To circulate the link to the recent Joint Targeted Area Inspection (JTAI) report.	**HS**	**LCICB**		Circulated 17/06/2024
17/24	**22 May 2024**	**Risk Management Report**	To review the articulation of risks included on the Leeds Place risk register to ensure that descriptions and mitigations are person-centred and reflect strategic risks set out within the BAF.	**SR/TR**	**LCICB**		Risk Register reviewed by Directors on 21/08/2024. Outputs are set out in the Risk Management Report (11/08/2024)

Communicating Change
September 2024 Briefing Paper

This briefing paper is aimed at service providers and commissioners. It provides an overview of what we have heard about people's experiences of three recent significant service changes in Leeds and how they have been communicated:

Change of children's orthodontics providers: On 31st March 2022, contracts with existing providers of children's orthodontics in Leeds came to an end due to planned re-procurement. Contracts with new providers didn't commence until 1st June 2022, leaving a three-month gap with no provision. Despite new contracts beginning in June 2022 there was a further delay for many patients due to the time taken for NHS England to transfer patient data over to the new providers.

Change of audiology provider: From 1st April 2024, Westcliffe Health Innovations terminated its audiology sub-contract with Specsavers, choosing to provide its audiology diagnostic and fitting service directly, rather than through a sub-contractor. Following the change there was a delay of several months before the service became fully functional.

Removal of public access to the adult mental health crisis Single Point of Access phoneline: On 8th May 2024 crisis support for the public via the Leeds and York NHS Foundation Trust (LYPFT) single point of access ceased. This coincided with the rollout in West Yorkshire of NHS 111 offering a mental health crisis support option for the public as part of a national rollout.

This paper highlights the impact on people of these changes and how they were communicated, as well as what can be done differently to improve communication in the future.

Communication of changes

In all three of these examples, there was a lack of clear information to prepare people using services for the changes and what it would mean for them.

We requested copies of Equality Impact Assessments and Health Inequality Impact Assessments from commissioners and providers relating to all three changes. We didn't receive anything back about Orthodontics.

For Audiology there was some engagement done ahead of the procurement to inform the service specification. However, this was done in 2014 and 107 people responded about Audiology. A more recent survey received 18 responses. We've been told that following the procurement, providers were advised about communicating / engaging with patients.

Leeds and York Partnership NHS Foundation Trust didn't give details of any impact assessments but told us that the change to the Single Point of Access had "been through several stages including the crisis transformation group and board, the trusts oversight governance group and also the crisis redesign engagement event with Service users and carers". Leeds ICB have provided us with the West Yorkshire QIA that was completed as part of the work. We've been told that a Leeds place one wasn't completed by LYPFT at the time of change, which has been acknowledged as an oversight.

Orthodontics and Audiology

Patient information leaflets were eventually produced for children's orthodontics and audiology, but only following the change in contracts. Leeds Integrated Care Board also sent out a letter to everyone on their contact list for audiology, but this didn't reach a lot of people as they didn't, and still don't, have details of all the people that Specsavers were seeing.

Neither leaflet was systematically sent out to all service users, resulting in confusion and a reliance on people having to contact their old providers to find out what was happening. Both leaflets said that people would be contacted to keep them informed about what was happening. However, this didn't happen for many, and even when people did receive communications, it was often very delayed. This left people not knowing where to turn for information or treatment, resulting in high volumes of enquiries to Healthwatch Leeds. The correspondence sent to people contained no apology or explanation about the reasons for the delay.

We were told that all patients should have initially received a copy of the respective information leaflets. However, everyone who contacted our information and advice service in relation to orthodontics said they had never been sent this leaflet. In terms of audiology, a high proportion of people who had seen the leaflet produced by Specsavers, had so by chance having been given it in their local Specsavers branch when trying to book an appointment.

With orthodontics, the leaflet directed people to contact 'their provider' or NHS England with any concerns. Since many people were 'between providers', not knowing who their new provider would be, this was not helpful. As a result, people resorted to contacting their old providers who were unable to give them any new information. People who contacted NHS England to raise their concerns, told us that they never got a response. We were also advised that people should contact the local Yorkshire and Humber dental returns email which wasn't even mentioned in the leaflet. People reported either a complete lack of response from them, or a generic response that didn't tell them anything new.

"There is no contact from NHS whatsoever. His braces are getting loose now, and I am afraid that it might lead to mouth injuries as there is no one who I can contact. I don't know how to resolve this issue, who to contact and how."

With Audiology, the contact details on the leaflet (produced by Specsavers) were confusing for people, advising them to contact Westcliffe Health Innovations if they had any queries or feedback about the change but omitting to say that Westcliffe would be the provider going forward. It also included Healthwatch Leeds along with Leeds Integrated Care Board to contact with any queries about "how this contract has been procured". The lack of clarity and plain English in the leaflet resulted in many people contacting Healthwatch Leeds and dropping into our office thinking they'd be able to arrange an audiology appointment because they didn't understand the wording in the leaflet. We also received feedback that the leaflet wasn't accessible because of the small font size, something that should have been considered given the large cohort of older people under the audiology service. It has to be noted that this leaflet was produced by Specsavers, in isolation and without liaising with or any input from the ICB or Westcliffe.

"Although dated 7 March 2024, I did not receive this letter from Westcliffe Health Innovations re: hearing aid services until 16 March 2024. This is very short notice, and I do wonder if there is not a statutory obligation to give clients fair warning of such changes. I think two weeks' notice is simply not good enough."

We received feedback from multiple people about the difficulties they'd experienced getting through to the Westcliffe Health Innovations number.

"The phone is just ringing, and I was on the phone for an hour. I've also tried leaving messages and the callback option hasn't worked either. On several occasions I've been in the queue but then get cut off. It's so frustrating!"

Mental health crisis single point of access

As far as we are aware, there were no communications to the public, service users and stakeholders prior to the change in function of the mental health crisis single point of access. The automatic message

people heard when calling the single point of access only changed on the day that the service to the public ceased.

The message told people that the single point of access was no longer open to the public and that people should call 111, with little other explanation or reassurance about the change. As such, many people will have found this out at the point of being in crisis and trying to reach out for help. In addition to people finding out in this way, we didn't feel that the tone or content of the voice message was in line with a trauma-informed approach. We fed this back to LYPFT and following our feedback the message was changed.

Information on the Mindwell and LYPFT websites for both the public and professionals didn't change until after the service change. National communications about the introduction of the mental health option to NHS 111 didn't appear until the end of August 2024, more than three months following the change. This information was also misleading saying that, "People… who are in crisis or concerned family and loved ones can now call 111, select the mental health option and speak to a trained mental health professional." In reality, the 111 service is automated, resulting in people having to go through several options before they can speak to someone in person.

Although we were told that local communication had gone out to stakeholders in Leeds in May 2024 following the change to the single point of access, we were told by several GPs that they were not aware of the change:

"The lack of updates to GPs in signposting this change was a bit alarming. We were only notified of this when a patient told us of the change themselves."

Impact on people

Orthodontics

The physical and emotional impact on both children, young people and their parents and carers was significant, as many were left for periods of up to 8 months with no communication from either commissioner or new providers.

"The very basics of communication appear to be missing. It highlights to me what seems to be a total disregard for us as parents or the stress we continue to experience."

The impact on people was exacerbated by the long gap in the provision of orthodontic services (over five months for many people).

"It is now three months since his braces were fitted and we have had no contact with the new provider. His braces are now broken in four places causing him pain and discomfort. I have had to resort to using wire cutters in his mouth to remove the sticking out wire that was causing him pain."

People told us that when they had asked their old provider or one of the newly commissioned services what they should do if they had a problem in the interim, were told to contact NHS 111 or their regular dentist, neither of whom would be able to resolve issues relating to orthodontic treatment.

"She is in pain and distress, but there seems to be no way of securing her an appointment. When I ring 111, all they can say is "go to the GP". When I go to the GP, the GP says it's nothing to do with them and we have to go to the provider – but there appears to be no provider actually offering a service at present."

There was also financial impact for some who felt that they had no other option but to go private.

“My grandson has had bits of wire sticking into his gums and at 16 this is affecting his mental health. I have myself paid £150 for an emergency appointment at at a private orthodontist as I could not bear him to suffer any longer. There could be thousands of pounds to pay for follow up treatment not on the NHS.”

Audiology

We have had to date around 230 enquiries from members of the public about the change in audiology services as well as 250 visits to our webpage providing information about the changes. We heard that people were confused, frustrated and angry at the lack of communication and information provided to them.

“I wrote to Westcliffe to ask if an audiologist will be assigned to me and if and when I will get an aftercare appointment. I received an automated message which did not reassure me. None of my questions were answered so I now feel I have no aftercare at all. I am now seriously considering stopping wearing my aids as I feel nervous about putting them in my ears every day without advice on hygiene and general care or an audiologist I can contact, with any concerns. I am a huge supporter of the NHS but now feel 'dumped' and a victim of a discriminatory system - an elderly 'have not'.”

The changes affected many older people, many with mobility issues, disabilities or dementia who had relied on a very local service from Specsavers. Many expressed worries about having to travel to Bradford to access an audiology service, particularly during the period of several months before all the local hubs were operational. This is highlighted by the following two enquiries we received.

Enquiry 1: A cancer patient, who is a carer to his wife, expressed concerns about the Specsavers's recent loss of their audiology contract. Attending appointments at the local Specsavers was an important opportunity for them to get out, especially considering their limited mobility. They fear that if the battery replacements are coming in the post, they might get lost, especially since they live in a multi-floor apartment complex.

Enquiry 2: Person explained that he suffers with Dementia and is hearing impaired and elderly and cannot get to Harrogate Rd, Bradford. He hasn't been able to wear his hearing aids for several days now, as the rubber ends have worn away. He is very confused by the whole situation and feels very embarrassed having to ask people to repeat themselves as he can't hear properly.

Mental health crisis single point of access

Although we have no direct feedback from people who have tried to phone the Single Point of Access in recent months, it isn't difficult to imagine the impact this will have had on people who will have found out about the change via recorded message at one of the most vulnerable points in their lives. Communicating to people like this is neither good practice nor trauma informed.

We have received feedback from the public that compared to the single point of access some people don't trust speaking to NHS 111 because it is not perceived as a local service, or one that they have a relationship with. This will be compounded for some people by the fact that we already know from previous work that many aren't comfortable talking about their mental health over the phone.

"Should be preventing this [move to 111] by having drop-ins for people. Phoning a phone line and being sign posted to here and there is pointless."

Some people also told us that they had the perception that call handlers wouldn't be trained to deal with mental health. We know that people's experience of NHS 111 is variable with feedback telling us that sometimes people have to spend a long time on the phone being passed between different professionals whilst others experience delays in getting call backs. Experiences such as these are likely to contribute to a lack of trust in the new system.

One Leeds GP told us that since the change to NHS 111 as they had noticed a rise in patients seeking mental health support.

"For many, having a dedicated crisis line with a defined phone number that they could directly reach out to felt more personal and accessible. The transition to calling 111 and then being triaged to crisis support has been met with some frustration from patients. The feedback I've received is that the 111 process can feel impersonal, and some patients have expressed feeling 'fobbed off' by being given that generic helpline rather than a number that is issue specific. Think of phoning the hospital switchboard rather than a specific department... and trying to do that whilst you are in a mental health crisis could add additional delays and also create additional (real or perceived) barriers for those in crisis."

Our recommendations

1. Providers and commissioners must meet their legal requirements to do formal consultation and undertake Equality Impact Assessments and Health Inequality Impact Assessments where there is a closure, relocation or substantial change to a service. The potential impact on people, particularly those experiencing health inequalities must be considered and inform how change is communicated.
2. As part of the Equality Impact Assessments and Health Inequality Impact Assessments there should be communications plan to inform how changes should be communicated sensitively to different communities.
3. Communications should happen well before any change happens, to ensure that patients, the public and other stakeholders know what will be happening, are prepared for any potential impact, and know who to contact with any queries.
4. Services that are closing or facing significant reduction or change should, along with commissioners and new providers be responsible for communicating with their current and future service users about changes that will affect them.
5. Communications should always be trauma-informed. This is particularly important when change happens within mental health services.
6. Information about change should be made available in different formats and be accessible to the target audience in line with the Accessible Information Standard.
7. In any information communicated, it is important to include relevant contacts where people can raise queries, concerns or complaints. Providers and/or commissioners need to be prepared for a surge in enquiries and have the capacity to respond to them effectively.

Meeting name:	Leeds Committee of the West Yorkshire Integrated Care Board
Agenda item no.	51/24
Meeting date:	27 November 2024
Report title:	Population and Care Delivery Board Update
Report presented by:	Nick Earl, Interim Director of Strategy, Planning and Programmes
Report approved by:	Nick Earl, Interim Director of Strategy, Planning and Programmes
Report prepared by:	Nick Earl, Gina Davy, Lindsay McFarlane, Catherine Sunter

Purpose and Action			
Assurance ☐	Decision ☐ (approve/recommend/ support/ratify)	Action ☒ (review/consider/comment/ discuss/escalate)	Information ☒
Previous considerations:			
Executive summary and points for discussion:			

Leeds (whether as ICB Office, a CCG, three CCGs or their predecessors) has a long culture of population health and value-based health and care approaches. Population Boards have formed a key part of the governance and reporting structures across the Leeds Health and Care Partnership, with regular assurance reports coming to all three sub-committees to provide an overview of all the work underway associated with each population. The Leeds Committee of the West Yorkshire Integrated Care Board have also received presentation updates on the work of individual Population Boards to previous meetings.

Over recent months, the Leeds Partnership Development programme has progressed work to co-design and secure endorsement for updated partnership governance arrangements to enable the LHCP to build and take decisions more effectively and efficiently. The updated arrangements specifically included the future role and responsibilities of Population Boards

This report describes the updated ways of working for Population Boards, as well as clearer definitions of what they will or won't do.

The report also provides an applied example of learning from the work of the End of Life Board and ongoing considerations to note.

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. Reflect on the shift in focus for Population Boards and implications for the role the partnership in Leeds plays in supporting them.
2. Consider how the Committee might be assured of the work of the Population Boards with regards to specific population segments (for example, by considering the format of the assurance reports).

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

N/A

Appendices

N/A

Acronyms and Abbreviations explained

1. LHCP - Leeds Health and Care Partnership
2. EoL – End of Life
3. PLT – Partnership Leadership Team

What are the implications for?

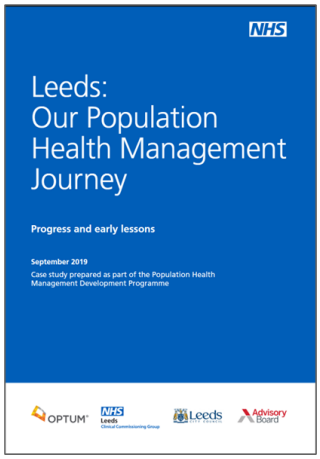
Residents and Communities	Increasingly, transformation overseen by Population Boards will be delivered or trialled in neighbourhoods and communities. This should have a positive impact - ensuring services are tailored, managed and transformed closest to the communities they support.
Quality and Safety	N/A
Equality, Diversity and Inclusion	N/A
Finances and Use of Resources	Population Boards will be expected to be involved in some of the larger value-shifts in health and care within their populations. Resources may move between organisations to support this work, and resources may be released by it, but most of the transformation programmes are not expected to require additional resource.
Regulation and Legal Requirements	N/A
Conflicts of Interest	N/A
Data Protection	N/A
Transformation and Innovation	Population Boards will spend more of their time focussing on key transformation programmes – this

	should enhance the transformation capacity within Leeds.
Environmental and Climate Change	N/A
Future Decisions and Policy Making	Population Boards may build fewer decisions on ad-hoc pieces of work, including efficiency programmes.
Citizen and Stakeholder Engagement	N/A

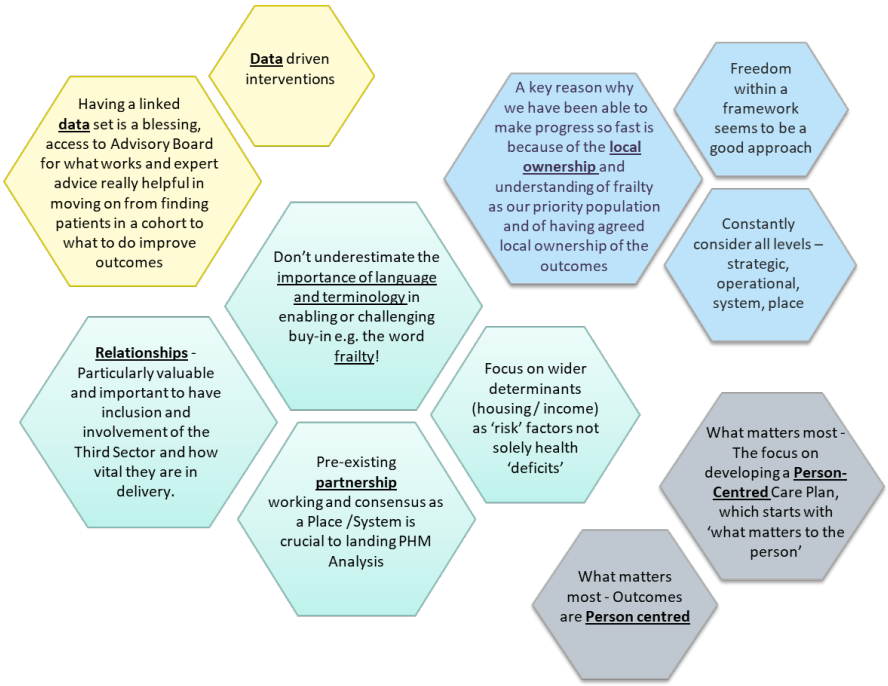
1. Background

1.1 Leeds (whether as ICB Office, a CCG, three CCGs or their predecessors) has a long culture of population health and value-based health and care approaches. Figure 1 below illustrates this – it is the report following a Population Health Management Development Programme undertaken in Leeds in 2019.

1.2 The language and themes will be familiar to many of the members of the Leeds Committee. The programme, delivered by NHS England and Optum consulting, brought together partners in Leeds around a single population of focus, the Frailty population, with a view to establishing targeted interventions to improve their health and wellbeing outcomes.



(Links to NHS Futures resource)



1.3 Following this programme – and recognising the value of bringing system partners together around a common population to develop interventions, Leeds looked to replicate, standardise, and extend this approach by iterating and evolving existing city arrangements. In 2021/22 a population segmentation model was established that divided the Leeds population into 9 mutually exclusive and collectively exhaustive segments. For each segment, a Population Board was formed from an existing partnership meeting already operating in this space (occasionally combining multiple meetings) and moderated so that all the boards were clinically led, with a single and consistent structure, purpose and Terms of Reference. Much of this was informed by the work of Muir Gray and the Oxford Centre for Triple-Value Healthcare (see *Stewardship Forums*[1]). Each board oversaw a programme of work and established a population outcomes framework

[1] See *Accounting for Value in End of Life Care* - https://www.sthelena.org.uk/getmedia/e255035e-94b2-47c8-b395-884bab515b68/NEE-Accounting-for-Value-in-EoLC-June-2020.pdf

that was used to guide decisions alongside population-specific data, insight and finance reports.

1.4 Population Boards have formed a key part of the governance and reporting structures across the Leeds Health and Care Partnership, with regular **assurance reports** coming to all three sub-committees to provide an overview of all the work underway associated with each population. The reports have evolved, moving from separate papers for each of the three sub-committees to a single paper covering all, tightening in focus from 30 pages per report in 2023 to 15 pages in 2024.

1.5 As the Leeds Health and Care Partnership has developed, so too has the understanding of where Population Boards can add the most value. A review of their effectiveness a year and a half ago highlighted reflections from partners around a potential mismatch between *what* they were being asked to deliver and their ability to respond effectively (with two smaller but potentially related challenges around organisational representation and a perception that they were ICB forums rather than partnership spaces). For example, they were conceived as forums that might be able to steward the sum total of resource spent on a population, but they have no direct control over that resource – and often the representatives have (had) no clear route to manage or redirect resources within their organisation – which made the task increasingly difficult.

1.6 Over recent months, the Leeds Partnership Development programme has progressed work to co-design and secure endorsement for updated partnership governance arrangements to enable the LHCP to build and take decisions more effectively and efficiently. The updated arrangements specifically included the future role and responsibilities of Population Boards. The outputs from this work are summarised in the next section – and describe the updated ways of working for Population Boards, as well as clearer definitions of what they will or won't do.

1.7 The submission of the aforementioned **assurance reports** to the subcommittees paused during the review of how the boards function, and is expected to restart from April. A key consideration will be, given the refreshed *function* of the Population Boards, what is the right *focus and form* of their reporting approach.

2. Updated ways of working for Population Boards

[The below has been lifted directly from the "Final Detailed Partnership Governance Arrangements" – for the full document, please contact Gina.Davy@nhs.net]

2.1 The aim of Population Boards continues to be to bring partners together to work collaboratively to improve outcomes, experience and value

(achieving the best health outcomes using the available resource) for their defined population.

2.2 The remit of Population Boards is the health and care contribution to the goals and priorities agreed as part of the Healthy Leeds Plan.

2.3 Population Boards were set up around the segmentation model agreed for the Leeds Data Model which was in-turn informed by the internationally validated ‘Bridges to Health’ segmentation model –there is no intention to change the population segmentation model on which Population Boards are based.

2.4 Each Board has the remit of taking a partnership approach to improving outcomes, experience, and value for their designated population segment.

2.5 The expectation is that the work and focus of Population Boards is increasingly driven by data and insight (including lived experience) about the current and future needs and experience of the populations and the people within.

2.6 By focussing on the development and delivery of initiatives that will achieve our partnership priorities set out in the Healthy Leeds Plan, the workplans of Population Boards will contribute towards our partnership's ambition to reduce health inequalities.

2.7 The multi-professional and organisational representation on Population Boards ensures that they are uniquely placed to identify and inform decisions about how we can achieve best value (achieving the best health outcomes using the available resource) in an environment of financial prudence.

2.8 It is important to acknowledge that Population Boards do not cover, and nor is the current intention to cover, every area of work undertaken by partners. Population Boards will have a tighter focus on a set of agreed partnership transformation programmes and priorities for their specific population rather than focusing on the discharging of specific statutory responsibilities of individual partners.

Population Boards will:	Population Boards will not:
• Have a primary function to identify and develop potential transformation initiatives to help deliver agreed partnership priorities (to feed into the annual prioritisation process). • Oversee delivery of transformation priorities (as opposed to setting up separate programme boards to oversee transformation delivery). • Have a narrower workplan with the primary focus to deliver the agreed priority transformation initiative(s). Then if capacity permits, delivery of lower priority change projects that the Board have selected to work on together. Workplans will be shaped and signed off by each organisation (as appropriate) through their representative. • Make recommendations to inform decisions taken within organisations and in some cases other LHCP groups such as PLT. • Identify and recommend opportunities to drive value from existing spend across the whole LHCP (the Leeds £) as opposed to limiting this to NHS spend –recognising the role of Population Boards in recommending rather than taking decisions. • Explicitly focus time and energy on the development and delivery of transformation and change-projects targeted at improving outcomes for people living within IMD1 and, within the context of the city's emerging health inequalities architecture, respond to the specific needs	• Be responsible or accountable for a delegated population budget. However, to understand and make recommendations about where the biggest opportunity exists to drive improved outcomes and experience from best use of Leeds health and care resources, Population Boards will want and need to understand the current spend and costs of care delivery for the population. • Be asked to find in-year savings as part of organisational savings and efficiency programmes. • Consider everything that every partner undertakes to support a given population. Population Boards exist alongside a breadth of other partnership forums responsible for addressing the wider determinants of health and delivering other statutory and organisational functions.

of inclusion groups. • Have a more clearly defined annual work plan, aligned to PLT and agreed LHCP business processes such as prioritisation. • Usually meet no more frequently than on a 6-8 weekly basis, recognising that a lot of the work takes place outside of Board meetings. Chairs and Programme Directors will determine if the Boards need to meet more frequently for example, if they are overseeing delivery of a major transformation programme.	

2.9 In September 2024, PLT endorsed the new governance arrangements for the LHCP, including the revised role and focus of Population Boards. Work is now underway, with the Chairs and members of Population Boards, to implement the changes required to enable Population Boards to fulfil their stated role within the LHCP. This includes introducing new Terms of Reference, making changes to membership, developing more focussed workplans and providing development support and skills development for chairs and Board members. The work required to transition the Boards to the future arrangements will have concluded by the end of March 2025 to enable the Boards to be operating in the new capacity by April 2025.

3. Applied example – End of Life

3.1 The above description of how Population Boards will work has only recently been confirmed and released (11th November 2024). Whilst the core purpose of the Population Boards hasn't changed – they still exist to support the reallocation of resources from lower to higher value interventions for their populations. How they do this has changed though. This section describes what these refreshed expectations might feel like, learning from the work of the End of Life Board. This population board have been designing, overseeing and supporting an LHCP priority programme on respiratory needs for those at end of life or severely frail, with substantial programme support from the Strategy, Planning and Programmes Directorate, local insight and engagement support from the Local Care Partnership Development Team, and data and analytical support from the Leeds Office of Data Analytics.

3.2 There are several perspectives that could be employed to articulate this shift in approach (for example from the perspective of a single transformation programme and the role of the board overseeing it, or from the perspective of the board across the year and how their work covers scanning for multiple opportunities, proposing ideas, refining them, and

then – following a prioritisation process across the partnership, then moving into delivery and transformation). We are here opting to describe it from the perspective of board member capabilities – and how they are applied.

3.2.1 **Expertise** – the EoL (End of Life) Population Board members applied their expertise to refine and scope the original opportunity for a programme of work, following its identification through the Healthy Leeds Plan analysis. They have since used their expertise to oversee the multi-disciplinary teams undertaking the diagnostic work at a person-level (with the Local Care Partnerships and PCNs in Cross Gates, Middleton and Hunslet and Seacroft). They have also advised on the case note reviews that identified where there may be opportunities to improve and what changes would be needed to achieve these.

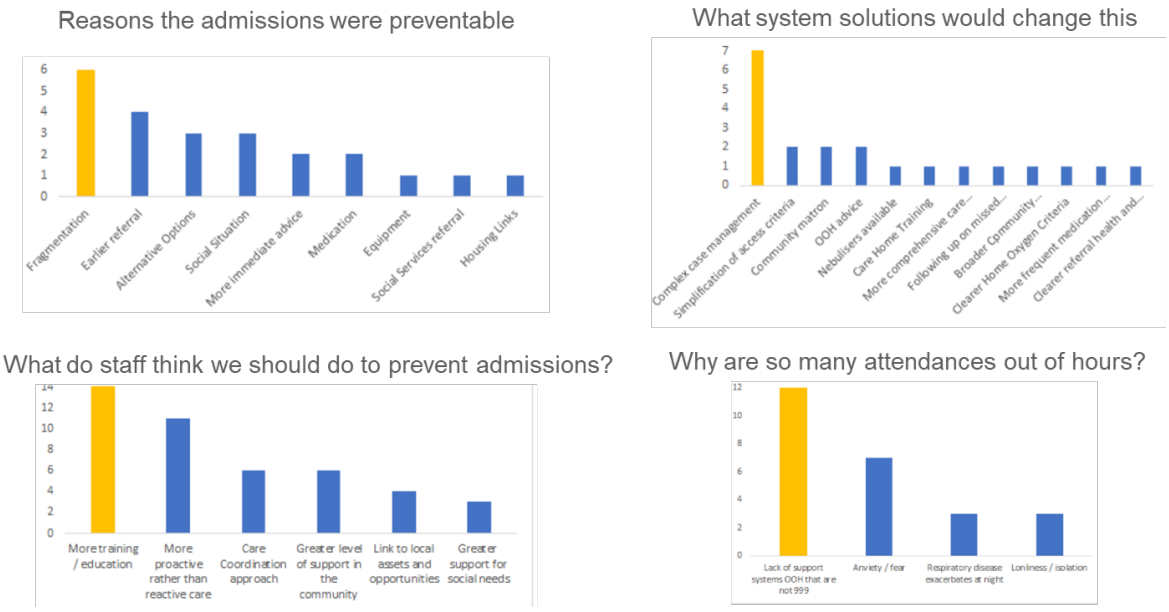


Figure 1: Outputs of some of the initial diagnostic work guided by the EoL Population Board

3.2.2 **Engagement and advocacy** – Once the diagnostic work was completed, EoL Population Board members engaged with leaders in their organisations to obtain support, build understanding and test proposals for the delivery of changes (e.g. bringing in wider political and organisational considerations). Members joined the Partnership Leadership Team alongside programme team members to ensure that clinical and person-level views remained connected to organisational and system level decisions.

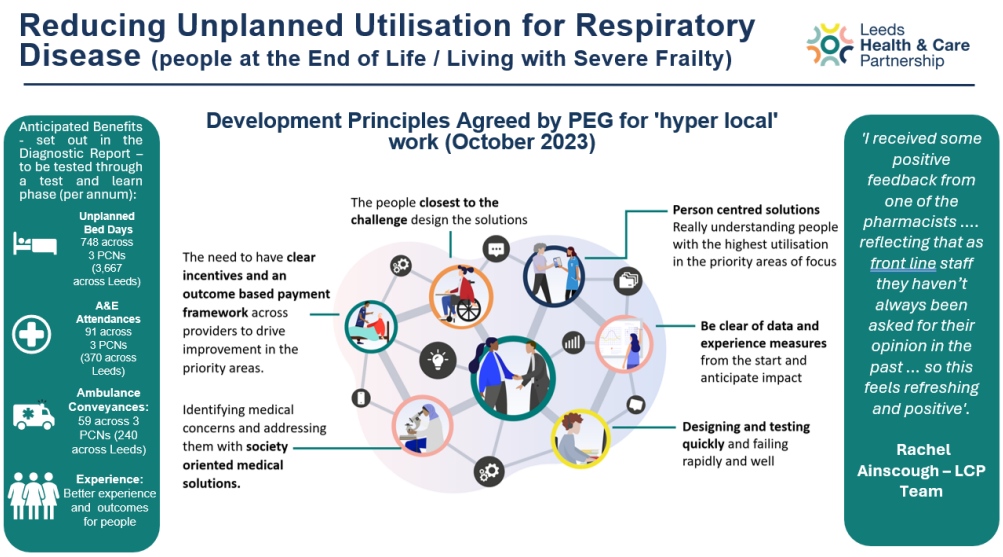


Figure 2: 'Placemat' used by the EoL Population Board for engagement with PLT

3.2.3 **Navigation and data** – some of the opportunities identified in the diagnostic, such a telephone support service for those experiencing breathlessness at End of Life, related to other teams, clinical leads and functions across the Leeds Health and Care Partnership that the programme team did not have access to. Population Board members helped navigate them to the right people and parts of the system. Other programme board members have undertaken similar work within their organisation, ensuring the programme teams are also maximising the use and application of organisational data, and that problems are initially worked through by the organisations best placed to do so.

3.2.4 **Delivery and problem solving** – as the programme gets underway, Population Board members will likely be a key point of escalation (beyond the programme team and prior to PLT) for supporting change and troubleshooting key issues associated with the work.

3.3 Beyond the application of these capabilities toward delivery of priority transformation programmes, the EoL Population Board need to **meet** on a regular basis. This provides a recurring point in time where partners can come together to review their work in a structured and formal way (recognising that many of the above capabilities are deployed outside of this meeting). These meetings would typically cover:

- Opportunity identification / development (reviewing risks, insight from service-users, local and national data and analysis on performance and outcomes, clinical and organisational intelligence from members and financial data to understand the overall challenges and develop proposals for future areas of work within this population)
  and / or

- Transformation oversight (reviewing progress of the key programme(s) of work against plan, making decisions around next steps – including determining what requires PLT involvement and support – and both requesting targeted pieces of work and helping identify what resources are used to
  as well as
- A review of board workplans, confirmation of key actions, information sharing / updates on work or initiatives that connect to the board and any other business.

3.4 The board may need to flex these meetings in line with the delivery of its priority areas.

3.5 The end of life population in Leeds is relatively small, at circa 3000 people. Other Population Boards, such as Long Term Conditions, cover a much larger population. In these instances, it is still assumed that the above represents the main way of working, but the board may also want to receive updates from other working groups.

4. Ongoing considerations to note

4.1 When the End of Life Population Board brought its transformation proposal to the Partnership Leadership Team for approval of moving to implementation, they confirmed a number of key principles by which the work would be delivered. The last of these was 'Don't let perfection be the enemy of the good'. This principle is equally applicable to the way boards function as ways of working evolve. Outstanding areas that are currently under discussion or consideration include:

4.1.1 **Risk visibility:** Ensuring Population Boards retain visibility of population risks, without 'owning' these risks.

4.1.2 **Scaling interventions:** The right approach for scaling hyper-local interventions to achieve city-level impact, balanced against both overall and local (LCP) transformation capacity.

4.1.3 **New funding:** Handing new opportunities that arise mid-year against our prioritisation framework.

4.1.4 **Multi-board initiatives:** Identifying, building, agreeing, co-ordinating and delivering initiatives that might span multiple boards.

4.1.5 **Board to board and board to enabler engagement:** Facilitating the right discussions between key governance forums (including between Population Boards) and securing pertinent expertise from enablers and advisory functions to shape and support changes in e.g. enablers

(workforce, digital and estates) and advisory functions (people's voice, health inequalities, clinical and professional leadership and finance) in relation to the refreshed ways of working for Population Boards.

4.1.6 **Types of transformation initiative**: Balancing the necessary skills and capacity at different scales for initiatives that might be city-wide (e.g. shared care records or a multi-morbidity research hub) but require local LCP input for testing.

4.1.7 **Neighbourhood capacity:** Ensuring that the city's focus on deprivation does not overburden teams working in the most deprived areas, or views those teams as the *only* areas where new transformation initiatives can be developed.

4.1.8 **Shifting resource / incentivising change:** Linked to scaling considerations – how are the city's resource deployment mechanisms (staff, buildings, equipment, funding) set up so that the change which adds value to the city is incentivised and can occur organically without placing undue risk in any single organisation.

4.2 Committee members are welcome to comment on these areas – they are not exhaustive but are highlighted as an acknowledgement of areas where our understanding is likely to evolve. For almost each consideration, discussions are underway within key programme areas (e.g. Partnership Development, HLP Priority Delivery).

5. Recommendations

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

a) Reflect on the shift in focus for Population Boards and implications for the role the partnership in Leeds plays in supporting them.

b) Consider how the Committee might be assured of the work of the Population Boards with regards to specific population segments (for example, by considering the format of the assurance reports).

Meeting name:	Leeds Committee of the ICB
Agenda item no.	52/24
Meeting date:	27 November 2024
Report title:	Place Lead Update
Report presented by:	Tim Ryley, Place Lead and Accountable Officer
Report approved by:	Tim Ryley, Place Lead and Accountable Officer
Report prepared by:	Various

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

Previous considerations:

N/A

Executive summary and points for discussion:

The report highlights emerging features of the national direction from the new government as well as detailing the current priorities and how these are being considered in Leeds. The committee are asked to consider implications for the Leeds Health & Care Partnership and the influence we may wish to exert. The Committee are also asked to approve the extension of the Chronic Kidney Disease Joint Working agreement.

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

☒ Improve healthcare outcomes for residents in their system

☒ Tackle inequalities in access, experience and outcomes

☒ Enhance productivity and value for money

☐ Support broader social and economic development

Recommendation(s)

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

a. Note and comment on the report, giving specific attention to the emerging national context and priorities (Sections 1 and 2).
b. Support extension of the CKD Joint Working Agreement (Section 4)

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:

Performance

Financial Plan
Appendices
1. Letter from Rob Webster 2. ToR Place Review 3. AAA Report – Leeds Committee 11 September 2024
Acronyms and Abbreviations explained
1. VSCE - Voluntary, Community and Social Enterprise

What are the implications for?

Residents and Communities	Stronger focus on neighbourhoods
Quality and Safety	None noted
Equality, Diversity and Inclusion	None noted
Finances and Use of Resources	Medium Term Plan only
Regulation and Legal Requirements	None noted
Conflicts of Interest	None noted
Data Protection	None noted
Transformation and Innovation	None noted
Environmental and Climate Change	None noted
Future Decisions and Policy Making	National context and emerging issues
Citizen and Stakeholder Engagement	Opportunity to contribute to 10-year plan noted

1. National and Regional Context

1.1 The government have set out three broad missions that are particularly pertinent to health and care. These will shape our agenda going forward particularly through the comprehensive spending review. These are: the cross-government work to ensure health is a consideration within all departments, the NHS 10-year plan, and Adult Social Care Reform. Alongside this health is also being seen as critical to economic growth and described in these terms. These will form the backdrop to the health & care agenda across the next few years.

1.2 These sit above and alongside the three shifts the Health and Care sector is expected to make and described as, 'Treatment to Prevention', 'Hospital to Community', and 'Analogue to Digital'. Again, these will be major themes that we expect to play out in the NHS 10-year plan and should be informing our planning and decision making now.

1.3 Next spring, the NHS will publish a new 10-year plan. This will be developed to underpin NHS submissions to the Comprehensive Spending Review and then published, probably, in late spring 2025. It will guide the priorities and funding for the NHS through the rest of this parliament starting in April 2026.

1.4 Eleven task groups have been set up to shape the content, four looking at the vision and priorities, and seven the underpinning enablers. We are currently being asked to input into the consultation process. As well as individual organisations and West Yorkshire ICS, the Leeds Health & Care Partnership will be completing a submission. Members views are welcome.

1.5 As well as organisations, staff and members of the public are invited to participate at change.nhs.uk .

1.6 In the meantime, both this year and expected as major features of next year's planning guidance, due imminently, we see a strong emphasis on delivery of:

- Elective Recovery
- Winter Sustainability
- Productivity Improvement, and
- Moving towards a Neighbourhood Health Service.

1.7 The Secretary of State has also indicated a strengthening of focus on performance through the publication of trust league tables, regulation of management and a more interventionist approach. These are interesting ideas first tried between 1998 and 2005. We await to see more details.

1.8 Amanda Pritchard, NHS England Chief Executive, has written to all Trusts and ICB's setting out greater clarity on the roles of NHS England and the ICB's going forward as NHS England continue to evolve their operating model. NHSE will have a clearer role in the management and oversight of providers that are underperforming in terms of quality, finance, or access to services. The ICB will be responsible for planning services for their population, with an increased focus on integrated neighbourhood health, prevention and addressing inequalities. This feels very much aligned to the approach in West Yorkshire and Leeds. A letter from West Yorkshire ICB Chief Executive summarising this is attached at Appendix 1.

1.9 Given a number of changes across West Yorkshire in leadership of the ICB and partner organisations, and the importance of maintaining progress on developing *place partnerships* the ICB has initiated a review of place arrangements led by Anthony Keeley, Director of Planning and Performance prior to his retirement next year. The Terms of Reference are attached (Appendix 2), and there will be an opportunity to feed in as a committee at our development session in December. This will provide us with an opportunity to build on our strong partnership in Leeds and is **not** a wholescale revision of the ICB operating model.

2. Current Priority Areas in Leeds

2.1 Elective Waiting Times. All NHS Trusts were originally meant to have reduced the number of people waiting more than 65 weeks to zero by the end of September 2024. The NHS across England missed this objective, in part due to industrial action earlier in the year. Leeds Teaching Hospital, a major regional specialist trust, has c500 people waiting more than 65 weeks. As a result, it has been put in Tier 1 of NHS England's support regime for elective waiting times. The ambition is for the NHS, including Leeds, to deliver this ambition by March 2025.

2.2 Winter. The NHS faces another challenging winter. We have been undertaking work across Leeds as a partnership, and with West Yorkshire colleagues to develop and test our planning in terms of escalation capacity, prevention, and co-ordination for a number of months. These plans have been tested and reviewed by regional partners, the Adults, Health and Active Lifestyles Scrutiny Board, the Leeds Health and Wellbeing Board 'Board to Board' and the ICB in Leeds Delivery Sub-Committee. The Leeds Committee is asked to note the levels of scrutiny and assurance. Whilst we are entering the winter in a better place in terms of capacity in the system as a result of

the Home First programme, there is no complacency on the challenges we face as a system across the next 4 months.

2.3 Finance, Productivity and Medium-Term Planning. The finance report will detail the current financial position across the NHS in Leeds. All NHS organisations have major programmes to drive efficiency and improve productivity having set the best plan as a place across West Yorkshire. There is considerable risk in the reported positions. It is also important for the committee to note these pressures in light of the wider performance agenda and considerable financial challenges in Leeds City Council and among General Practices and the Third Sector.

2.4 Work is being undertaken on the medium-term financial plan and planning for next year. At the development session in December there will be an opportunity for the committee to input into the planning ahead of NHS planning guidance and final plans coming back to the ICB committee early next year.

2.5 Neighbourhood Health. The Partnership Leadership Team in November received a report on further developing our neighbourhood model building on the good work we have already undertaken through Local Care Partnerships. There has been a strong steer nationally to linking a preventative approach to neighbourhood health through 3 concentric circles: inner circle the greater integration of services to manage people at home; the second circle with a strong focus on primary and secondary prevention, and the third and outer circle focussed more on social determinants of health and community health.

2.6 There have also been a number of events across the partnership looking at what this will mean in practice. West Yorkshire is drafting an Integrated Neighbourhood framework which will set out key principles to guide thinking.

2.7 We agreed that we need to build on existing strengths and that the model would develop iteratively, but with greater pace and oversight than previously. We also wanted to make sure that inequalities were front and centre of our approach and not lose sight of proportional universalism in shaping our offer.

2.8 Neurodiversity. Demand for diagnosis in both adult and children's ADHD and Autism remain very challenging. The LYPFT ADHD service for adults has closed for new referrals and in children's services families have been made aware of the length of waiting times. We have put in and are developing further plans to address some these concerns and will return to the Committee in due course as part of planning for next year.

3. The Third Sector

3.1 The Third Sector in Leeds plays an important role in the health of the city, often working alongside the NHS and bringing together communities and the statutory sector. The ICB in Leeds published a 'Position Statement' in early October that describes its strategic intentions in light of national policy and the Healthy Leeds Plan and what opportunities these could present; describes the current NHS investment and how that might change; and articulates a set of commitments. This is attached at the back of the papers for reference.

3.2 One of the things the ICB will be looking to do is think differently about the number and nature of the contracts it holds and how these are operated. The later item on the agenda on Community Mental Health and VCSE is reflective of this.

3.3 Forum Central are undertaking a couple of pieces of work at the moment. One is about the nature of VCSE infrastructure organisations in the city and their invaluable role and it is also refreshing its state of the sector report which is critical for all of us in understanding the risks the sector faces.

4. Matters Arising and Matters to Note

4.1 **Chronic Kidney Disease Joint Working Agreement.** Leeds Committee members will recall a Joint Working Agreement (JWA) concentrating on chronic kidney disease (CKD) and getting people (a target of 1250) with CKD reviewed and initiated on the NICE recommended TA drugs; SGLT2s. The JWA was approved by the January 2024 Leeds Committee meeting, due to the related prescribing costs. The Joint Working Agreement commenced in March 2024 for one year, working with the following PCNs; Seacroft, BHR, West Leeds and Morley. Resources have been deployed as required by all PCNs, and the project team. From this work we have a lot. The rate of initiation of these drugs is a lot lower than anticipated; with significant patient education required to facilitate initiations of this drug. As at the end of October 2024, we have achieved 231 initiations (of our target 1250)) – 18% of the target. To date 447 other reviews (often requiring multiple appointments) have been completed – with the outcome of these reviews not resulting in initiation of the drug (medicine declined, not tolerated, etc). We can evidence to AZ that reviews are taking place, and we have a lot of learning to share via evaluation.

4.2 It recognised by all parties that we will not reach the 1250 KPI target as applicable patients for review will be exhausted due to an identified lower than anticipated conversion rate. It is recommended however that we extend

the existing JWA for a further 6 months (from March 2025 – August 2025) to allow further collation of data/coding, as PCNs complete final reviews that may run into the 6 months post current agreement (March 2024-February 2025). No additional resources will be provided via this extension/participating PCNs will not be required to align additional resource. The extension is purely, data collection continuation and evaluation write-up, with reflection on legacy working established by each participating PCN. Seacroft, BHR, West Leeds and Morley are thanked for their participation in this project; their commitment to delivery has been fantastic. It proposed that the extension is signed by the ICB for a further 6 months by Tim Ryley in December 2024.

4.3 Following a review of internal decision-making processes, it was decided by the accountable officer not to continue with the decommissioning of the MAECare Circles of support this financial year. This has been communicated to the organisation.

4.4 The ICB Team in Leeds is vacating Wira House, the former Leeds CCG Headquarters at the end of February. We are currently in consultation with staff for a change of base which is moving to White Rose Office Park with Leeds Community Health NHS Trust. We also have office capacity at Merrion House with Leeds City Council. We are also committed outside these venues to utilising space with Third Sector partners for meetings to ensure we cycle NHS funding into the Leeds Health & Care System. It is important symbolically that we are located with partners in the Leeds Health & Care Partnership given our responsibilities to support integration. However, there are also practical accessibility and cost reasons that our lease at Wira House has ended. Members are asked to note this change which whilst not significant will impact some ICB colleagues.

Recommendations

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

1) Note and comment on the report, giving specific attention to the emerging national context and priorities (Sections 1 and 2).
2) Support extension of the CKD Joint Working Agreement (Section 4)

2. Appendices

1) Letter from Rob Webster
2) ToR Place Review
3) AAA Report – Leeds Committee 11 September 2024

West Yorkshire
Health and Care Partnership

NHS West Yorkshire
Integrated Care Board (ICB)

Appendix 1

White Rose House
West Parade
Wakefield, WF1 1LT
Visit: www.wypartnership.co.uk
X: @WYpartnership

15 November 2024

TO: Members of the WY Partnership Board
Members of the NHS WY ICB Board
Members of the WY System Leadership Executive Group
All NHS WY ICB Staff

Dear Colleague,

An update on recent Government and NHS England announcements

You will have seen the coverage of the recent announcements made by the Secretary of State for Health and Social Care (SofS), Wes Steeting and the Chief Executive of NHS England (NHSE), Amanda Pritchard on the future arrangements for management and accountability in the NHS. I am writing to provide an update on this and share my perspectives. I am also sharing the letter we have received from Steve Russell, Chief Delivery Officer for NHSE and Adam Doyle, National Director of System Development for NHSE which has been published on the NHS England website; and the link to the workplan for the NHS Management and Leadership Framework which was published earlier this week.

The announcements aim to achieve a number of things:

- To clarify oversight and accountability arrangements for NHS providers. NHSE will have a clearer role in the management and oversight of providers that are underperforming in terms of quality, finance or access to services. This will be done in accordance with a clear and transparent regulatory framework.

- To increase the emphasis on strategic commissioning. The ICB will be responsible for planning services for their population, with an increased focus on integrated neighbourhood health, prevention and addressing inequalities. A strategic commissioning framework will be developed to support and enable this.

- To place stronger emphasis on NHS leadership and supporting leaders to be effective, backed by a new management and leadership framework.

There is clearly further detail to be worked through to understand the implications of this. I and other leaders in the system will be actively involved in this over the coming months and the expectation is that new arrangements will not be in place until 1 April 2025. Some of my initial reflections on these announcements are as follows:

- Providers are a key part of our integrated care system and a key partner of the Integrated Care Board (ICB). We have a strong and trusted relationship with providers and their collaboratives. This close partnership has served us well over the years and will continue to do so. We will seek clarity on how and when regulatory intervention will work. It is helpful that the attached letter acknowledges that this will be done with ICBs. I am confident we can navigate this with our strong relationships and leadership.

- There is strong alignment between the national direction on strategic commissioning and our five functions as an ICB (population planning, transformation, partnership development, system coordination and workforce). I am hopeful for greater national focus on integrated models and place work.

- We have a successful arrangement with NHSE in our region that means we work together collectively on performance and improvement locally; and that the four ICBs and the region work together in a “4+1” arrangement, as set out in this report from Professor Sir Chris Ham CBE.

- The work we have already begun on reviewing Place leadership arrangements is exploring these issues and will help with our response.

- There are clearly some tensions between the language and rhetoric of grip and control versus the longer-term ambition for greater devolution and flexibility to Places. We must have the right focus on the short-term priorities (including responding to the financial challenge in the next couple of years) and our medium term ambition for greater devolution and integrated working aligned to our Partnership’s 10 Big Ambitions and the four overall purposes of an Integrated Care System (ICS).

I recognise that these changes will cause some uncertainty for you and that some of the reporting around the announcements has focused on the consequences of failure, the tone and language used in political discourse which will cause some concern. I am confident we can navigate this and continue to recover services, innovate and meet our collective ambition to improve outcomes for local people. We

know that the financial position across the public sector, including the NHS, remains challenging and we are expecting that the continued focus on delivery, productivity, transformation and care closer to home will continue, all to be delivered within the financial envelope and resources we have. I anticipate even more focus on the neighbourhood health service, and it is a positive that the SofS has made this one of his top priorities. Tom Riordan's appointment to Second Permanent Secretary for at the Department of Health and Social Care and focus on this work underlines this.

Whilst it will be important for us to influence and shape national thinking over the coming months to ensure that any changes are beneficial for the way that we work together as a partnership across West Yorkshire, it is critical that we are not distracted and that we continue to focus on delivering our ambitions for the local population. An over-emphasis on the mechanics of planning and oversight could divert us from the daily reality of providing safe care and planning for a sustainable future. That is something we should never allow.

This is a time when the new Government is stating its commitment to the NHS and care system, backed by a relatively generous settlement for us in the budget, compared to other Whitehall spending departments, including ring-fenced capital funding. That brings with it pressure and expectation which can be transmitted from Whitehall to every organisation in the system. As we navigate the winter, plan for next financial year and help shape the 10-year health plan, we should all recognise this reality, stay true to our way of working and remain focused on what matters.

Thank you for your continued leadership.

Yours sincerely,

Rob Webster CBE
Chief Executive

NHS West Yorkshire Integrated Care Board
West Yorkshire Health and Care Partnership

Appendix 2

Review of Place Partnership arrangements in West Yorkshire

Terms of Reference

Context

1. West Yorkshire Health and Care Partnership is founded on strong system leadership, effective place working and good provider collaboratives.

2. The NHS West Yorkshire Integrated Care Board (WY ICB) has a role in leading and supporting partnership development at system, place and provider collaborative levels.

3. The need for a renewed focus on partnership development has become clearer following the review of the ICB operating model for compulsory reductions in management costs. A number of changes to the leadership arrangements in West Yorkshire, alongside the need for significant efficiencies, mean we now have an opportunity to review how the partnerships work between system and place, and between place and providers and consider the scope for further integration.

Opportunities to review partnership arrangements

4. At this time, a number of pieces of work are going on in places to assess the impact of leadership changes and associated issues. These include:

    - The retirement of the ICB Accountable Officer for Kirklees from 1 April 2025;
    - An independent review of leadership arrangements in Wakefield following changes to Council structures;
    - A review of place arrangements in Bradford involving issues in relation to culture, provider configuration and nursing leadership; and
    - The recruitment of a new Chief Executive of Leeds City Council

5. These developments will require strong collaboration with places and changes should take into account the opportunities that this may bring.

6. The challenging financial position across the whole system, major capital developments, and ongoing consideration of issues like the configuration of non-surgical oncology, ATUs and fragile services means there is also a need to review patient pathways and service configuration into the medium term. Work on these priorities, often led by WYAAT, will also need to be taken into account in considering future place partnership arrangements.

Scope of this review

7. A review of partnership arrangements will:

    i. Consider the inter-relationships between the current work in places identified above;

    ii. Review the options for stronger coordination of the work;

    iii. Make recommendations on the optimal place configurations to interface with local communities and provider partnerships;

    iv. Consider the implications for the footprints for delegation and for senior leadership roles;

    v. Have due regard to work in partnership on integration, patient pathways and configuration in the WYAAT, MHLDA and community provider collaboratives;

    vi. Have due regard to work on integration models in place including the development of Integrated Neighbourhood Teams;

    vii. Put in place a mechanism for overseeing and coordinating work; and

    viii. Develop and agree a timeline for implementation of changes.

8. It will be important for the review to take account of emerging plans from NHS England as the 10-year plan is developed.

9. The findings of the review and recommendations will be set out in a report with clear recommendations for the ICB Board.

10. An interim report will be produced by the end of November 2024. A final set of recommendations by the end of January 2025.

11. The work will be led by WY ICB and supported by the provider collaboratives and other partners. It will build on, but not be bounded by, the previous work on the future system architecture.

12. Anthony Kealy will act as programme director for the ICB to lead the review. He will be supported by ICB core and place teams, provider collaborative leadership, and appropriate programme leads.

Appendix 3

Committee Escalation and Assurance Report – Alert, Advise, Assure

Report from: Leeds Committee of the WY ICB

Date of meeting: 11 September 2024

Report to: West Yorkshire Integrated Care Board (WY ICB) on 24 September 2024

Report completed by: Sue Baxter, Head of Partnership Governance, ICB in Leeds on behalf of Rebecca Charlwood, Independent Chair, Leeds Committee of the WY ICB

Key escalation and discussion points from the meeting
Alert:
Financial Pressures – The Impact on People The ICB in Leeds financial plan for 2024/25 reported a £12.3m deficit at month four, with additional pressures of pay award, impact of junior doctors industrial action, potential risk for LTHT's achievement of elective recovery fund. Significant risks and potential pressures were reported, which will need to be managed to achieve a balanced position. This includes delivery of a significant efficiency programme in 2024/25. Building on the PWC's independent review of finances of WYAAT, a further review of the ICB and other NHS partners has been agreed. The Committee noted that the financial plan had already required some very difficult decisions and ratified these after seeking assurance on the process to identify and where possible mitigate impacts of the decisions.
Advise:
Risk management and Board Assurance Framework The review of finance and other risks held on the Leeds Place Risk Register will be informed by the BAF update in cycle three, and will focus on ensuring that descriptions and mitigations are person-centred and give consideration of strategic risks set out within the Board Assurance Framework (BAF). (Financial position RR 2413 score 20) **Neurodiversity services Adults and Childrens** An audit undertaken provided an assessment of capacity of 16 per month, with the demand at around 170, compared to around 20 when the service was established in 2011. The waiting list was reported at around 4,400 people. The committee recommended that the ICB Board be advised of the gap between capacity to assess and the rise in demand on both Adults' and Childrens' assessment services and resulting waiting list. (Adults neurodevelopment risk 2354 score 15 and Childrens neuro development risk 2301 score 15)

Assure:

People's Voice

Following on from the video recorded in February 2024, that was viewed as part of the May Leeds Place Committee meeting, the Committee were asked to consider insights from "How does it feel for me, Mercy's summary report" which sets out how Mercy's story has informed quality improvement work to-date across health and care organisations in Leeds. Members were asked to share reflections on the insights and agreed the insights will also be used by relevant Population Boards to inform discussions and decisions. In addition, the reports will feed directly into the Leeds Health and Care Partnership, including the citywide Person-Centred Care Board and the Quality and People's Experiences Committee.

Fairer Healthier Leeds – a Marmot City

Leeds Health and Wellbeing Board made a commitment for Leeds to become a 'Marmot place'. In April 2023, and a formal two-year partnership began with the Institute of Health Equity (IHE) – led by Professor Sir Michael Marmot. The aim of **'Fairer, Healthier Leeds'** programme has been to enable the city to better understand how to maximise opportunities to address health inequalities. Raising the health of all and flattening the gradient of inequalities is recognised as closing the gap, according to Marmot. The programme has been delivered to date via three interconnected workstreams: whole system review, collective action and cross-cutting priorities. Leeds place committee considered year one progress and the reports 15 system level recommendations that addressed: leadership and accountability, effective partnerships and research and monitoring. The committee accepted the recommendations noting that these will shape an action plan to be developed by November 2024.

Director of Public Health Annual Report 2023

An overview on the Director of Public Health's Annual Report 2023 – Ageing Well: Our Lives in Leeds, outlined experiences of ageing well in Leeds, bringing together lived experiences alongside a review of data and evidence relating to ageing well. Key findings focussed on actions to create the conditions for healthy ageing and increasing the number of years spent in good health. The Leeds committee welcomed the recommendations in the report and noted the Healthy Leeds Plan was in part a response to a number of these.

Decisions taken by the committee

- Leeds place approved a second Joint Working Agreement (JWA) with AstraZeneca for phase 2 of the Leeds MART Project which aims to transform asthma management in adults with poorly controlled asthma
- The Urgent Decision taken on the 17 July 2024 to approve the Provider Selection Regime (PSR) route for the Social Prescribing service: Direct Award C was ratified by the Leeds place committee

Committee Escalation and Assurance Report – Alert, Advise, Assure

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

Date of meeting: 16 October 2024

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

Date of meeting reported to: 27 November 2024

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

Key escalation and discussion points from the meeting
Alert:
N/A
Advise:
Single Care Record The sub-committee discussed the progress being made in developing a single care record (SCR) in Leeds. Members noted the need for good public engagement to raise awareness and increase understanding of data sharing between health services in order to support staff to deliver quality care. It was recognised that the Home First programme was progressing well in enabling provider access to the SCR. The sub-committee agreed to invite the Chair of the Digital Board and the Digital Lead for the ICB to the next QPEC meeting in January 2025. Members also recognised their responsibility in seeking assurance of the SCR's development timeline within their own organisations. **Pending Special Educational Needs and Disabilities (SEND) Inspection** The sub-committee received a report of the preparations made by the Leeds Health and Care Partnership (LHCP) for the pending special educational needs and disabilities (SEND) inspection by Ofsted and the Care Quality Commission (CQC). The inspection would be carried out under the new inspection framework that had been introduced in January 2023 to assess how effectively education, health and social care services in the area work together to improve experiences and outcomes for children and young people with SEND aged 0 to 25 years, and their families. The new cycle of inspections was based on three judgements to be made by inspectors: it was the view of the partnership that the likely expected judgement would be in the mid-range. Members were reminded to respond promptly when requested to provide information during the inspection. The sub-committee thanked colleagues for their responsiveness over the last six months in preparing for the inspection.
Assure:

Review into the care of a Young Man with Complex Needs and the Leeds and WY ICB responses to recommendations

The sub-committee received a report following an independent review into the care received by a young man with complex needs. The report included the LHCP's response to the review recommendations. A situation review and complex needs audit had been undertaken, along with engagement work with the young man's family and stakeholders. The work had culminated in an action plan to address the recommendations in the review. Members discussed the need for partners to have shared accountability for young people in crisis and was clear on the need for coordination between partners. Members also noted the significant impact on staff resulting from the young man's care, both in terms of mental health and physical injuries and agreed the importance of a system duty of care to staff.

The QPEC sub-committee wished to assure the Leeds Committee that it would review the action plan at each of its sub-committee meetings until assurance had been received on completion of the recommendations.

Risk Management Report

The QPEC Sub-Committee received the Leeds place risk report for risk cycle 3 of 2024/25. Five risks were aligned to the sub-committee and shared with the Leeds Delivery Sub-Committee. There were eight high scoring 12+ risks in total; no risks had been added or removed from the risk register.

ICB in Leeds Quality Highlight Report

The sub-committee was updated on progress being made with the Leeds Community Equipment and Telecare service which had experienced a 12% increase in demand. A detailed operational review was underway to assess staffing, service quality and cost-efficiency, aiming to ensure service continuity for vulnerable users. A report would be brought to the QPEC meeting in January 2025.

The sub-committee welcomed the development of a signed memorandum of agreement and a new schedule of reporting from the three Leeds Host Commissioner services for learning disabilities and autism. Members noted that the agreement addressed previous concerns regarding a potential gap in oversight of the three independent providers.

Committee Escalation and Assurance Report – Alert, Advise, Assure

Report from: Leeds Delivery Sub-Committee

Date of meeting: 24 October 2024

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

Date of meeting reported to: 27 November 2024

Report completed by: Karen Lambe, Corporate Governance Officer, WY ICB on behalf of Yasmin Khan, Independent Member and Chair of Delivery Sub-Committee

Key escalation and discussion points from the meeting
Alert:
N/A
Advise:
Following the development session held on 17 September 2024 for the sub-committee, it had been agreed that subject to approval by the Leeds Committee, the Delivery Sub-Committee would be stood down at the end of the 2024/25 governance cycle. A report outlining the proposed change to the sub-committees' governance structure will be brought to the Leeds Committee on 26 February 2025. **People's Voice** The sub-committee received the Communicating Change briefing paper produced by Healthwatch Leeds. The paper highlighted three significant service changes in Leeds and how they had been insufficiently communicated to service users and a number of recommendations. With regards to the service change to the adult mental health (MH) crisis Single Point of Access (SPA) phoneline, members were informed the change was part of a national rollout and NHS England had led on the communication. The sub-committee wished to advise the Leeds Committee of concern that, while equality impact assessments (EQIAs) for local communities were carried out at place and ICB levels, there were potential gaps when changes were nationally driven and nationally communicated. It was noted that Leeds and York Partnership NHS Foundation Trust (LYPFT) had responded promptly to concerns raised regarding the SPA helpline message and continued to communicate the change to GPs. It was agreed that the recommendations relating to the legal requirements of providers and commissioners would be worked through, as well as the interface between national and local communications.
Assure:
WY ICB Quarterly Performance Report The sub-committee received the WY ICB Quarterly Performance report which highlighted that the MH out of area placements target trajectory had been met since

May 2024 and was better than plan for August 2024. With regards to primary care, the number of GP appointments had been above plan at 1,232K, while 86.3% of GP appointments were within two weeks.

It was reported that referral to treatment (RTT) 65-week waits had fallen from 681 patients to 393 patients. The sub-committee was assured that work was ongoing to meet the target of 0 patients with RTT 65-week waits.

Risk Management Report
The sub-committee received the risk management report for cycle 3. There were eight high scoring open risks scoring 12 or above in cycle 3. No risks were closed and no new risks were added since the previous reported risk cycle.

Following a discussion regarding the interrelation between the financial environment, service delivery and health inequalities, the sub-committee agreed that it was **partially assured** of the effective management of the risks and controls in place. Members agreed that this reflected the volatility of circumstances as opposed to the quality of mitigations.

Preparation for Winter
The sub-committee received the Preparation for Winter 2024/25 report which highlighted that the system remained on track to deliver further improvements against the four hour Urgent and Emergency Care standard. Ambulance handover times had remained one of the strongest in the region although times were above the national expected target of 15 minutes at 18.15 minutes in August 2024. As of September 2024, No Reason to Reside (NR2R) length of stays (LoS) for people requiring supported discharge had reduced by 31% compared to baseline, although this was slightly higher than the previous year.

With regards to bed modelling, assurance was given that Leeds Teaching Hospitals NHS Trust (LTHT) had planned the opening up of 57 beds across Leeds from January to April 2025. Although there remained a deficit, improvement work with the HomeFirst programme was ongoing to create additional capacity to support the modelled demand for acute hospital beds and discharge packages over the winter period.

The sub-committee noted the focus on prevention, particularly the need to encourage uptake of COVID-19 and flu vaccinations among vulnerable populations and front-line staff.

Winter plans and risks would be monitored at Active System Leadership Group with System Resilience Operational Group stood up at times of extreme pressure. The sub-committee was assured that the system was working well to manage winter demand.

Committee Escalation and Assurance Report – Alert, Advise, Assure

Report from: Leeds Finance and Best Value Sub-Committee

Date of meeting: 23 October 2024

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

Date of meeting reported to: 27 November 2024

Report completed by: Karen Lambe, Corporate Governance Officer, WY ICB, 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:
Financial Position Update at Month 6 The sub-committee was informed that the Leeds Health and Care Partnership (LCHP) position was reporting £6m behind plan year to date with a likely mitigated case by year end of £29.3m adverse to plan. The Leeds Teaching Hospitals Trust (LTHT) position was cited as a key risk, reporting a £28.6m adverse variance under a mitigated likely case. The LTHT position reflected pressures on high cost drugs/devices, under delivery of length of stay savings, pay award funding shortfall and slippage on waste reduction programme. Members wished to alert the Leeds Committee of the potential risk to service delivery due to the current financial climate. The ICB in Leeds was reporting a £5.8m deficit at Month 6 which was ahead of plan by £0.3m, but with a forecast year end position of £0.7m adverse variance. Members discussed the overspend in continuing healthcare (CHC) and mental health high cost care packages. Additionally, the sub-committee was informed that WY was £17.2m off plan in Month 6, which had been largely driven by significant pressures within acute providers. Members were advised that the worsening financial position overall had increased the risk of NHS England intervention and that finance teams across the WY Places were working to address actions identified by the recent independent review commissioned by the ICB to mitigate the position.
Advise:
Risk Management Report The sub-committee discussed the scoring of risks on the risk register that were already issues in clinical practice and whether these could provide too much reassurance in the escalation system. Members discussed the importance of viewing risks through a best value lens as well as a patient safety lens.
Assure:
Medium Term Financial Plan Update

The sub-committee was informed of the draft underlying position for the Leeds Health and Care Partnership (LCHP) as moving from a £8.2m planned deficit in 2024/25 to a £62.5m underlying financial position at the end of the financial year, reflecting significant financial pressures across the partnership. A number of assumptions such as inflation, tariff uplift, demand and growth had been modelled on top of the underlying position. Assumptions were based on those of the previous year and were consistent across WY. The current draft position medium term financial plan (MTFP) modelling showed a £310m deficit for the LHCP before efficiencies at the end of the five year period, with a £127m gap for 2025/26 which equalled 11% efficiencies over five years to deliver a break-even position with 4% efficiency requirement for 2025/26. Efficiencies and productivity opportunities would be built into the plan following the PwC review and the development of providers' own efficiency plans. The sub-committee welcomed the positive work done to date in developing the MTFP.

Risk Management Report

Members received a report providing an update on the Risk Register and the risks aligned to the Finance and Best Value Subcommittee, one of which was also aligned to the Delivery Sub-Committee. There were eight high scoring open risks scoring 12 or above. No risks were closed and no new risks were added.

With regards to risk 2016 – 'There is a risk of harm associated with longer waits faced by patients and limited capacity for treatments', members reflected that not all needs were being met. There was a further discussion regarding the risk of the current financial position and the need to plan early for Quality, Innovation, Productivity and Prevention (QIPP) efficiencies for 2025/26. Members noted the importance of pre-empting potential impact of controls on addressing health inequalities and the need to add mitigations. The sub-committee agreed it was **partially assured** of the effective management of the risks and the controls in place.

Meeting name:	Leeds Committee of the West Yorkshire ICB
Agenda item no.	LC55/24
Meeting date:	27/11/24
Report title:	Financial Update at Month 6
Report presented by:	Alex Crickmar, Director of Operational Finance
Report approved by:	Alex Crickmar, Director of Operational Finance
Report prepared by:	Alex Crickmar, Director of Operational Finance

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

Previous considerations:

Finance and Best Value Sub Committee
Directors Team Meeting

Executive summary and points for discussion:

The purpose of this report is to provide an update to the Committee on the Month 6 financial position of the ICB in Leeds and the wider Place and West Yorkshire Position.

Overall, the Leeds Health and Care Partnership position is reporting £6m behind plan YTD (LTHT £6.7m) with a likely mitigated case by year end of £29.3m adverse to plan (LTHT £28.6m, ICB £0.7m).

The ICB in Leeds, LYPFT and LCH are broadly reporting a break-even variance against plan at Month 6 with LTHT reporting a £6.7m variance against plan.

LTHT are reporting a £28.6m adverse variance under a mitigated likely case and £57.6m adverse variance under a worst case.

Leeds City Council are reporting a c.£22.2m forecast year end deficit at Month 6 with overspends of £8m in Adults and £18.8m in Childrens.

The ICB in Leeds is reporting a £5.8m deficit at Month 6 which is ahead of plan by £0.3m but with a forecast year end position of £0.7m adverse variance.

The month 6 year-to-date position for the West Yorkshire ICS was an actual £29.7m deficit against a planned £12.4m deficit; a shortfall/adverse variance against plan of £17.2m. Scenario analysis suggests potential of up to £96m of risk across the system.

Which purpose(s) of an Integrated Care System does this report align with?
☐ Improve healthcare outcomes for residents in their system ☐ Tackle inequalities in access, experience and outcomes ☒ Enhance productivity and value for money ☐ Support broader social and economic development
Recommendation(s)
The Leeds Committee of the West Yorkshire Integrated Care Board is asked to: 1. Note the month 6 position, specifically the emerging risks and mitigating actions
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 provides an update in terms of financial sustainability and deliver of in year financial plans.
Appendices
N/A
Acronyms and Abbreviations explained
N/A

What are the implications for?

Residents and Communities	
Quality and Safety	
Equality, Diversity and Inclusion	
Finances and Use of Resources	Sets out the financial position for the Leeds Health and Care Partnership
Regulation and Legal Requirements	
Conflicts of Interest	
Data Protection	
Transformation and Innovation	
Environmental and Climate Change	
Future Decisions and Policy Making	
Citizen and Stakeholder Engagement	

Proud to be part of West Yorkshire
Health and Care Partnership

NHS West Yorkshire
Integrated Care Board

NHS West Yorkshire ICB

ICB in Leeds Financial Position

Month 6 2024/25

Context and Background

NHS West Yorkshire
Integrated Care Board

Context and Background information

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.

Under the proposed national NHSE oversight framework each ICB and provider is assigned a segment between 1 and 4 indicating their respective level of delivery and support or intervention needs. West Yorkshire system has now moved into segment 3+ at Month 6 given its worseining financial position. It is within this context and the challenging financial plan set across West Yorkshire, that the ICS has commissioned an independent review by PwC of its financial position. Significant information has now been provided to PwC over the last few weeks and a ICB in Leeds interview meeting was held with PwC on the 1st October. The report is expected in the next few weeks.

In terms of key national updates:

- Pay Award guidance and allocations has now been received.
- Industrial action allocations of £3.5m were received in WY, against costs of £4.2m.
- £50m deficit support money received by the ICB and being paid to AFT, CHFT and MYTT in October.
- Nationally the message continues to be the NHS expected to deliver the plans it has committed to. The impact of the budget on this year and next year is unknown at this point. The assumption also continues to be that next spring we should expect multiyear NHS budget (revenue and capital) following the spending review.

Leeds Place - Month 6 Financial Position

NHS West Yorkshire Integrated Care Board

Organisation	YEAR TO DATE - M06 I&E reported Month 06 24/25			FORECAST - M01 to M12 I&E forecast			Scenarios - Org assessment			
	Plan £m	Surplus / (Deficit) £m	Reported Variance £m	FOT Plan £m	FOT Surplus / (Deficit) £m	FOT Variance £m	Best Case Variance £m	Likely Case Variance £m	Likely Case (Mitigated) £m	Worse Case Variance £m
Leeds ICB	(6.2)	(5.8)	0.3	(12.3)	(13.0)	(0.7)	3.4	0.0	(0.7)	(11.7)
LYPFT	(1.4)	(0.9)	0.5	1.0	1.0	0.0	0.0	0.0	0.0	(3.8)
LCH	0.5	0.4	(0.1)	1.0	1.0	0.0	0.0	0.0	0.0	(4.5)
LTHT	(16.8)	(23.5)	(6.7)	2.1	2.1	0.0	0.0	0.0	(28.6)	(57.6)
Leeds Place Total	**(23.9)**	**(29.8)**	**(6.0)**	**(8.2)**	**(8.9)**	**(0.7)**	**3.4**	**0.0**	**(29.3)**	**(77.6)**

Overall, the Leeds Health and Care Partnership position is reporting **£6m behind plan YTD** (LTHT £6.7m) with a **likely mitigated case by year end of £29.3m adverse to plan** (LTHT £28.6m, ICB £0.7m). The worst-case position has improved significantly from £104.5m at Month 5 to £77.6m at Month 6.

- The ICB in Leeds, LYPFT and LCH are broadly reporting a break-even variance against plan at Month 6 with LTHT reporting a £6.7m variance against plan.
- LTHT are reporting a £28.6m adverse variance under a mitigated likely case and £57.6m adverse variance under a worst case.
- Leeds City Council are reporting a c.£22.2m forecast year end deficit at Month 6 with overspends of £8m in Adults and £18.8m in Childrens.
- The ICB in Leeds is reporting a £5.8m deficit at Month 6 which is ahead of plan by £0.3m but with a forecast year end position of £0.7m adverse variance. The month 6 year to date and forecast outturn positions for the ICB in Leeds are set out below.

ICB in Leeds Month 6 Financial Position

NHS West Yorkshire Integrated Care Board

	YTD Plan	YTD Spend	YTD variance	Annual Plan	Forecast Spend	Annual Variance
	£000	£000	£000	£000	£000	£000
RESOURCE						
Allocation - Programme	805,777	805,777	0	1,593,268	1,593,268	0
Allocation - Primary Care Co-Commissioning	83,779	83,779	0	160,603	160,603	0
Allocation - Running Costs	2,955	2,955	0	5,910	5,910	0
TOTAL RESOURCE	**892,511**	**892,511**	**0**	**1,759,781**	**1,759,781**	**0**
SPEND						
Acute	438,609	438,798	(189)	865,555	865,614	(59)
Mental Health	124,511	125,777	(1,266)	249,022	251,563	(2,541)
Community	113,061	113,008	54	226,078	225,945	133
Continuing Care Services	41,922	42,749	(827)	83,845	85,645	(1,800)
Prescribing and Primary Care	86,245	84,200	2,045	172,112	168,410	3,701
Primary Care Co-Commissioning	86,853	86,803	50	166,751	166,676	75
Other	4,574	4,597	(23)	9,148	9,213	(64)
Programme Reserves	(70)	0	(70)	(6,340)	(5,840)	(500)
Subtotal Programme spend	**895,706**	**895,933**	**(227)**	**1,766,170**	**1,767,226**	**(1,056)**
Running Costs	2,955	2,423	532	5,910	5,564	347
TOTAL SPEND	**898,661**	**898,356**	**306**	**1,772,081**	**1,772,790**	**(709)**
SURPLUS/(DEFICIT)	**(6,150)**	**(5,845)**	**306**	**(12,300)**	**(13,009)**	**(709)**

ICB in Leeds Month 6 Financial Position

NHS West Yorkshire
Integrated Care Board

The main overspending areas within the ICB in Leeds are within Mental health (MH) services and Continuing Health Care (CHC) services.

- MH is forecasting a £2.5m overtrade due to rehab placements and ADHD referrals and there remains a further risk around S117 costs (c£1m). Within CHC there is a forecast £1.8m overspend driven by a historic case issue (c.£0.6m) along with significant risks around delivery of efficiency plans (£0.8m forecast vs £2.2m plan).
- These are both being offset by a forecast underspend within the Prescribing budget by c.£3.7m based on July data. However, the prescribing position is very early on in the financial year and historically can move significantly month to month. Added to this the impact of the GP collective action is still unknown but poses a potential significant risk.
- Other key issues include the delivery of efficiency schemes in a number of areas including acute, where the CDC allocation could yet be reprofiled again (awaiting confirmation of treatment from NHSE) and in the worst case a c £4-6m non-SUS Provider ERF risk. The running costs for the ICB are showing a small forecast underspend of £347k at month 6 and are currently on track to hit our reduced budget for 24/25 of £5.9m (down from £12.7m in 23/24).

ICB in Leeds Month 6 Financial Position - Scenarios

NHS West Yorkshire Integrated Care Board

Under the worst case scenario the ICB in Leeds is forecasting an £11.7m adverse variance to plan, and a best case scenario of £3.4m favourable to plan. The key differences between the likely case and worst case are:

- c. £4m non-SUS Provider ERF risk
- c £0.8m CHC historic case risk
- c. £3.7m no assumed prescribing benefit against plan
- c. £1m CHC and MH high-cost packages
- c £0.4m loss of running cost underspend

Best case scenario is driven by Prescribing.

	Best Case £m	Likely Case £m	Worst Case £m
Acute	0.3	-0.1	-3.8
Community	0.3	0.1	-0.2
Continuing Health Care	-1.2	-1.7	-3.0
Mental Health	-2.2	-2.5	-3.5
Primary Care	6.1	3.7	-0.7
Other	0.1	-0.2	-0.5
Total ICB in Leeds	**3.4**	**-0.7**	**-11.7**

WY System Month 6 Financial Position

NHS West Yorkshire Integrated Care Board

Organisation	YEAR TO DATE - M06 I&E reported Month 06 24/25			FORECAST - M01 to M12 I&E forecast			Scenarios - Org assessment			
	Plan £m	Surplus / (Deficit) £m	Reported Variance £m	FOT Plan £m	FOT Surplus / (Deficit) £m	FOT Variance £m	Best Case Variance £m	Likely Case Variance £m	Likely Case (Mitigated) £m	Worse Case Variance £m
Bradford ICB	(3.9)	(8.3)	(4.4)	(7.8)	(14.6)	(6.8)	(1.6)	0.0	(6.8)	(16.1)
Calderdale ICB	0.0	0.6	0.6	0.0	0.1	0.1	0.8	0.0	0.2	(2.4)
Kirklees ICB	0.0	1.0	1.0	0.0	(2.4)	(2.4)	1.2	0.0	(2.5)	(7.9)
Leeds ICB	(6.2)	(5.8)	0.3	(12.3)	(13.0)	(0.7)	3.4	0.0	(0.5)	(11.7)
Wakefield ICB	0.0	(0.2)	(0.2)	0.0	(1.9)	(1.9)	4.1	0.0	(1.9)	(10.2)
WY ICB	20.3	21.0	0.7	41.5	53.2	11.7	0.0	0.0	(17.0)	(17.1)
West Yorkshire ICB Total	**10.2**	**8.2**	**(2.0)**	**21.4**	**21.4**	**0.0**	**8.0**	**0.0**	**(28.6)**	**(65.2)**
Airedale NHS Foundation Trust	(0.5)	(4.4)	(3.9)	(6.9)	(6.9)	0.0	0.0	0.0	(8.9)	(14.2)
Bradford District Care NHS Foundation Trust	(1.1)	(1.3)	(0.1)	0.0	0.0	0.0	0.0	0.0	(1.0)	(1.7)
Bradford Teaching Hospitals NHS Foundation Trust	(12.0)	(12.0)	0.0	(14.0)	(14.0)	0.0	0.0	0.0	(12.5)	(20.3)
Calderdale And Huddersfield NHS Foundation Trust	9.1	8.8	(0.3)	(1.3)	(1.3)	0.0	0.0	0.0	(4.9)	(10.7)
Leeds and York Partnership NHS Foundation Trust	(1.4)	(0.9)	0.5	1.0	1.0	0.0	0.0	0.0	0.0	(3.8)
Leeds Community Healthcare NHS Trust	0.5	0.4	(0.1)	1.0	1.0	0.0	0.0	0.0	0.0	(4.5)
Leeds Teaching Hospitals NHS Trust	(16.8)	(23.5)	(6.7)	2.1	2.1	0.0	0.0	0.0	(28.6)	(57.6)
Mid Yorkshire Hospitals NHS Trust	(1.7)	(4.6)	(2.9)	(3.4)	(3.4)	0.0	0.0	0.0	(11.7)	(24.0)
South West Yorkshire Partnership NHS Foundation Trust	0.7	(1.0)	(1.7)	0.0	0.0	0.0	0.0	0.0	0.0	(8.2)
Yorkshire Ambulance Service NHS Trust	0.5	0.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	(6.1)
West Yorkshire Provider Total	**(22.7)**	**(37.9)**	**(15.2)**	**(21.4)**	**(21.4)**	**0.0**	**0.0**	**0.0**	**(67.7)**	**(151.2)**
West Yorkshire ICS Total	**(12.4)**	**(29.7)**	**(17.2)**	**0.0**	**0.0**	**(0.0)**	**8.0**	**0.0**	**(96.2)**	**(216.4)**

WY System Overview - Month 6 Update

NHS West Yorkshire
Integrated Care Board

- The month 6 year-to-date position for the ICS was an actual £29.7m deficit against a planned £12.4m deficit; a shortfall/adverse variance against plan of £17.2m.
- The month 6 adverse variance of £17.2m has worsened from the adverse variance at month 5 of £14.3m, a deterioration of £2.9m.
- The main reasons for the month 6 adverse variance are slippage on delivery of waste reduction/efficiencies, additional costs of drugs/devices, and pay overspends, offset in part by an improvement in the ICB prescribing position.
- ICS plans now include recognition of 7/12 of the £50m deficit support funding notified by NHSE. This means that the revised full year plan for the system is now break-even (compared to the £50m deficit plan in Month 5). The plan continues to be phased in a way that means the deficit worsens until month 8 and then improves in all of the remaining months. Reported forecasts for all ten NHS provider organisations and ICB remain at planned levels.
- Scenario analysis suggests potential of up to **£96m of risk** across the system.
- A system gap of £17m was included within submitted plans and this is held within the ICB; will be phased into the position from month 7. Reported forecast for the ICB remains at planned level. Scenario analysis suggests potential risk of up to £28.6m of risk.

Financial Sustainability - Month 6 Update

NHS West Yorkshire
Integrated Care Board

Summary of Financial Sustainability Savings to date as at October 2024

Original Planning Assumption	£38,532,000
Month 6 Forecast	£36,109,674* *2x new schemes identified
Expected Variance	£2,422,326* *Includes unidentified and known slippage
Scheme forecasting to deliver but awaiting data	£5,454,083
Risks (Table below)	£4,390,000
Worse Case	£12,266,409

	Plan 24/25	Forecast 24/25	Variance
Technical Finance led schemes	£20,243,000	£18,993,000	(£1,250,000)
Pathway and System Integration	£6,589,000	£6,075,066	(£513,934)
Prescribing (Medicines Optimisation)	£9,000,000	£9,097,608	£97,608
CHC	£2,200,000	£910,000	(£1,290,000)
Unidentified	£500,000	£0	(£500,000)
Total	£38,532,000	£36,109,674	(£2,422,326)

Financial Sustainability - Month 6 Update

NHS West Yorkshire
Integrated Care Board

Key Risks and Issues

Impact of DOAC switch to apixaban	£1,500,000
General Practice Collective Action Impact	£1,500,000
CHC	£1,290,000
Outstanding QEIA	£100,000
Total	£4,390,000

Mitigation Scheme Awaiting Finalisation

Mitigation scheme costings based on three models of delivery provided by third party. Data is currently under review to form recommendations to Director Team.

Scheme No	Scheme Name	Value
O083	DOAC - Switch to apixaban	£1,500,000
	Total	**£1,500,000**

Impact of General Practice collective action on prescribing compliance

- Following the British Medical Association starting collective action in General Practice, there is a high risk that this has an impact on cost saving work through the switch-off of Medicines Optimisation software, however there is some mitigation through local incentive schemes; at the recent GP Assembly LMC advice was not to proceed with the action to switch off cost saving software due to the link to GPOP
- The focus continues to be on interface related issues and escalating risks regarding wound care however it is recognised that further action may continue as we move through winter to create further disruption.

Scheme No	Scheme Name	Value
N/A	Various Prescribing Schemes	£1,500,000
	Total	**£1,500,000**

Financial Sustainability - Month 6 Update

NHS West Yorkshire Integrated Care Board

It is possible there will be further financial risks associated with Primary Care Ballot which cannot be quantified at this stage:

- Disengagement to cost effective switching which has been seen in Kirklees.
- Active decision making to create cost pressures by prescribing outside the commission policy e.g. the weight management drugs.

CHC

There is risk to implementation timescales to deliver and track savings. Resource has been assigned to support CHC with developing implementation plans and agree methodologies for tracking. Additional impact to savings has been understood with work underway.

Scheme No	Scheme Name	Value
O009	Pre-Paid Cards	£0
O013	Review of spend on enhanced care (above framework) from CHC funded care home placement, alongside LCC	£220,000
O014	Improved utilisation of LCH night service to reduce spend on independent home care (fast Track) LCH Nights Team to also review CHC patients where capacity allows	£430,000
O126	Review of Top 100 Packages of Care - this is very dependent on the implementation of commissioning principles O143. Note: Merged schemes O015 and O126	£640,000
	Total	**£1,290,000**

Financial Sustainability - Month 6 Update

NHS West Yorkshire Integrated Care Board

Outstanding QEIAs

Scheme No	Scheme Name	Value	Issues
O052	Further integration and improving value within Adult Mental Health Crisis Pathway	£100,000	• Proposal for Crisis Cafes completed and confirmed with providers and QEIA being developed. Second scheme with LSCS will start April 2025. • Mitigated via Brudenell Road connections to offset in year.
	Total	**£100,000**	

West Yorkshire decision making required for financial savings in Leeds

- CHC Commissioning Policy – delaying implementation of some elements of the CHC QIPP scheme
- Semaglutide (Wegovy) for weight management could create a cost pressure as highlighted in previous DTM papers. Contained in Leeds for now due to restriction of places in weight management services but legal advice is that we need to be working on expanding services.
- Expecting Tirzepatide (Mounjaro) TA in October which will have bigger implications than Wegovy as it is including the likelihood that primary care will be allowed to prescribe eliminating the current containment strategy. Clear implementation plan will be needed across WY. Cost pressure as yet unknown but likely to be in the tens of millions for Leeds.
- Sleep pathway – this is designed to offset a £1.5m cost pressure for WY but has been delayed since April going to Transformation Committee – Now due to go in November.
- Low dose vitamin D – Awaiting QEIA to reduce prescribing vitamin D for maintenance as over the counter is significantly cheaper than prescribing. Impact will be £900k spend in WY £340k for Leeds
- The Medicines Optimisation Team is working with Visseh Pejhan-Sykes to unblock these via the Transformation and Efficiencies Group in September.

Risks and Conclusion

NHS West Yorkshire
Integrated Care Board

Given the emerging risks currently flagged in the first six months of the year, the ICB in Leeds is now reporting an adverse variance from plan and therefore we need to be looking for additional mitigations. We also need to be aware of the national and WY context and ensure full engagement in the WY PwC review being commissioned.

The current risks that are emerging relate to:

- The forecast slippage within the QIPP programme especially in CHC. On top of this there are potential risks relating to capturing all independent sector activity within ERF and the impact of any GP collective action on assumed prescribing savings.

- The main overspending areas are within Mental health (MH) services and Continuing Health Care (CHC) services. Further assurance is needed on delivery of efficiency opportunities in these areas, especially in the context of the ICB in Leeds being an outlier in this area. A programme board is being set up for complex care packages starting in November.

Recommendations and Actions

NHS West Yorkshire
Integrated Care Board

The Leeds Committee is asked to:

- Note the month 6 position, specifically the emerging risks and mitigating actions

Meeting name:	Leeds Committee of the West Yorkshire Integrated Care Board
Agenda item no.	LC 57/24
Meeting date:	27 November 2024
Report title:	Consolidating VCSE Mental Health Contracts - Provider Selection Regime Intentions
Report presented by:	Eddie Devine, Programme Director (Mental Health, Learning Disability & Neurodiversity)
Report approved by:	Helen Lewis, Director of Pathway and System Integration
Report prepared by:	Eddie Devine, Programme Director

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

Previous considerations:

N/A

Executive summary and points for discussion:

This paper sets out :

(i)the intention to consolidate nine current separate ICB held contracts/grant awards with VCSE provider partners, into two lead provider led contract lots, and the recommendation with rationale for progressing a Most Suitable Provider (MSP) award process under the Provider Selection Regime (PSR) regulations.

(ii) A summary of the work undertaken aligned to the community mental health transformation programme to co-produce a collaborative delivery model with VCSE provider partners that facilitates further integration, improve efficiency, and enables the consolidation of contracts as described..

(iii)An overview summary of the key benefits risks, and mitigations identified through the draft QEIA

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 a recommendation to proceed with the Provider Selection Regime Most Suitable Provider process for consolidation of contracts as set out in the paper, to improve outcomes and reduce administrative burdens on providers and the ICB.
2. Note the next steps within the MSP procurement timeline set out on Tab 2 of the appendix excel table, and in particularly the route for approval of a decision to award process through Leeds Committee on 26th February 2025

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:

Helps to reduce fragmentation of contract management to some VCSE providers, and to provide longer contract terms

Appendices

1. PSR MSP Process (excel document)

Acronyms and Abbreviations explained

1. PSR- Provider Selection Regime
2. MSP- Most Suitable Provider
3. VCSE- Voluntary, Community and Social Enterprises
4. QEIA- Quality and Equality Impact Assessment.

What are the implications for?

Residents and Communities	
Quality and Safety	
Equality, Diversity and Inclusion	
Finances and Use of Resources	Facilitates system collaboration and integration, and improves efficiency
Regulation and Legal Requirements	
Conflicts of Interest	
Data Protection	
Transformation and Innovation	Enables the procurement and implementation of the VCSE alliance model, as an inherent part of the new model of care for integrated primary-community mental codesigned in Leeds.
Environmental and Climate Change	

1. Main Report Detail

1.1 The Provider Selection Regime (PSR) came into force on 1 January 2024. This replaced the Public Contracts Regulations (2015) and the National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations (2013) for procuring NHS and local authority funded health care services, and aims to:

- make the process of procuring healthcare providers more efficient and flexible.
- facilitate system collaboration and integration.
- reduce bureaucracy and costs and emphasise transparency, fairness and proportionality in the arrangements made with providers.

1.2 The first tab (MSP contracts) in the PSR MSP excel table (attached as appendix) sets out nine current ICB held contracts/grant awards with VCSE partners aligned to delivering the community mental health transformation outcomes. These are all due to expire at the end of March 2025.

1.3 Focused work has been progressed to co-produce the development of an alliance delivery model with existing VCSE provider partners for these contracts. The development of a collaborative delivery model aims to both facilitate further integration and improve efficiency, through consolidation of nine existing contracts/grant awards into two lead provider contracts.

1.4 As the consolidation into two larger lead provider contracts forms new contracts which are materially different to existing contracts, a direct award process is not permissible through Provider Selection Regime (PSR) regulations. Equally it would not be appropriate to conduct a competitive procurement process in the context of a long-stated system aim through the community mental health transformation programme to progress further integration of existing partners and avoid disruption to staff.

1.5 The intended PSR procurement process in this context is to:

- Modify the 9 existing contract/grant award end-dates for a further three months (permissible under PSR regulations) until the end of June 2025. The total value of the modification of existing contract end-dates by three months is £719,843.
- Undertake a procurement through the PSR Most Suitable Provider (MSP) process to consolidate into two lead provider contracts from 01 July 2025 with a contract length of 5years (3+2)

1.6 There is an additional benefit of staging future mental health contract reviews throughout the annual cycle, to ensure these are more manageable within resources going forward.

1.7 The governance route for approval to proceed to procurement for the PSR Most Suitable Provider route is through Leeds Committee. This is due to the ICB scheme of delegation and the likely lifetime contract value of the two consolidated contracts. The total annual value of the consolidated contracts across both lots is £2,579,877 (see tab 1 of appendix MSP table)

1.8 A Quality and Equality Impact assessment (QEIA) has been undertaken collaboratively with VCSE partners. This remains in draft at the time of writing this paper and is being submitted to be considered at the ICB QEIA panel on 28th November for sign off. The QEIA has highlighted the following positive impacts:

- Facilitates a planned move towards an outcomes-based model of care, that focuses on throughput and patient outcomes rather than contracting for capacity and activity, with greater flexibility in how resources are utilised and deployed to meet need most effectively.
- Delivers more sustainable contractual arrangements for VCSE partners, consistent with the ambitions in working with VCSE partners set out in ICB in Leeds market position statement, and lays foundations for innovative, longer-term planning.
- more integrated contractual arrangements that reduce contractual and reporting burden on partners- opportunities to reduce duplication across multiple individual contracts and target a greater proportion of investment into frontline delivery.

1.9 The QEIA also highlights several core risks related to consolidation of contracts into two lead provider contracts such as:

- The inability to guarantee price increases above the NHS settlement and productivity requirements risks providers giving notice within the contract term, creating instability of delivery.
- A risk of impact on people's outcomes if the service is not able to deliver or maintain sufficient throughput or balance demand across services.
- Risk that the identified lead provider VCSE partner takes an organisational risk, without a legal obligation from partner VCSE organisations to support them in the event of organisational crisis.
- Risk that identified lead providers are unable to absorb the additional responsibilities and accountability within a new multi-partner delivery model within existing resources.

Mitigations that have been identified across these risks include contract negotiation; specifically agreeing a reasonable management overhead with providers as part of the procurement process, risk/gain share arrangements, and partnership agreement/memorandum of understanding between VCSE partners, defining the two contract lots in accordance with core business focus of the identified lead providers of each, and tracking core KPIs and metrics identified in the revised specification through appropriate partner governance groups to ensure resources are appropriately aligned.

Next Steps

2.1 Tab 2 (MSP timeline) of the MSP excel table (attached) sets out a procurement timeline for the next steps.

2. Recommendations

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

a) Approve a recommendation to proceed with the Provider Selection Regime Most Suitable Provider process for consolidation of contracts as set out in the paper, to improve outcomes and reduce administrative burdens on providers and the ICB.

b) Note the next steps within the MSP procurement timeline set out on Tab 2 of the appendix table, and in particularly the route for approval of a decision to award process through Leeds Committee on 26th February 2025

3. Appendices

1. PSR MSP Process

Appendix 1

Most Suitable Provider Process (MSP)

VCSE Community Mental Health Transformation - Contract and Service delivery consolidation through Lead Provider Model

Lot (1 x Lead Provider / Contract per lot)	Jaggaer contract number	Provider	Service	Contract Type	Current Contract Start Date	Current Contract end date	Annual Contract value 24/25	Value of extension to 30/06/2025 (number of months vary due to end dates)
1 - Complex Services	con_770	Barca	Community Connectors	NHS Standard Contract Short Form	01/02/2022	31/01/2025	£ 149,748.00	£ 62,395.00
1 - Complex Services	con_771	Northpoint	Community Connectors	NHS Standard Contract Short Form	01/02/2022	31/01/2025	£ 149,748.00	£ 62,395.00
1 - Complex Services	con_773	Touchstone	Community Connectors	NHS Standard Contract Short Form	01/02/2022	31/01/2025	£ 149,748.00	£ 62,395.00
1 - Complex Services	con_5073	Touchstone	CST & Outlook	NHS Standard Contract Short Form	01/04/2024	31/03/2025	£ 428,154.00	£ 107,038.50
1 - Complex Services	con_5075	Touchstone	Inpatient discharge peer support workers pilot	NHS Grant Agreement	01/04/2024	31/03/2025	£ 179,864.19	£ 44,966.05
1 - Complex Services	con_4810	Leeds Community Foundation	Community Grants programme	NHS Grant Agreement	01/04/2024	31/03/2025	£ 237,500.00	£ 59,375.00
1 - Complex Services	con_4812	Forum Central	Community Grants programme	NHS Grant Agreement	01/04/2024	31/03/2025	£ 22,500.00	£ 5,625.00
2 - Peer Support / Work Place Leeds / Grants / IPS	con_5078	Leeds Mind	Peer Support Roles	NHS Standard Contract Short Form	01/04/2024	31/03/2025	£ 280,724.00	£ 70,181.00
2 - Peer Support / Work Place Leeds / Grants / IPS	con_5066	Leeds Mind	Work Place Leeds MH employment service (IPS)	NHS Standard Contract Short Form	01/04/2024	31/03/2025	£ 981,891.00	£ 245,472.75
						Sub-totals - Lot 1	£ 1,317,262.19	£ 404,189.55
						Sub-totals - Lot 2	£ 1,262,615.00	£ 315,653.75
				6 x Contracts 3 x Grants		**TOTALS**	£ 2,579,877.19	£ 719,843.30

Action	Outcome
Permitted modification of contract end date to **30/06/25** to **THEN allow for MSP process** and new combined, **"Lot 1"** contract from 01/07/2025	**Lot 1 Single Contract (3 years + 2)**
Permitted modification of contract end date to **30/06/25** to **THEN allow for MSP process** and new combined, **"Lot 1"** contract from 01/07/2025	
Permitted modification of contract end date to **30/06/25** to **THEN allow for MSP process** and new combined, **"Lot 1"** contract from 01/07/2025	
Permitted modification of contract end date to **30/06/25** to **THEN allow for MSP process** and new combined, **"Lot 1"** contract from 01/07/2025	
NEW GRANT AWARD for 3 months to **30/06/2025** to **THEN allow for MSP process** and new **"Lot 1"** contract from 01/07/2025	
NEW GRANT AWARD for 3 months to **30/06/2025** to **THEN allow for MSP process** and new **"Lot 1"** contract from 01/07/2025	
NEW GRANT AWARD for 3 months to **30/06/2025** to **THEN allow for MSP process** and new **"Lot 1"** contract from 01/07/2025	
Permitted modification of contract end date to **30/06/25** to **THEN allow for MSP process** and new combined, **"Lot 2"** contract from 01/07/2025	Lot 2 Single Contract (3 years + 2)
Permitted modification of contract end date to **30/06/25** to **THEN allow for MSP process** and new combined, **"Lot 2"** contract from 01/07/2025	

5 year totals (3+2) £ 6,586,310.95 Lot 1
5 year totals (3+2) £ 6,313,075.00 Lot 2

MSP Timeline for VCSE MH contracting

Activity	Lead	Timeline
Complete notification of modifications to existing contracts, decision records and complete relevant documentation	Contracting lead	October - January 2024
Key documentation needs to be finalised: • Specification • Key criteria • How the key criteria will be measured • Confirmation of the funding envelope for the service	Pathway and System Integration (PSI) leads	November 2024
Statement of works needs to be signed off – information in the step above needs to be finalised before this can happen.	PSI/Contracting leads	November 2024
Internal Leeds Place governance processes for sign off of modification process plus approval to follow PSR route	Programme Director PSI	Leeds Place Committee 27th November 2024
Letter to Providers to notify them of Modification and MSP intentions	Contracting lead	Early December
Publish F01 Prior Information Notice Intention to follow MSP Process	Contracting lead	Early December 2024 (The notice must be published for at least 14 calendar days before the relevant authority proceeds to assessment of likely providers)

Evaluate and assess any providers against Key Criteria. Based on the assessment and the evidence collected, the relevant authority must confirm that a contract can be awarded under the most suitable provider process.	PSI leads	mid- December 2024 – January 2025
Recommendation to award to Most Suitable Provider Decision to award to be approved by Leeds Place Committee	Programme Director PSI	Leeds Place Committee 26th February 2025
Publish intention to award notice under most suitable provider F03 Contract Award Notice	Contracting lead/Procurement	February 2025 (Standstill needs to be 30 days but can award contract if no representations received after 8 days).
Award contract to most suitable provider	Contracting lead	March 2025
Publish contract award notice F14 Corrigendum FTS	Contracting Lead/Procurement	March 2025 (Within 30 days after contract award)
Mobilisation Period		1st April 2025 – 30th June 2025
Finalisation of record of decision making	Contracting lead	June - July 2025
New contract start date		1st July 2025

Meeting name:	Leeds Committee of the West Yorkshire Integrated Care Board
Agenda item no.	58/24
Meeting date:	27 November 2024
Report title:	Risk Management and Board Assurance Framework Report
Report presented by:	Tim Ryley, Place Lead, ICB in Leeds
Report approved by:	Aimee Willett, Head of Corporate Governance and Risk, WY ICB
Report prepared by:	Harriet Speight, Corporate Governance Manager, WY ICB

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

Previous considerations:

Quality and People's Experience Sub-Committee – 16 October 2024

Finance and Best Value Sub-Committee – 23 October 2024

Delivery Sub-Committee – 24 October 2024

ICB in Leeds Directors Team Meeting – 23 October 2024

Executive summary and points for discussion:

This paper presents the ICB in Leeds High-Scoring Risk Report (risks scoring 15+) during risk cycle 3. All risks have been reviewed by the Risk Owner, the allocated Senior Manager and by the Executive Management Team (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 sub-committees.
2. **RECEIVE** and **NOTE** the WY ICB Board Assurance Framework (BAF) Summary and Heat Map.
3. **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 24 September 2024 (link)

Appendix 3: Leeds Health and Care Partnership Partner Top Risks (as at November 2024)

Appendix 4: Risk on a Page Report

Appendix 5: BAF Summary and Heat Map

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 3 which commenced on 24 September 2024 and will end after the ICB Board meeting on 17 December 2024.

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 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 14 to 22 of the West Yorkshire ICB Risk Report 24 September 2024 for the Corporate Risk Register, and pages 32 to 43 for 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 will be presented to the relevant WY ICB committee on the following dates:

- West Yorkshire Integrated Care Board – 17 December 2024
- West Yorkshire ICB Finance, Investment & Performance Committee – 26 November 2024 (AM)
- West Yorkshire ICB Quality Committee – 26 November 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, imbalance of capacity and demand 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 10 open risks on the risk register. There are currently 10 risks on the Leeds Place Risk Register, with one risk marked for closure.

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

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

Following an update of the Risk Register by Risk Owners and review of individual risks by the allocated Senior Manager, all risks are reviewed by the Directors of the ICB in Leeds. Risk cycle 3 of 2024/25 was reported at the sub-committee meetings that took place throughout October 2024.

At their meetings held this cycle, the Delivery Sub-Committee and the Finance and Best Value Sub-Committee noted partial assurance to the effective management of the risks and the controls in place. More detailed feedback from the sub-committee risk discussions is provided through the Alert, Assure and Advise reports.

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 2 (2024/25).

3.2 There are six open high scoring risks (15+) and the following changes have taken place during cycle 3:

Risk	Cycle 2 2024/25	Cycle 3 2024/25	Movement
2413 – There is a risk that the financial position across the Leeds system will not achieve financial balance	20	20	Static Risk - Monthly financial sustainability meetings with MH, CHC, Acute and Medicines Management team to ensure grip and control is maintain around the year end forecast. More communications to be sent to ensure the whole teams understand the position and review of all uncommitted budgets to identify opportunities.
2414 – There is a risk that measures being taken to control expenditure in Leeds City Council will have an impact on other place partners	16	16	Static Risk – Leeds City Council are reporting a £22.2m forecast year end deficit at Month 4 with overspends of £7.9m in Adults and £18.8m in Children's, finance teams meeting bi-weekly to update on any relevant issues.
2019 – There is a risk of harm to patients in the Leeds system due to people spending too long in Emergency Departments (ED)	16	16	Static Risk – Risk impact and likelihood remain unchanged due to occupancy currently at 95% and 12-hour waits remaining fairly static. Key controls, key control gaps, assurance controls and positive assurance updated.

Risk	Cycle 2 2024/25	Cycle 3 2024/25	Movement
2415 – There is an increasing risk of widening health inequalities and poorer health outcomes across Leeds due to the reduction or loss of VCSE services	16	16	Static risk - Key controls, mitigations, assurances and gaps have been identified and added to the risk by the Accountable Officer, detailed in Appendix 1.
2301 – There is a risk of Children and Young People being unable to access a timely diagnostic service for neurodevelopmental conditions (Autism and ADHD)	15	15	Static Risk – Pathway development continues. Letters sent out now, informing schools, parents and carers of delays in assessments. To help with waiting well, all signposted to services who can support whilst waiting. Advised also that they have a Right to Choose an alternative provider and support given to access via MindMate SPA for those on the waiting list. Working as a partnership together help resolve the issues, additional capacity funded by the ICB short term to support the work.
2354 – There is a risk of unsustainable Neurodevelopmental assessment and treatment pathways for adults (autism and ADHD)	15	15	Static Risk – Key controls, key control gaps and assurance controls updated - ICB Place resource is focused on supporting the development of a WY accredited provider list to support and manage quality and tariffs associated with RTC referrals; ADHD service is developing an impairment ladder to manage clinical prioritisation; and Leeds Data Model will include ADHD data.

3.3 Of these risks, all 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.

4 Risks Aligned to the Leeds Committee

4.1 There are two risks aligned directly to the Leeds Committee. Of these risks:

a) One risk is scored at 12
b) One risk is marked for closure

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

Risk Number and Risk Title	Cycle 2 2024/25	Cycle 3 2024/25	Movement since previous risk cycles
2024 – Deprivation of liberty (DoLS) legislation	12	12	Static Risk - Though this is regularly monitored and the team continue to prioritise DoLS in the community the risk remains static. The team continues to have a large vacancy factor and a recruitment freeze as all organisations across the city try to meet their financial targets. The plan in Q2 is to identify training money to increase number of staff to support this work.

4.3 **Risks Marked for Closure**

Risk Number and Risk Title	Cycle 2 2024/25	Cycle 3 2024/25	Movement since previous risk cycles
2011 - There is a risk that the ICB in Leeds is perceived by partners in the Leeds Health and Care Partnership (LHCP) as not 'adding value' to the LHCP.	6	6	Risk to be closed – Following the partnership development proposal sign off by PLT and positive feedback on the work delivered in relation to this, we have agreed with Tim Ryley as the Senior Manager to close this risk. The work undertaken by the Partnership Development matrix team (P&E BU and Health Partnerships) has been positively received and the proposals for the implementation of the PD work supported. It has been agreed that the risk no longer remains open as each of the areas identified within the risk have been controlled and mitigated against.

5 Board Assurance Framework (BAF)

5.1 As part of the effective risk management processes which are crucial to ensuring that the ICB's strategic priorities are delivered and compliant with all legislation and regulatory frameworks, the BAF provides the ICB with a method for the effective and focused management of the principal risks and assurances to

meeting its objectives. By using the BAF, the ICB can be confident that the systems, policies, and people in place are operating in a way that is effective in delivering objectives and minimising risks.

5.2 An extract of the overarching BAF West Yorkshire and Place heatmaps is included at Appendix 5. This version was presented to the ICB Board at its meeting in September 2024, to ensure the board was mindful of its role in management of several principal risks.

5.3 The document is included now in pursuance of building the sub-committee's understanding of the interrelationships between the BAF and the corporate and place risk registers within the overall risk management regime, and to increase the sub-committee's familiarity with the documentation as the BAF is further developed.

5.4 Following the internal audit review of the BAF during 2023/24, it was concluded that there needed to be a more overt link between board and committee discussions and the principal risks facing the ICB. Sharing this BAF extract as part of the sub-committee's agenda also ensures that links can be made throughout the meeting, and appropriate assurance gained and reflected in any AAA reports.

6 Next Steps

6.1 Subsequent to the Leeds Committee meeting, the risks will be carried forward to the next risk review cycle which will commence after the WY ICB Board meeting on 17 December 2024.

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

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 sub-committees.
2. **RECEIVE** and **NOTE** the WY ICB Board Assurance Framework (BAF) Summary and Heat Map.
3. **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.

8 Appendices

Appendix 1: Risk Register extract (High Scoring risks and risks aligned to the Leeds Committee)
Appendix 2: West Yorkshire ICB Risk Report 24 September 2024

Appendix 3: Leeds Health and Care Partnership Partner Top Risks (as at November 2024)
Appendix 4: Risk on a Page Report
Appendix 5: BAF Summary and Heat Map

Appendix 1

Risk ID	Date Created	Risk Type	Strategic Objective	Risk Rating	Risk Score Components	Target Risk	Target Score Components	Risk Owner	Senior Manager	Principal Risk	Key Controls	Key Control Gaps	Assurance Controls	Positive Assurance	Assurance Gaps	GBAF Ref No(s)	GBAF Entry Description(s)	Risk Status
2413	20/03/2024	Finance and Best Value Committee	Enhance productivity and value for money	20	(4x5)	6	(3x2)	Matthew Turner	Alex Cridcmar	There is a risk that the financial position across the Leeds system will not achieve financial balance due to the combination of undelivered CIPP and new cost pressures in 2024 – 25. This could result in the system as a whole not meeting its statutory duties to break even.	Budgetary reporting and control meetings with DMT and budget holders/managers. SFI's/SO's Monthly meetings with DoFs and CEOs/AOs through the SFEG. Internal and external audit West Yorkshire finance framework Weekly Leeds DoF meetings Fortnightly meetings with Leeds Council	There is an active approach adopted across the ICB in Leeds and the wider WY ICB means that all parts of the WY system are actively looking at further opportunities to ensure that the ICB can deliver its agreed financial plan for 2024-25. Development of a medium term strategic financial plan to demonstrate the path to recurrent balance is ongoing across Leeds and West Yorkshire.	Policies and Procedures Financial performance framework Weekly Leeds DoF meetings Fortnightly meetings with Leeds Council	We are starting the financial year with a £12m planned deficit at the ICB and a total £8m deficit across all NHS partners in Leeds. This is the lowest level of deficit compared to other places in West Yorkshire. There is ongoing benchmarking work across West Yorkshire to identify further potential opportunities to close the financial gap.	Limited further options to close the remaining gap at the ICB at this time, with limited data on benchmarking opportunities. Medium term financial plan yet to be produced to achieve recurrent financial balance.			Static - 2 Archive(s)
2415	21/03/2024	Delivery Committee	Tackle inequalities in access, experience, outcome	25	(4x1.4)	9	(3x1.3)	Sam Ramsey	Tim Ryley	There is an increasing risk of widening health inequalities and poorer health outcomes across Leeds due to the reduction or loss of VCSE services and closure of VCSE organisations in the current economic and financial context. Loss of VCSE services will result in increased demand on already overstretched mainstream and community NHS services.	Annual position statement published which includes overview of NHS spend in the sector and commitments to increase NHS funding in the sector in line with underlying NHS allocations and stronger focus on community and inequalities. Forum Central and wider Third Sector participation in Leeds Health & care strategy and prioritisation processes.	Factors outside the NHS - NHS England financial regime - NHS investment in Third Sector is only one part of the picture with Local authority, Grant Funding, Revenue generating activity. - NHs investment limited to those areas that link to its role in the system in providing services, secondary prevention and equity of access	West Yorkshire ICB level review of place approaches Leeds Committee of the ICB oversight of financial plans Two meetings per year with Sector to review progress	Further to be added in Q3	Need to develop broader partnership overview in Leeds at the moment still too fragmented so assurance is limited.			Static - 2 Archive(s)
2414	20/03/2024	Both Delivery and Finance and Best Value	Enhance productivity and value for money	16	(4x1.4)	6	(3x1.2)	Matthew Turner	Alex Cridcmar	There is a risk that measures being taken to control expenditure in Leeds City Council will have an impact on other place partners, due to the financial pressures being experience by most councils across West Yorkshire and their statutory requirement not to overspend against budgets. This may lead to a potential impact on hospital discharges resulting in higher costs being retained within the Leeds and WY NHS system (additional costs borne by NHS provider organisations for which there may not be mitigations, thereby resulting in	1. Working with Leeds City Council to understand the issues, options being considered and the potential impact on system partners. 2. Review use of intermediate care capacity 3. System leadership oversight and consideration of options to minimise impact	WY councils are separate statutory organisations with no NHS oversight	System oversight of wider health and care financial position	Close working relationships between the NHS and councils in place and representation of councils on system partnership board	Lack of medium term plan to understand how recurrent financial balance position can be achieved.			Static - 2 Archive(s)
2019	30/06/2022	Both Delivery and Quality and People's Experience	Improve healthcare outcomes for residents	16	(4x4.4)	9	(3x3.3)	Helen Smith	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) and across the system partners, supported by Decision management tool ward based transfer of care model rolled out to all in scope wards in LTHT to help early decision making and identification of need Detailed seasonal surge plans developed and overseen hrough Active System Leadership Structures System Escalation Actions and Processes revised continuously Integrated OPEL Framework 2024/26 due for publication in Oct 24. OPEL & System Pressures Reporting Regime - refreshed in view of the revised OPEL (Nov 23) Communications work with Public to suggest alternatives to ED Investment in Home First services and in assessment capacity through Adult Social Care Discharge Fund Winter capacity plans in place to support discharge capacity Improvements in pathways, processes and in hospital waiting times for social workers and care act assessments have reduced the length of time people wait on pathways 1 & 3 where a care act assessment is required for long-term care.	Key controls in place responding to high levels of demand. Current controls are still not sufficient to reduce the risks when there is exceptionally high demand on the system or where outflow is constrained through Industrial Action or other absence While occupancy has improved, this isn't always correlated with a reduction in people spending a long time in ED - in part because the bed availability doesnt always match the specialty that is in demand Increased 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. This is in the contast of additional winter capacity in primary care and social work. (Sept 24)	Health & Social Care Command & Control Groups: Active System Leadership,Active System Leadership Executive Group (Silver) Integrated Commissioning Executive Partnership Leadership Group Quality and Performance Committee New System Visibility Dashboard is in place to support assurance and decision making	Bi-weekly meeting in place for services to report on capacity /demand (will flex if surge occurs) Reviewed Silver Action cards Revised System Resilience Structure System Visibility dashboard in place and driving change Strong programme of Home First work in place Short Term Assessment pathway in place to support care at home to maintain capacity and ensure focus on home first even if there are constraints in statutory provision Improvements in the waiting times for pathway 3 have been made by process changes Big and sustained improvements in pathway 2 (rehab beds)	OPEL reporting system under development for ASC but not yet finalised or shared. Recruitment and retention remain significantly challenging and limit the ability to create additional capacity, Still too many people over 6 and over 12 hours in ED which we know is linked to risk of harm 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) . Long waits for admission in inappropriate ED environments for mental health beds linked to high MH bed occupancy. Funding to maintain capacity within LTHT and to support Social care assessments is likely to become more difficult in coming months SW capacity, recruitment and retention remain a key risk alongside groups such as therapists			Static - 6 Archive(s)
2354	14/08/2023	Both Delivery and Quality and People's Experience	Tackle inequalities in access, experience, outcome	15	(3x1.5)	9	(3x1.3)	Philip Chan	Helen Lewis	There is a risk of unsustainable Neurodevelopmental assessment and treatment pathways for adults (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 ICB Place resource is focussed on supporting the development of a WY accredited provider list to support and manage quality and tariffs associated with RTC referrals. This also aims to improve patient outcomes and experience when seeking treatment and entering shared care in the local area. ADHD service (LYPFT) has closed to routine referrals temporarily - support team being established to proactively contact waiters in IMD1 and/or with other risk characteristics to offer support with the needs that led to seeking referral, and to respond to queries from those on the waiting list who have all been written to. The service will work through the waiting list and work with partners to provide assessment options and also support to patients on the waiting list. The solution(s) will involve a system response and incorporate the WY ICB work on RTC. At place, there will be a focus on: - initial support and guidance for those on the ADHD waiting list - ADHD prescribing capacity/pathways being discussed with primary care provider. WY accredited provider list service specs compliment this approach - pre-diagnostic support to support 'waiting well' including to develop and curate the support offer from third sector organisations.	ADHD service will be closing to new referrals which will probably increase Right To Choose referrals. Spend in this area needs to be monitored and is an area of unknown/risk. WY accredited provider work will help with the cost per case but may still increase overall spend, but not in place until April 2025. Waiting lists of RTC/private providers is likely to grow which needs to be considered. There continues to be a significant strain on staff capacity of the ADHD service due to consultant resource for prescribing. Demand for assessment continues to outstrip capacity for assessment. Transformation of pathways is needed. There is no explicit national ADHD Strategy including a clear steer on RTC guidance to support the WY work. There is a NHS England ADHD task force which the WY programme and clinical colleagues are linked into. Clinical prioritisation advice requested. Seeking funding/grants to support pre- and post diagnostic support offer. Lack of access to targeted funding to support service development and transformation projects. Gap in accessibility to information, resources and personalised pre-diagnostic needs-led support through VCSE/social prescribing for Adults with ADHD. Regular reporting for Right to Choose information especially linked to shared care spend.	Autism and ADHD diagnostic waiting list times ADHD treatment waiting list times ADHD annual review waiting list times. ND service annual quality report. Service specification reviews Oversight of Right to Choose ND diagnostic pathway referrals and spend Neurodiversity priorities agreed though Learning Disability and Neurodiversity Population Board Leeds Autism Strategy Leeds data model including ADHD and autism data to steer priorities.	Service annual quality board ND programme plan outlining key workstreams and work progressing Learning Disability and Neurodiversity Population Board report.	- Lack of targeted/identified recurrent funding streams provide ongoing challenge for sustainable improvement through non-recurrent mechanisms. - National Task Force set up, but potentially then risks local solution development as people wait for national steer			Static - 6 Archive(s)

2301	16/05/2023	Both Delivery and Quality and People's Experience	Tackle inequalities in access, experience, outcome	15	(I3xL5)	6	(I3xL2)	Karren Leach	Helen Lewis	There is a risk of CYP being unable to access a timely diagnostic service for neurodevelopmental conditions (Autism and ADHD) due to rising demand for assessments and capacity of service to deliver this (ICAN for under 5, CAMHS for school age). Delays in access to timely diagnosis may impact upon children's outcomes, access to other support services across health, education and social care, and also compliance with NICE standards for assessment within 3 months from referral.	Development of "ND - thinking differently case" presented to PEG in March and outlining the need to think about a needs based approach to providing support to CYP who are neurodivergent Priority workstream for year 1 within SEND Inclusion plan Development of pre assessment support (MindMate ND hub, pilot delivering ND support with a cluster for 23/24) Links made to West Yorkshire ND programme of work particularly looking at how we as a WY ICB address the rising demand around the right to choose agenda and ensure a consistent method of delivery across the ICB. ND citywide development workshop undertaken on 19th July. Representatives from across health came together (including Education and parent/carer representation) to understand the current position and challenges facing us both locally, regionally and nationally. Forwards plan for working groups following this and a further education focussed time out in October. Links made to the West Yorkshire programme of work particularly in relation to responding to the ND choice financial pressure. Funding has moved to LCH to outsource assessments for our most vulnerable cohorts. Outsourcing to commence in September. Provider has now been sourced (update from last cycle)	Development of ND governance under development to include working group to develop and set out strategy for plans over next year 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). Available funding and workforce will make rapid improvements difficult. Staff availability with appropriate skills remains a key risk nationally and locally	Data from LCH on waiting times Once working group established this will report regularly to SEND Partnership board and CYP population board Meeting in place with ICB, LCH and LCC to determine development plan and shared position statement	Capacity in IS confirmed for highest risk cases ICB establishing a clinical reference group to support model design written to all families on the waiting list to sign post to additional resources that will offer support	Increasing public focus with request from Scrutiny to update Cllrs in September and increasing letters from MPs to service provider (LCH).			Static - 7 Archive(s)
2024	30/06/2022	Leeds Committee of the WY ICB	Improve healthcare outcomes for residents	12	(I4xL3)	1	(I1xL1)	Andrea Dobson	Jason Broch	There is a risk of not meeting legislative responsibilities in relation to community deprivation of liberty for fully funded CHC cases; due to assessor capacity and availability of court of protection time; resulting in deprivation of liberty in breach of legislation. There is a significant additional risk that patients will not have the advocacy they need to go through the process due to a lack of commissioned resource. Family members can act as the RPR if they are objective, however in the majority of cases that is difficult.	Monthly meetings held with Health Case Management managers to monitor current position, plan LPS and maintain numbers. Prioritise cases based on complexity and risk of challenge Assessments are completed in line with the availability of court time to ensure they do not go out of date. However, delays to court proceedings have meant that a large number of cases have had to be redone as they became 'out of date' whilst awaiting a hearing. This has increased the workload of the HCM team. MCA Lead is working in collaboration with the health case management team and appointed solicitors to minimise delays and maximise performance. More case managers have received relevant training and experience to complete the assessments. Fast track caseload moved to Continuing Care	Please add actions in addition to the controls listed to reduce risk to target - with date for completion- see guidance p4. The following have been copied from Datix: Liberty Protection Safeguards LPS has been delayed in its implementation indefinitely. There is insufficient budget and resource at place to undertake preparatory work for all potential cases of DoL or to engage legal representation in order to progress all cases to the court of protection. The court has raised concerns on a number of occasions about the use of family members as appropriate rule 1.2 representatives, this requires additional legal support and HCM work.	LCH provide performance reports, highlighting the current position. The ICB Mental Capacity Act Lead meets with LCH quality Leads and Beachcroft solicitors quarterly to track progress and unpick any delays or performance issues	Regular meetings with the HCM Managers to ensure issue remains in focus. Mental Capacity Act Lead is working both at the place and ICB level to monitor all associated risks. Adam (CHC System) has been updated to record DoLS, enabling improved monitoring and recording of DoLS	No current gaps identified			Static - 7 Archive(s)
2018	29/06/2022	Both Delivery and Quality and People's Experience	Tackle inequalities in access, experience, outcome	12	(I4xL3)	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, 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.	Improving Flow Programme -led by LYPFT in collaboration with system partners- workstreams established to optimise flow through inpatient settings by focusing on maximising our alternative to hospital provision, ensuring that all admissions are purposeful, reducing prolonged length of stay and proactively discharging our service users at the right time to the right place. Remodelling of crisis alternatives provision in Leeds informed by MH crisis pathways to optimize targeting resources to meet the needs of population cohorts most at-risk. This has incorporated focused improvement to strengthen the integrated delivery of Oasis crisis house with LYPFT crisis team and utilisation of a single information system to increase occupancy as an alternative to hospital admission. Mobilisation of integrated primary-community mental health new model of care from March 2024- for testing and refining ahead of phased rollout from Q3 24/25 Crisis Transformation Programme- Consolidating integrated commissioning (ICB in Leeds and Leeds City Council) for supported accommodation for people with complex mental health needs into a single re-procurement process, targeted to reduce unnecessary delays in discharge from MH inpatient beds- remodelling underway, with LYPFT connected into work to agree specification	Access to urgent crisis assessment within the MH trust within 4hrs whilst improved remains below target. Early mobilisation challenges with embedding NHS111 MH in Leeds	Waiting and access times to services monitored through performance metrics, Healthy Leeds Plan, and Mental Health Population Board data dashboard (power BI insight hub) Inpatient Flow Oversight Group within LYPFT	Evaluation of impact and outcomes from testing transformed new model of integrated primary-community mental health model of care in three early implementer sites presentation at CMH Transformation Partnership Board on 30.09.24. Partners agreed a refreshed plan to mobilise the clinical functions, MDT structures and ways of working tested citywide commencing February 2025, alongside progressing and testing the more enhanced integration within the early implementer sites. planned trajectory remains on track to achieve nationally mandated target to increase access to community mental health services in Leeds work to reduce the waiting list for access to step 3 CBT in NHS talking therapies has maintained improvement- with many people now able to commence high intensity therapy within 4 months and target for waiting list anticipated to be met in Q3 24/25 Improving MH Flow Programme -delivery update presentation to MH Population Board evidences progress on track against the core workstreams-including evidence of positive impacts from the pilot and learning review of focused mini MADE process supported by NHSE, and process improvements including development of barriers to discharge dashboard, and progress made towards system visibility dashboard for mental health. In context of sustained pressures reported through OPEL for LYPFT - this programme of work evidenced some effective progress,	As of 01/10/24 LYPFT continue to report OPEL 3E, with sustained demand for MH inpatient beds, 22% DTOC in acute MH beds, 18 OOA placements (13 Acute, 4 PICU, I OPS/dementia)- this is above planned trajectory - please note in context of positive assurance noted from Improving MH Flow Programme. Access to urgent crisis assessment within the MH trust within 4hrs whilst improved remains below target. Some early challenges with embedding mobilisation of NHS111 MH into the Leeds system for crisis access- comms plan developed to mitigate. Long delays for those waiting for mental health beds in ED on occasions as balance risk of people at home versus those in ED			Static - 1 Archive(s)

2016	29/06/2022	Both Delivery and Quality and People's Experience	Tackle inequalities in access, experience, outcome	12	(4x L3)	12	(I4x L3)	Lindsay Mcfarlane	Helen Lewis	As a result of the longer waits being faced by patients and limited capacity for treatments, there is a risk of harm, due to failure to successfully target patients at greatest risk of deterioration and irreversible harm, resulting in potentially increased morbidity, mortality and widening of health inequalities.	Joint working between ICB places and WYAAT trusts to maximise access to Independent Sector (IS) provision with a focus on increasing complexity and longest waiters. From October 2023, patients who have waited more than 40 weeks for an appointment or who have a decision to treat but do not have treatment date have been able to request a transfer to another provider with a shorter waiting list (PIDMAS) Consistent messaging to patients re waiting times. Greater use of advice and guidance to help manage patients pre-referral / whilst waiting for appointments Implementation of patient initiated follow up (PIFU) LTHT using methodologies to account for learning disability and deprivation in assessing clinical priority (as part of Healthy Hospitals Network) LTHT implementation of clinical harm reviews of patients awaiting treatment longer than 52 weeks - ICB should be made aware of issues/ concerns as update is shared with ICB post review at the LTHT Quality Assurance Committee on patient harm whilst awaiting treatment. ICB attend weekly LTHT Service Delivery	Uncertainty of sustained deliverability of recovery plans linked to industrial action, workforce and funding Awaiting clarification of process with ICB Quality team and LTHT re quarterly monitoring reports on patient harm whilst awaiting treatment. Capacity gaps in pressured specialties are similar across other regions so the actual opportunities to access care in alternative locations will be limited.	Monthly meetings with Leeds ICB and providers (LTHT/ LCH and community /IS providers) to identify and maximise opportunities to support with waiting lists. Choice Agenda now operational (from October 2023) patients who have waited more than 40 weeks for an appointment or who have a decision to treat but do not have a treatment date will be able to request a transfer to another provider with a shorter waiting list. Advice and guidance and PIFU agreed key components of outpatients strategy/ management of long waiters and fully supported by the Planned Care Delivery Board - January 2024. Monthly Corporate Performance reporting in place / Planned Care Delivery Board oversight LTHT Harm Review process in place for long waiters Cancer - data driven discussion at WY&H Cancer Alliance Board levels and follow up analysis and actions agreed at place. Cancer Care Delivery Board taking a lead role in developing solutions at a system wide cancer level, through access to SDF monies. Ongoing meetings with ICB at Leeds/ LTHT cancer team and wider partners.	Consultant and resident medical staff have accepted offers. Elective Recovery Funding clarified for 24/25, but against a very significant Cost improvement programme for LTHT	Intermittent industrial action will set back progress due to need to prioritise those patients of greatest clinical need. Size of the overall waiting lists needs to reduce to ensure longer term sustainability and to meet trajectories Initial updates from PIDMAS/ Choice work is that of those patients who initially suggested they would access care outside of Leeds there has been very low levels of actual take up. 2 x funded posts within LTHT (initially funded by city wide HI funding) due to end 24/25 - no alternative funding identified, this is included on LTHT risk register and cost pressures.			Static - 8 Archive(s)
2011	29/06/2022	Leeds Committee of the WY ICB	Improve healthcare outcomes for residents	6	(3x L2)	6	(I3x L2)	Sam Ramsey	Tim Ryley	There is a risk that the ICB in Leeds is perceived by partners in the Leeds Health and Care Partnership (LHCP) as not 'adding value' to the LHCP due to 1) a lack of understanding about the purpose of the ICB in Leeds across the LHCP 2) a misalignment of priorities and areas of focus between the ICB in Leeds and other members of the LHCP and 3) behaviours of members of the ICB in Leeds This could result in the LHCP not being able to operate effectively to deliver its ambition to use collective resources to improve outcomes and reduce inequalities for the population of Leeds and the WYICB being unable to effectively discharge its duties through the ICB in Leeds.	02.07.24 - Proposals supported through PEG meeting (28.06.24) outlining improved arrangements for the role and purpose of PLT (formerly PEG). Work undertaken by ICB in Leeds Partnership and Effectiveness BU and was well received within partnership and demonstrates value-add of ICB in Leeds 05.2024 - Highly positive feedback received about place-based risk workshop, facilitated and convened by Clinical Leadership and Partnership and Effectivness BUs in Leeds 27.03.24 - Implementation of new operating model, more targeted to resource to progress Partnership Development across 4 PD questions and est. of core business processes within the partnership will demonstrate greater value-add of ICB n Leeds 28.11.23 ICB in Leeds leading work across LHCP to progress Partnership Development - provides opportunity to demonstrate value-add of ICB in Leeds within LHCP 26.09.23 Plans to progress KLOI and seek learning with SI PPS about strengthening relationship and adding value between partners and 'integrator' 20.07.23 Sessions at Leeds Committee Development Session (Aug 9) and PEG (Aug 11) to share proposed place based design and seek feedback on perceived value-add Development of clear 'story / elevator pitch' about the core purpose of the ICB in Leeds within the LHCP and opportunity to engage with partners of the proposed future Operating Model. Ongoing engagement with LHCP AOs re development of WYICB Operating Model and	WYICB Operating Model design currently underway, phase one of design to conclude by June 23 Agree all 23/24 objectives to progress Business Unit contributions to all and explicit focus on value-add Add specific standing item on EMT agenda to share feedback and learning relating to the perceived value-add of the LOICS and agree any required actions. Appetite to provide ad-hoc progress updates with PEG or Leeds Committee of the ICB private workshops? - In discussion with Head of Governance re adding to forward plan Draft ICB in Leeds objectives to be socialised with AOs and Equivalent Directors (in the LHCP) during Spring 23 and as part of the responsibility of senior leaders through their networks (ongoing)	27.03.24 - Operating Model predominantly recruited to readiness to go-live from April 24 - overview of structure provided to PEG 22.03.24 TR 1:1s with all LHCP AOs re value-add of LHCP Development of WYICB Operating MOdel being led by TR so strong connection back to LHCP Anticipate that we might see this reduce to a six by End June when we will be through the implementation and further developed partnership.	Feedback from LHCP chairs that supportive of Option 4 and appetite to move to option 5 within 24 months.	Engagement with partners on detail of proposed ICB in Leeds Operating Model yet to commence No central process/system/mechanism to capture and act on anecdotal feedback re perception and value-add of LOICS. Appraisal system not yet updated to systematically require feedback on value-adding contribution of senior leaders from partners within the LHCP			Closed - Risk no longer relevant to the CCG

Leeds Health & Care Partnership

NHS West Yorkshire Integrated Care Board

Appendix 3

Leeds Health and Care Partners - Top Risks – as November 2024						
The ICB in Leeds	20	**Financial Position** There is a risk that the financial position across the Leeds system will not achieve financial balance due to the combination of undelivered QIPP and cost pressures in 2023 – 24. This could result in the system not meeting the statutory duties.	16	**Risk of Harm – Emergency Department Waiting Times** There is a risk of harm to patients in the Leeds system due to people spending too long in Emergency Departments (ED) due to high demand for ED, the numbers, acuity, and length of stay of inpatients and the time spent by people in hospital beds with no reason to reside, resulting in poor patient quality and experience, failed constitutional targets and reputational risk.	16	**Widening Health Inequalities – VCSE Sector** There is an increasing risk of widening health inequalities and poorer health outcomes across Leeds due to the reduction or loss of VCSE services and closure of VCSE organisations in the current economic and financial context. Loss of VCSE services will result in increased demand on already overstretched mainstream and community NHS services.
Leeds Teaching Hospital Trust	16	**High occupancy levels and insufficient capacity and flow across the health and social care system causing impact on patient safety, outcomes, and experience** There is a risk to maintaining sufficient capacity to meet the needs of patients attending hospital and being admitted for planned/elective care and unplanned (acute) care caused by demand being greater than the available hospital capacity.	20	**Delivery of the financial plan and operational capital plan for 2024/25**. There is a risk that the Trust does not achieve its planned control total and deliver the operational capital plan in 2024/25 due to additional cost pressures and under-delivery of WRP, in particular in relation to reductions in Length of Stay. This would have the following impact: Reducing the internal funding for the Trust's ambitious Five-Year	16	**Workforce risk** There is a risk in filling staff vacancies across all professional groups and support workers, caused by local and national shortages of qualified and unqualified staff, exacerbated by external financial pressures impacting on decisions to recruit to vacant posts; resulting in a potential failure to provide safe care and treatment, protect staff from psychological and

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

		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 a risk of patient harm, including healthcare associated infection, and deconditioning due to prolonged hospital stay. There is also a risk to the delivery of constitutional standards, impacting on the Trust's delivery and efficiency ratings and reputation.		Capital programme, potentially requiring capital cash support resulting in an increased cost in revenue. Cash shortfall and risk to supplier payment. Potential to contribute to the Integrated Care System not meeting its overall control total. Reputational damage, as the Trust fails to deliver on a key statutory duty (financial plan) and the Trust fails to invest in equipment, estate, and digital infrastructure to support service development. Potential non-compliance with regulatory requirements, including new medical devices regulation (Regulation EU 2017/45). Increased clinical risk due to inability to replace capital assets within agreed replacement schedules.		physical harm (burn-out), loss of stakeholder confidence and/or material breach of regulatory conditions of registration.
Leeds Community Healthcare Trust	⇔	**Neurodiversity Waiting Times** There is a risk of unsustainable Neurodevelopmental assessment and treatment pathways (autism and ADHD) due to demand for services surpassing the capacity resulting in unmet need of patients and long waiting lists which will cause impact to patient outcomes.	⇔	**Imbalance of Capacity and Demand** Increasing demand for services (specific risks on the risk register relate to Neighbourhood Teams, CAMHS, Speech and Language Therapy, ICAN) coupled/reflected with increased complexity of the services required, resulting in reduced quality of patient care,	⇔	**Financial Position 2024/25** 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

				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.		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 and is being managed through the Quality and Value Programme. It is likely that require service changes will impact on stakeholders.
Leeds and York Partnership Foundation Trust	⇔	**System flow and Out of Area Placements** There is a risk to the quality of care of our service users as a result of ineffective patient flow within the system with an increasing use of Out of Area Placements, compounded by a	⇔	**Financial Position** There is a risk that the Trust does not meet its planned efficiency targets in 24/25 which could impact on delivering the overall financial plan. Non recurrent mitigations are not sustainable and there is a likely impact on	⇔	**Investment in Mental Health and Learning Disability Services** There is insufficient capacity to meet the level of demand of mental health needs within Leeds; this is manifested through the availability of core

		lack of recurrent funding and a resulting financial cost to the system.		quality of care over time. This is due to the underlying deficit and service pressures which compound the in-year position.		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. Delivery of new collaborative contracts and responding to tenders.
Forum Central - Voluntary, Community and Social Enterprise	↑	**Strategic:** Reduced capacity to provide a strategic voice for health & care third sector and manage rep & eng across the ICB/LHCP systems, compounded by changing structures and roles means incr number of risks; issues and opportunities missed. Missed opportunities due to extreme system financial pressures not looking to VCSE	↑	**Financial:** Where reduction in VCSE 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 home after a stay in hospital (reducing service efficiency). VCSE is effectively being stopped from supporting HLP priority goals. If resources could be shifted it would relieve	↑	**Operational:** Increased demand and level of complexity of need of people accessing VCSE services, alongside reduced capacity due to reduced contract values and contracts ending / short term funding. As VCSE sector is increasingly unable to support existing as well as rising demand amongst the most vulnerable groups

		sector to mitigate wider system pressures. Reducing and ending contracts rather than investing on best value cost benefit options which support system goals. Lack of clarity of where system decisions made so uncertainty of where to focus limited resources to support the most effective decision making as a system. Significant risk of health inequalities being missed/not recorded/not escalated due to immature systems and processes that are focused on no. of people affected not level of health inequality faced. i.e. discussions of risks at pop board level not captured/ escalated to committee level due to not hitting risk scoring threshold e.g. redn in commissioned bereavement support.		system pressures. System is making counterproductive decisions due to financial pressures. Loss of contracts and / or lack of full cost recovery leading to closure of local Third Sector organisations. Resulting in loss cannot be built back from and learning from previously successful programmes. Pilots and new services should have legacy planning prior to being commissioned/funded as s/t funding decreases cost / benefit of service due to balance of time spent budgeting / recruitment rather than delivery.		and communities we expect to see Harm to people, especially those with the greatest Health Inequalities (HIs) Cuts and restrictions on NHS/LCC services, in addition to rising poverty, mean VCSE 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, both using services and workforce.
Leeds City Council	⇔	**Workforce** Workforce resource not in place to deliver the service to the required standard. Worsening workforce pressures (including health, safety and wellbeing) and market sustainability position. Problems in both Adults and	⇔	**Major cyber incident** Cyber-attack / major IT outage has an adverse impact on our ability to keep delivering critical services (including those for Health and Social Care). Sources:	⇔	**Sustained financial pressures** Financial and budgetary pressures within the organisation - in particular for Adults & Health and Children & Families directorates - is still very real/relevant and is high

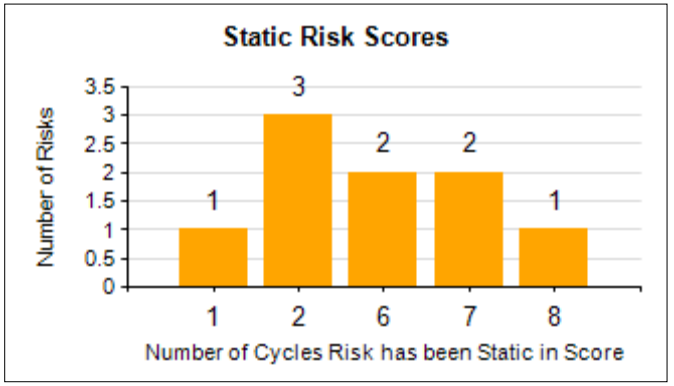
		Health and Children and Families directorates in recruiting and retaining care staff (in particular: social workers, professionals, educational psychologists, schools) leading to increased resource pressures and adverse impact on our ability to deliver a wider range of services. Workforce capacity pressures also within the wider social care market arising from anticipated increases in staff-related costs i.e. NLW/RLW, increase in NI Employer Contributions. Risk that the workforce capacity gap could worsen. <u>Sources:</u> Increased demand and complexity and experience of working in increasingly complex community contexts, including at times, heightened community tension. 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		Internal and external threats to cyber security e.g., human error, malware, ransomware and increasing sophistication of cyber-criminal activity. Cyber disruption from geopolitical conflicts.		risk.

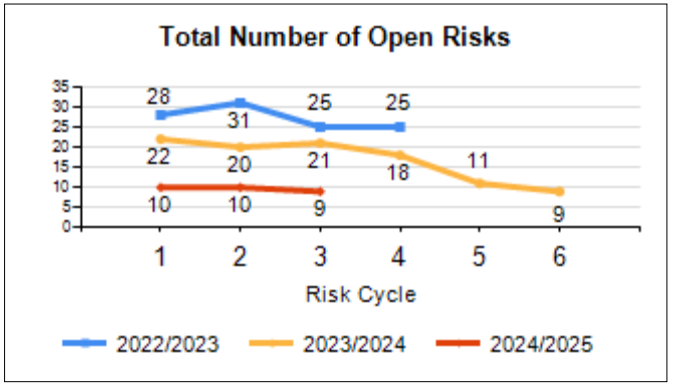
		jobs in other industries. Long term problems from the pandemic and Brexit.				

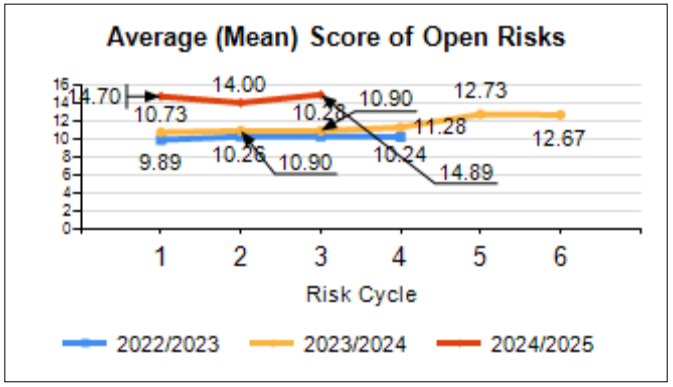
Appendix 4: Risk on a Page Report for the Leeds Committee of the West Yorkshire Integrated Care Board
Risk Cycle 3: September - December 2024

Total Risks	10
Delivery	1
QPEC	0
Delivery and QPEC	5
Finance & Best Value	1
Delivery and Finance & Best Value	1
Leeds Committee	2

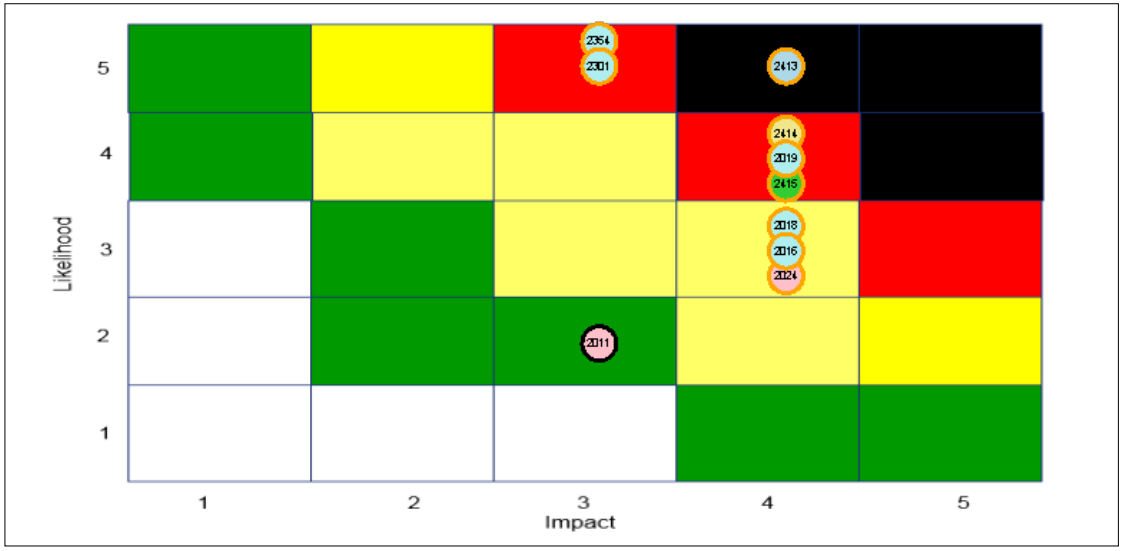
Movement of Risks	
New	0
Marked for Closure	1
Risk score increasing	0
Risk score static (1 cycle)	1
Risk score static (2+ cycles)	8
Risk score decreasing	0







Risk Overview



Key

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

Appendix 5 – Board Assurance Framework Summary and Heat Map

West Yorkshire Integrated Care Board - Board Assurance Framework - Summary						Version: 1.4	Date: March 2024
Mission		**Strategic risk**	**Risk appetite**	**Target WY score**	**Current WY score**	**Lead director(s) / board lead**	**Lead committee / board**
(1) Reduce inequalities	1.1	There is a risk that our local priorities to narrow inequalities are not delivered due to the impact of wider economic social and political factors.	Bold	16	20	Ian Holmes	ICB Board
	1.2	There is a risk that operational pressures and priorities impact on our ability to target resources effectively towards improving outcomes and reducing inequalities for children and adults.	Open	9	12	Ian Holmes / Jonathan Webb	Finance, Investment and Performance Committee
	1.3	There is a risk that we ration services due to insufficient resources in a way that does not reduce (or exacerbates) heath inequalities.	Open	8	8	Ian Holmes / Jonathan Webb	ICB Board
	1.4	There is a risk that we fail to join up services in our communities which means that we do not improve outcomes and reduce health inequalities.	Open	8	12	Ian Holmes	ICB Board *(linked to place committees)*
(2) Manage unwarranted variation in care	2.1	There is a risk that our inability to collectively recruit and retain staff across health and care impacts on the quality and safety of services.	Cautious	8	12	Kate Sims	Transformation Committee
	2.2	There is a risk that as a system we fail to innovate, learn lessons and share good practice that allows us to respond to service pressures resulting in widening variations across our footprint.	Open	4	12	James Thomas	Quality Committee
	2.3	There is a risk that we are unable to measure and assess performance across the system in a timely and meaningful way, which impacts on our ability to respond quickly as issues arise.	Open	6	6	Anthony Kealy	Finance, Investment and Performance Committee
	2.4	There is a risk that our infrastructure (estates, facilities, digital) hinders our ability to deliver consistently high quality care.	Open	9	16	Jonathan Webb / James Thomas	Finance, Investment and Performance Committee.Transformation Committee for Digital
(3) Use our collective resources wisely	3.1	There is a risk that we invest resources in a way which does not allow us to join up services nor maximise value for money.	Open	4	9	Jonathan Webb	Finance, Investment and Performance Committee
	3.2	There is a risk that we breach our statutory duties to operate within the resource envelope available by not delivering efficiency targets and/or controlling cost.	Cautious	6	20	Jonathan Webb	Finance, Investment and Performance Committee
	3.3	There is a risk that ICB capacity and infrastructure is not sufficient nor targeted effectively towards key priorities.	Open	4	12	Rob Webster	ICB Board
(4) Secure benefits of investing in health and care	4.1	There is a risk that partnership working on wider societal issues is deprioritised in order to meet current operational pressures.	Open	8	12	Ian Holmes	ICB Board
	4.2	There is a risk that we are unable to achieve our ambitions on equality diversity and inclusion due to ingrained attitudes that persist in society and across our health and care organisations.	Bold	8	12	Ian Holmes	Quality Committee
	4.3	There is a risk that threats to our people and physical and digital infrastructure, e.g. from cyber-attacks, terrorism and other major incidents, prevents us from delivering our key functions and responsibilities.	Averse	9	12	Anthony Kealy / James Thomas	Transformation Committee
	4.4	Due to climate change, there is a risk of increased demand for health and care services and disruption to the provision of services. This will result in health and care services that cannot effectively meet population needs.	Open	12	16	Ian Holmes	Transformation Committee

West Yorkshire Integrated Care Board - Board Assurance Framework - Heat map			Version 1.4													
Mission		Strategic risk	WYICB and 5 Places	West Yorkshire		Bradford District and Craven		Calderdale		Kirklees		Leeds		Wakefield		Date: March 2024
			Risk appetite (All)	Target score (WYICB)	Current score (WYICB)	Target score (BD&C)	Current score (BD&C)	Target score (Cald'e)	Current score (Cald'e)	Target score (Kirk's)	Current score (Kirk's)	Target score (Leeds)	Current score (Leeds)	Target score (Wake'd)	Current score (Wake'd)	
Reduce inequalities	1.1	There is a risk that our local priorities to narrow inequalities are not delivered due to the impact of wider economic social and political factors.	Bold	16	20	16	20	16	20	16	20	16	20	16	20	
	1.2	There is a risk that operational pressures and priorities impact on our ability to target resources effectively towards improving outcomes and reducing inequalities for children and adults.	Open	9	12	9	12	9	9	12	16	12	16	9	12	
	1.3	There is a risk that we ration services due to insufficient resources in a way that does not reduce (or exacerbates) heath inequalities.	Open	6	8	8	8	8	12	8	8	8	8	8	8	
	1.4	There is a risk that we fail to join up services in our communities which means that we do not improve outcomes and reduce health inequalities.	Open	8	12	8	12	8	12	8	12	8	12	8	12	
Manage unwarranted variation in care	2.1	There is a risk that our inability to collectively recruit and retain staff across health and care impacts on the quality and safety of services.	Cautious	8	12	6	12	8	12	8	8	9	12	8	12	
	2.2	There is a risk that as a system we fail to innovate, learn lessons and share good practice that allows us to respond to service pressures resulting in widening variations across our footprint.	Open	4	12	4	6	4	6	4	12	4	12	4	12	
	2.3	There is a risk that we are unable to measure and assess performance across the system in a timely and meaningful way, which impacts on our ability to respond quickly as issues arise.	Open	6	6	2	4	6	6	8	8	6	9	3	6	
	2.4	There is a risk that our infrastructure (estates, facilities, digital) hinders our ability to deliver consistently high quality care.	Open	9	16	9	12	9	16	6	9	9	12	9	12	
Use our collective resources wisely	3.1	There is a risk that we invest resources in a way which does not allow us to join up services nor maximise value for money.	Open	4	9	4	9	4	12	8	12	4	9	4	9	
	3.2	There is a risk that we breach our statutory duties to operate within the resource envelope available by not delivering efficiency targets and/or controlling cost.	Cautious	6	20	6	20	6	20	8	20	6	20	6	20	
	3.3	There is a risk that ICB capacity and infrastructure is not sufficient nor targeted effectively towards key priorities.	Open	4	12	4	12	4	16	2	12	4	16	4	12	
Secure benefits of investing in health and care	4.1	There is a risk that partnership working on wider societal issues is deprioritised in order to meet current operational pressures.	Open	8	12	8	12	8	12	8	12	8	12	8	12	
	4.2	There is a risk that we are unable to achieve our ambitions on equality diversity and inclusion due to ingrained attitudes that persist in society and across our health and care organisations.	Bold	8	12	8	12	8	12	8	12	4	9	8	12	
	4.3	There is a risk that threats to our people and physical and digital infrastructure, e.g. from cyber-attacks, terrorism and other major incidents, prevents us from delivering our key functions and responsibilities.	Averse	9	12	Not required	Not required	Not required	Not required	Not required	Not required	Not required	Not required	Not required	Not required	
	4.4	Due to climate change, there is a risk of increased demand for health and care services and disruption to the provision of services. This will result in health and care services that cannot effectively meet population needs	Open	12	16	Not required	Not required	Not required	Not required	Not required	Not required	Not required	Not required	Not required	Not required	

Meeting name:	Leeds Committee of the West Yorkshire Integrated Care Board
Agenda item no.	59/24
Meeting date:	27 November 2024
Report title:	Urgent Decision: Direct award of new contract for Short-term Community Beds in Leeds
Report presented by:	Rebecca Charlwood, Independent Chair
Report approved by:	Tim Ryley, Accountable Officer and Rebecca Charlwood, Independent Chair
Report prepared by:	Harriet Speight, Corporate Governance Manager

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

Previous considerations:

N/A

Executive summary and points for discussion:

Due to timescales, a decision was taken on 7th November 2024 by the Chair and Accountable Officer, in line with the urgent decisions section of the terms of reference, on behalf of the Leeds Committee of the West Yorkshire Integrated Care Board (WY ICB) to approve the Provider Selection Regime (PSR) route for the Short-term Community Beds: Direct Award C.

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

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

☐ Improve healthcare outcomes for residents in their system

☒ Tackle inequalities in access, experience and outcomes

☐ Enhance productivity and value for money

☐ Support broader social and economic development

Recommendation(s)

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

1. **RATIFY** the decision taken on 7 November 2024 to approve the Provider Selection Regime (PSR) route for the Short-term Community Beds: Direct Award C.

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. Direct Award for Procurement of Short-term Community Beds – Report dated 4 November 2024 2. Urgent Decision Notice (Signed) 7 November 2024
Acronyms and Abbreviations explained
N/A

What are the implications for?

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

Leeds Health & Care Partnership

Appendix 1

NHS West Yorkshire Integrated Care Board

Meeting name:	Leeds Committee of the West Yorkshire Integrated Care Board
Agenda item no.	UD1
Meeting date:	4 November 2024
Report title:	Direct Award for Procurement of Short Term Community Beds
Report presented by:	Helen Lewis, Director of Pathway Integration
Report approved by:	Helen Lewis, Director of Pathway Integration
Report prepared by:	Helen Lewis/Helen Smith/Peter Simpson

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

Previous considerations:

Previous approval given on 22 May 2024 for Competitive procurement

Executive summary and points for discussion:

The Committee previously approved a competitive procurement for an integrated model of provision for the short-term community beds required for the system.

Following that process, the outcome of the tender is that none of the bids submitted met the full requirements as set out in the documentation which has resulted in no provider being successful with their respective bids. The current short term bed contracts expire on 31 March 2025, and there is not sufficient time to repeat a competitive procurement. We are therefore proposing to speak to current providers around a Direct Award C approach for 15 months, with the intention of returning to a competitive procurement within 25/26 for a service start in July 2026.

The Standing Financial Instructions require the Leeds Committee to approve the procurement route for any contract that exceeds £5m over the life of the contract. Because one of the potential contracts that is proposed to be renewed, is for two separate bed bases, the cost exceeds £5m over the 15-month period. The paper includes all the current contracts, for completeness, but technically only one is over the threshold for approval.

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

☒ Improve healthcare outcomes for residents in their system

☐ Tackle inequalities in access, experience and outcomes

☒ Enhance productivity and value for money

☐ Support broader social and economic development

Recommendation(s)

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

1. **Approve** the use of a Direct Award C approach for the existing providers of Community Beds with the aim of continued improvement in quality and outcomes in line with our Home First Strategy and the work already delivered.
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. Provider Selection Regime approval flow chart
Acronyms and Abbreviations explained
1.

What are the implications for?

Residents and Communities	
Quality and Safety	Safe and high quality services to be commissioned from providers with appropriate track records
Equality, Diversity and Inclusion	
Finances and Use of Resources	Ensure services are commissioned at appropriate prices and continue to reduce numbers of beds commissioned in line with the continued improvement in Length of stay
Regulation and Legal Requirements	Proposal is in line with the Provider Selection Regime legislation
Conflicts of Interest	LCH and LCC are both providers of services that will be within the scope of the Direct Award C proposal
Data Protection	
Transformation and Innovation	
Environmental and Climate Change	
Future Decisions and Policy Making	Committee is asked to note intention to pursue an integrated model via a competitive procurement again in 25/6
Citizen and Stakeholder Engagement	

1.**Background**

1.1 In May 2024 the Leeds Place Committee signed off a procurement route for a competitive procurement for an integrated provider of short-term community beds for Leeds. The aim was to create a single provider, responsible for an integrated model of care, and for arranging surge capacity to ensure there was appropriate capacity to meet the modelled need for rehabilitation beds.

1.2 The procurement process has now ended, and none of the bids submitted was judged to be successful according to the specification agreed. The Leeds Health and Care Partnership does not currently therefore have any rehabilitation beds commissioned past 31 March 2025. All the contracts were designed to elapse together, and the core contracts have already been extended to their maximum.

2. Requirement

2.1 The LHCP still needs 1750 admissions annually to rehabilitation beds in the community from April 2025 as core capacity, with the ability to flex up seasonally. These beds require medical input which is currently commissioned separately. Based on the HomeFirst target length of stay of 30 days, this would equate to around 145 – 150 beds being needed. Based on a more conservative 33 day length of stay, we would need 158-167. Of the beds currently commissioned (see below) there are currently 170 beds in regular use (Over 50 fewer than this time last year, due to significant improvements in length of stay and use of alternative home-based pathways.)

The current providers and commissioned bed numbers are:

Provider	**Site(s)**	**No. Of Beds**
Leeds Community Healthcare	Wharfedale Recovery Hub	30
Leeds Community Healthcare (with LCC as registered manager)	NW Recovery Hub South Recovery Hub	34 29 plus 10 currently as The Willows specialist dementia beds
Leeds City Council:	East Recovery Hub	36
Loven Green Lane	Green Lane Intermediate Care Centre	34
Tamaris:	Harrogate Lodge	28
TOTAL		**191 (plus 10 The Willows)**

3. Proposal

3.1 5 procurement options have been considered and are assessed briefly as below.

		Benefits	**Risks**
Option 1	Allow all contracts to lapse and move to a spot purchase arrangement as required from	Would reduce overall spend No need to carry out procurement	Not practical to sustain flow, not in line with best practice; would significantly destabilise long term care home market; not practical for GP, Social work or therapy cover, and would be poor value for money.

	pre-existing framework with care homes		Likely poorer outcomes from people within the bed base would lead to high-cost long-term care and an associated financial pressure on LCC.
Option 2	Reissue a competitive procurement on the same basis as previously for the full activity and all staff including doctors	Remains preferred model for integrated service acting as system partner for bedded rehabilitation supporting risk and gain share opportunities	Unlikely to deliver a different outcome in the timescale available and not enough time left for mobilisation or alternatives for 1 April 2025. Also given providers have recently bid for this service it is unlikely a retendering at this stage would yield a different outcome without sufficient time to remodel their proposals.
Option 3	Reissue a competitive procurement in two lots (around 90-100, and the balance)	Moves us towards the preferred model and more aligned to the capacity available to providers in the system following market testing.	May not deliver the required level of integration in a short timescale, delays creation of full integrated model, finance available may not be deemed sufficient by bidders and then no solution for April.
Option 4	Progress Direct Award C negotiations with existing bed providers, and ask each provider to reduce their bed bases in the most cost-effective way for 9 months with flex for winter	Creates a continued offer for April 1st, so not putting capacity and staff at risk over winter period; safe transition and time to continue to work up integrated models and further work with the market	Funding available may not be acceptable to incumbents (though it is significantly above current price) Wouldn't deliver the vision of consistent, integrated care. Leaves medical cover arrangements separate and these also need to be procured Need to negotiate options to reduce core capacity to the numbers needed with an option to flex up for winter.
Option 5	LCC in house offer funded via section 75		This is not possible as the guidance requires PSR to be followed for healthcare services even for services delivered under a s256 or a s75

4. Financial Envelope available and Medical Cover

4.1 The total financial envelope for these services remains as previously signed off (£16.7m per year) but the amount available directly to the bed providers will be lower, given that the original sum included medical cover which will need to be

procured separately. We believe that including the medical cover within the contract offer for a Direct award would represent a material change in the model.

Our initial proposal for securing medical cover will be to offer a Direct Award C with the practices currently covering each of the bed bases and retain the consultant and resident doctor input from Leeds Community Healthcare (Option 4 above). There is a risk that this may not be accepted, given there has been a lot of engagement around the medical model over the past few months to develop a more integrated solution. In that case, we would move to an enhanced offer discussion with the same providers, and only if that fails move to a competitive or urgent award. The values would fall within delegated budgets and sign offs for procurement routes and will not require Committee approval.

5. Recommended approach

The recommended approach given the risks and benefits considered above is that the Leeds Committee authorises the team to approach the current providers of Short-Term Community Beds to negotiate contracts with them under Direct Award C of the Provider Selection Regime (see Appendix A for flow chart). We believe we need to offer this to all current providers, which would give us more capacity than is needed and affordable but believe we can manage this risk through discussions with providers. We believe this will provide the best balance between securing sufficient capacity for April 2025 and still maintaining our ambition for an integrated service model in 26/7.

The proposed contract length is for 15 months (to move us away from a March end date in line with winter pressures that often persist into April and May). We could then extend via the same Direct Award Route thereafter if needed. (This will be within the value for Direct Awards, other than for one provider where we may need to issue a shorter contract initially.)

A further procurement will be undertaken for an integrated service model once there has been further discussion with the market about the appetite and barriers to such a model. The recommendations outlined will provide the required model in the timeframe required as an interim solution.

6. Action required

The Leeds Committee is asked to **approve** the use of a Direct Award C approach for the existing providers of Community Beds with the aim of continued improvement in quality and outcomes in line with our Home First Strategy and the work already delivered.

Technically, under the scheme of delegation the Committee only needs to sign off the award of one of the contracts, as the rest will be under the £5m limit, but we are treating these as a single set of decisions for simplicity. (The LCH Contract for the Recovery Hubs for 15 months is the contract which would exceed £5m and formally require approval.)

This is sought as an Urgent Decision as waiting for 27 November meeting for approval would not give enough time for negotiation of bed numbers and prices and agreement of the appropriate medical cover before 1 April.

The Committee is asked to note that we will also be using a Direct Award C initially for Primary Care cover. If this is not successful we will need to consider a rapid competitive procurement or urgent action.

7. Recommendations

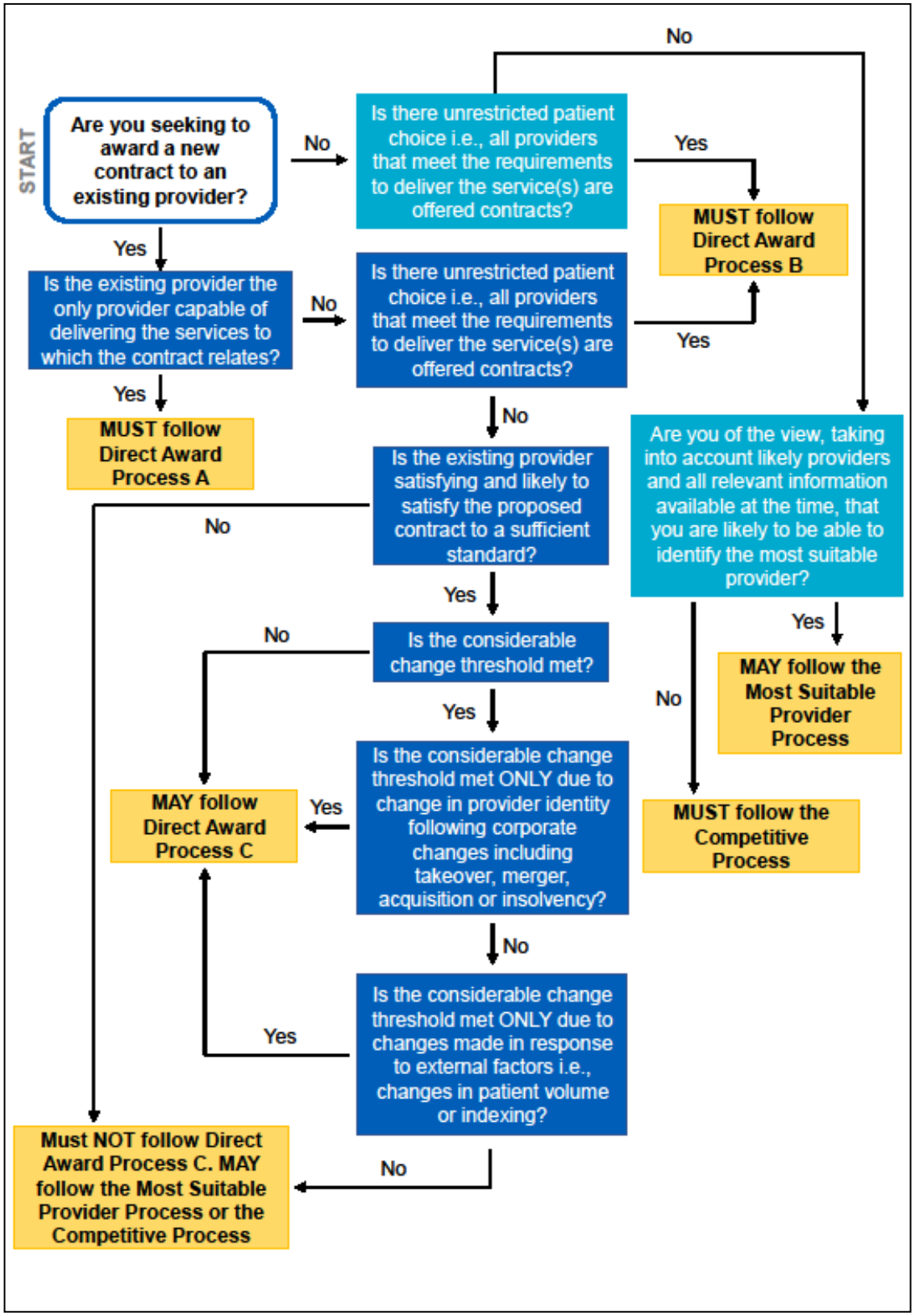
The Leeds Committee of the West Yorkshire Integrated Care Board is asked to:

1. **Approve** the use of a Direct Award C approach to the existing providers of Community Beds with the aim of continued improvement in quality and outcomes in line with our Home First Strategy and the work already delivered.

8. Appendices

1) Procurement flow chart

Appendix A


START
Are you seeking to award a new contract to an existing provider?
No
Is there unrestricted patient choice i.e., all providers that meet the requirements to deliver the service(s) are offered contracts?
Yes
MUST follow Direct Award Process B
No
Yes
Is the existing provider the only provider capable of delivering the services to which the contract relates?
No
Is there unrestricted patient choice i.e., all providers that meet the requirements to deliver the service(s) are offered contracts?
Yes
Yes
MUST follow Direct Award Process A
No
Are you of the view, taking into account likely providers and all relevant information available at the time, that you are likely to be able to identify the most suitable provider?
Is the existing provider satisfying and likely to satisfy the proposed contract to a sufficient standard?
No
Yes
Yes
MAY follow the Most Suitable Provider Process
No
Is the considerable change threshold met?
No
Yes
MUST follow the Competitive Process
MAY follow Direct Award Process C
Yes
Is the considerable change threshold met ONLY due to change in provider identity following corporate changes including takeover, merger, acquisition or insolvency?
No
Yes
Is the considerable change threshold met ONLY due to changes made in response to external factors i.e., changes in patient volume or indexing?
No
Must NOT follow Direct Award Process C. MAY follow the Most Suitable Provider Process or the Competitive Process

Appendix 2

REQUEST FOR URGENT ACTION

Urgent action is required from the Leeds Committee of the West Yorkshire Integrated Care Board (WY ICB) to approve the Provider Selection Regime (PSR) route for the Social Prescribing service:

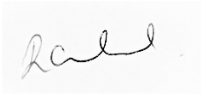
The recommended route for procurement is Provider Selection Regime: Direct Award C.

RESPONSIBLE DIRECTOR: Helen Lewis, Director of Pathway Integration

RESPONSIBLE MANAGER: Jaspreet Bhuhi, Contracts Manager (Community)

APPROVAL BY:

Leeds Committee of the WY ICB Chair

Signature:  Date: 07/11/2024

Name: Rebecca Charlwood

Place Lead and Accountable Officer

Signature:  Date: 07/11/2024

Name: Tim Ryley

To be ratified at the Leeds Committee of the West Yorkshire Integrated Care Board meeting on 27 November 2024.

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	JP/JM
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 Alert, Assure Advise (AAA) Reports	X	X	X	X	Chairs
Risk Management Report and Board Assurance Framework (BAF)	X	X	X	X	TR
Financial Position Update	X	X	X	X	AC
Terms of Reference Review	X				Chair
Sub-Committee Annual Reports	X				Chairs
ITEMS FOR DECISION					
GP Procurement / Merger of Practices	X			X	KT
Financial Plan 2025/26				X	TR/AC
Procurement - Provider Selection Regime Approval	X		X		HL
Assurance and update on our plan for financial sustainability in 24/25		X		X	TR
Joint Working Agreement – MART Phase 2		X			LM
STRATEGY & ASSURANCE					
Marmot City Update		X			VE
Medium Term Plan				X	AC
Director of Public Health Annual Report		X			VE

Additional paper 1

WORKING WITH THE THIRD SECTOR

Annual Position Statement 2024

NHS WEST YORKSHIRE ICB IN LEEDS

A Strong and Purposeful Partnership

Version 1.2

September 2024

Contents

‘Leeds is one of the leading areas in the country when it comes to partnership working with the Voluntary, Community and Social Enterprise sector. In the face of very challenging times across health and care, it is brilliant to see this proactive and positive approach in terms of planning for the future, tackling difficult times together and working collaboratively to make a difference for people and communities. We know that working in this way isn’t the easy route but, in line with our collective West Yorkshire ambitions and principles, it is not only the right thing to do but also more important than ever.’

Kim Shutler MBE, VCSE Sector Lead, West Yorkshire ICB

Foreword

As the collective voice for Leeds third sector in health and care, Forum Central warmly welcomes this annual position statement from the NHS West Yorkshire ICB in Leeds. This statement is the result of our long term working relationship using our Third Sector Leeds Strategy developed by Third Sector Leeds and honed in a collaborative workshop between the ICB and third sector colleagues in July 2024. It forms the basis for a strong partnership in the City, recognising all sectors on an equal footing.

The last few years have been extremely difficult for all of us working in health and care. All sectors, including the Third Sector, are often feeling overwhelmed with demand, and facing an incredibly challenging financial position. We all know that there are some aspects of this which are going to be unavoidable, given funding constraints in the statutory sector. This has been compounded by the uncertainty that short-term contracts and political change can bring, alongside somewhat limited clarity on strategic priorities and opportunities. This is therefore an important document, representing an intention to work differently together as a system; setting out both the ICBs intentions for working with the third sector, and also helping our NHS partners to better understand how we work.

The launch of the statement comes as the new Government and the Darzi report set out the challenge to identify how we best care for the health of people in our communities. The third sector will be the cornerstone of the Government's ask of a neighbourhood health and care system, which is recognised in the four broad features of the ICB approach in Leeds detailed below. The ambitions of the new Government - to move care from the hospital to community; from treatment to prevention and to support people in the move from analogue to digital - will only be possible if we can harness the third sector with our reach into communities alongside other partners. West Yorkshire Health and Care Partnership is the first 'Keep it Local' ICS in the country, and part of this position statement explores how the ICB in Leeds can work with partners to prioritise supporting, partnering with and commissioning local third sector partners.

West Yorkshire is leading the way as one of 7 out of the 42 Integrated Care Boards (ICBs) who have partnerships with the Voluntary, Community and Social Enterprise (VCSE) sector, and our West Yorkshire Memorandum of Understanding (MOU) with us as the VCSE sector is a significant commitment to embed the sector and deliver better health and well-being outcomes.

We are proud of our Leeds Health and Care Partnership Team Leeds approach to and are committed to ensuring that we continually improve how we work together to improve the lives of local people, particularly those living with the highest health inequalities.

Pip Goff	Jo Volpe
Director, Volition/Forum Central	CEO, Leeds Older People's Forum/Forum Central

1. Purpose and Contextual Overview

1.1 Purpose

"Working with the Third Sector" describes how the West Yorkshire ICB team in Leeds will build on and strengthen its relationship with the Third Sector over the next three years. It articulates the principles, priorities, and opportunities at the heart of the approach we are seeking to develop, and which we believe will underpin a strong and purposeful partnership.

It is heavily informed by the **"Healthy Leeds Plan"** and the principles of population health management. However, it has also been written in part as a response to the **"Leeds Third Sector Strategy"**, and to the West Yorkshire **"Keeping it Local"** commitment, and to the 7 principles agreed in May 2024 by the West Yorkshire ICB Board (See Appendix 1). We believe it is also in line with the **"Leeds Compact"** and we will contribute towards its forthcoming refresh.

It does not attempt to describe in detail every aspect or area of development, rather it identifies key areas where we will look to work as partners going forward and sets out the principles that will underpin our approach to the relationship.

It is intended to have a deliberately developmental feel. This is especially important as we have a new government, and over the next few years we are expecting to see a stronger emphasis on preventative and primary care, and on localities and neighbourhoods. The opportunities this presents will become much clearer in the year ahead with the publication of the NHS Ten year strategy due in spring 2025.

The voluntary, community and social enterprise (VCSE) sector in Leeds is a vital source of knowledge and expertise for our health and care system. Organisations within the sector have unique relationships with and understanding of our diverse communities, and innovative approaches to the delivery of care. Leeds has strong examples of where statutory partners have worked well with the sector and developed new ways of working.

As a system we understand that to achieve our shared vision of a healthy and resilient population where we improve the health of the poorest the fastest, we must invest in health-creating and preventative care, tackle health and care inequalities and support our communities to be resilient. We believe when care is delivered in must be through the lens of the 3C's of Communication, Coordination and Compassion. This is what the people and communities of Leeds have told us they want and need. We can only achieve

our shared goals through effective collaboration and power sharing with the VCSE sector, across our system, and the appropriate resourcing of the VCSE sector to deliver its role in our system.

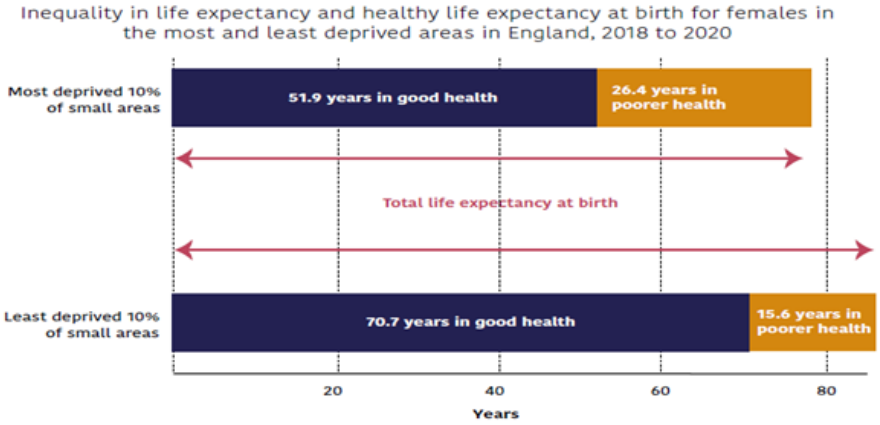
This document describes the contribution the ICB will make to this broader vision in partnership with the VCSE sector. It builds on our strong partnership recognition of the value of our Third Sector as a city asset. It is intended to inform not only the Third Sector, but also other colleagues in the partnership in Leeds as well as ICB colleagues internally to aid the further development and fostering of a strong and purposeful partnership that continues to benefit the people of Leeds across our diverse communities.

1.2 The Challenge Facing Healthcare in the UK

Like every health care system in the developing world the NHS is facing the demands of an ageing population. At the same time a longer life is often a success and something to celebrate. There are many healthy older people living independent lives and contributing in many ways to society and enjoying retirement. However, as we age the demands on health care increase. Alongside this we face growing mental health challenges; and emerging needs such as neurodiversity and increasingly complex needs.

The real challenge to the NHS (and wider society) is the increasing number of people living with poor health for more of their life including long before retirement. The gap between healthy life expectancy and chronological life expectancy is where most demand on NHS services comes from. As the population ages **unless the gap in healthy life expectancy closes** the demand for services will increase and the NHS will become less and less able to meet that demand.

We know poor health is compounded by inequality. The main drivers of poor health are social determinants (E.g. poverty, education and employment opportunities; housing; social networks; and where we live and the extent it facilitates exercise, a good diet and social connection) and those lifestyle factors often limited by social determinants (E.g., smoking, limited exercise). In a city with more than one-quarter of the population living in the most deprived 10% of the national population these issues present us with a stark challenge. The Chief Medical Officer for England and the recent Director of Public Health report for Leeds describe this in more detail. The diagram below sets this out powerfully.



Source: Chief Medical Officer's annual report 2023: health in an ageing society

However, we also know that good access to early identification of risk factors and disease, and appropriate preventative and treatment interventions can make a significant contribution to addressing healthy life expectancy.

At the same time as demands are growing, the national investment in health in the NHS, Public Health, and Local Authorities is not keeping pace. The Health Foundation reports that spend on health care in England is substantially lower than many other developed countries. If we were investing at the levels, we see in places such as Germany and France, we would have around £30bn per annum more. Even without the forecast increases in demand the providers of core NHS services are already under resourced compared to international comparators.

Whilst we are waiting for the cross governmental spending review to report there is no indication that in the lifetime of this parliament that this gap is likely to close substantially. This means that no sector is likely to have the sufficient funds to deliver care to the standards expected **without significant innovation** both in organisations and across our partnership.

1.3 The role of the NHS in Health

The NHS in England is not a single entity. It is made up of a number of statutory bodies, 42 ICB's and range of Acute, Mental Health and Community NHS Trusts. It also funds care through a range of independent providers that include General Practices, other primary care providers, care sector, private healthcare providers, and the Third Sector.

Most experts agree that the NHS contributes only about 15% to healthy life and life expectancy, whilst social determinants of health, lifestyle and primary prevention make a much bigger 85% contribution.

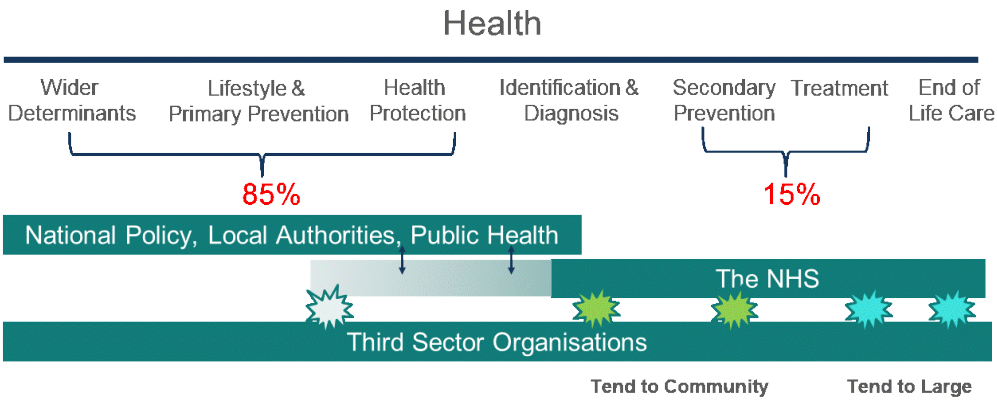
The NHS is funded to provide high quality and safe services and ongoing treatment to people when they are ill, whether that is with an acute or chronic illness. It is also

funded to identify and address risk factors through secondary prevention and ensure early and timely intervention to address poor health. “Stop thinking the NHS has any real influence over the causes of ill-health. The NHS scoops us up, fixes us up and gets us back, up on our feet again... it needs to focus on that” (Roy Lilley). A very significant proportion of NHS funding will inevitably continue to be used to deliver these services.

However, the NHS has duties and a responsibility to support the promotion of good health and support public health in delivering primary prevention and lifestyle advice, and health protection interventions such as vaccines, and also in directing people to support, for example quitting smoking.

Further we have a duty to provide all our services (including early diagnosis and identification risk factors and disease) to everybody equitably. Equity as a principle requires us not just to provide a service but to make a greater effort in ensuring those services are available and appropriately tailored to those who for whatever reason are less able to access them. The diagram below captures the role and responsibilities of the NHS in wider health. It emphasis where the focus of the interplay between the ICB and the sector will be in the years ahead. The blue stars are where much of the investment currently is and the green indicative of where we intend to do more whilst scaling back from areas further to the left outside the remit of the NHS.

The Role of the NHS



Therefore “Working with the Third Sector” is based on the premise that the ICB in its partnership with the sector will be focussed on the following three principal areas:

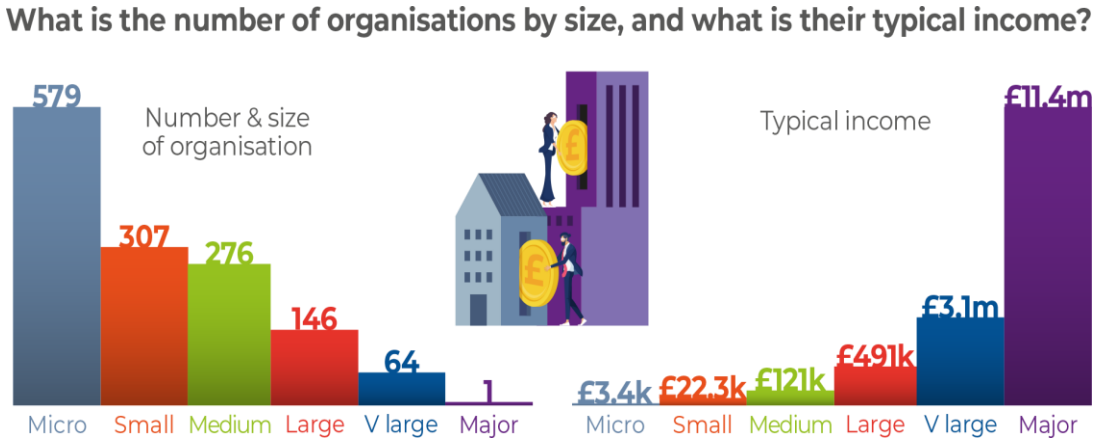
- Continuing to invest in service provision alongside statutory and independent providers with equal standing (See note on Social Value 5.2).
- Greater opportunity for support with the early identification of risk factors and access to appropriate preventative interventions particularly in addressing inequality in culturally appropriate ways.

- Addressing inequalities of access to health services in specific priority communities (of interest and/or geography).

The ICB recognises that the Third Sector plays a much broader role in health and works with multiple other partners especially colleagues in Leeds City Council and directly with communities. The ICB recognises this vital wider role. Whilst we do not have specific responsibilities for investment directly in those broader areas impacting for example social determinants and primary prevention, in our approach we recognise that by bringing greater stability to our own partnership with the sector and supporting social value we can play an important role in the broader viability of the sector and thus the contribution of the sector to essential societal and health benefits.

1.4 The Third Sector in Leeds

The Third Sector in Leeds is large, diverse and vibrant and has a huge amount of impact a wide variety of areas of life and all geographical areas. This variety is in terms of size, reach and purpose. The "**Leeds Third Sector Strategy**" and "**State of the Third Sector in Leeds**" reports describe this in detail. There are over 3200 voluntary, community, faith, and social enterprise i.e. not for profit organisations in Leeds of which 1373 are registered charities, 1288 of which contribute to health in its broadest sense. 168 of which are directly funded for health service delivery. The graph below shows the variation in scale of registered charities, whilst many of the other Third Sector organisations are likely also to be small.



Whilst a significant proportion of Third Sector income is from Statutory bodies (LCC and NHS) the sector also brings in considerable additional resources from other sources including grant making bodies, the national lottery, trading, and charitable donations. The sector brings additional value in kind - e.g. volunteering time; as well as the work small, grassroots organisations deliver which is often under the radar and un-funded -

These smaller organisations make up the majority of the sector (as shown in the graphic). This is an additional asset and contribution to the health of the population in Leeds.

The scale of the Third Sector contribution to the Health and Care System is in the latest Health and Care Academy workforce data, where it has the third largest workforce headcount.

This variation and capacity to boost the benefit of limited statutory resources provides both opportunities and challenges in partnership working. This variety contributes both niche expertise and culturally appropriate delivery and a reach that is often beyond large statutory organisations.

1.5 Limits and Constraints

The principles, approach and commitments set out in this statement **do not override** the ICB's statutory and legal duties including those related to living within our financial allocation, securing good quality and safe care, abiding by procurement law, and the duty to engage patients, people, and communities directly.

As a national body operating under national oversight there may be occasions when we are instructed to act in certain ways that are not fully in line with the desired approach. If such situations arise, we will communicate these as early as possible and work with the third sector to understand the implications whilst recognising the power to mitigate and where appropriate challenge them maybe more limited.

We work closely with Leeds City Council and have a number of jointly funded arrangements. We recognise that Leeds City Council will make decisions in line with their strategies and their constraints and that this may rightly impact on aspects of the commitments set out in this statement.

1.6 Next Steps

Following publication of the statement, each year the ICB will undertake an annual review in September including a summary of progress. We will twice per year hold a broader event with Third Sector leaders to support planning for the year ahead (Winter) and to consider progress against the commitments and priorities and look at further opportunities to strengthen the partnership working with existing structures and infrastructure bodies which will inform an update.

2. The Current and Future Distribution of Funding

2.1 Looking Forward

The ICB in Leeds is not planning to further reduce the overall spend in the Third Sector across the next three years, and **as a minimum** is looking to see growth in the funding of the sector in line with the growth in NHS allocations to Leeds as a whole.

If, as has been indicated in the manifesto pledges and early statements made by the government, there is a shift of funding towards primary and community services, and towards preventative and proactive care, then this minimum commitment may be exceeded in future years. In the next section on priorities where further opportunities for the sector to work in partnership are likely to emerge are described in more detail.

However, it is important to note, as set out in section 1.4, the distribution of this NHS investment in the sector will change over time steered by the priorities of the Leeds Health and Care Partnership. There will be a greater focus on investment in more deprived communities (of geography and interest) and on improving the early identification of disease and uptake of secondary prevention in line with our Leeds Health & Care Partnership priorities. This will mean a shift away from more general primary prevention and undifferentiated city-wide approaches.

2.2 Current Picture – Overview

The ICB in Leeds in the year 2024-25 is anticipating spending directly with the Third Sector just short of £20m (£19.87m). This is about £550,000 less than in the previous year, just under a 3% reduction.

On top of this the ICB also funds a range of Third Sector organisations jointly through Section 256 agreements and joint arrangements with Leeds City Council i.e. pooled budget agreements. There is still work to do to present this picture more completely. Leeds City Council in the year 2023-24 invested c£95m in the Third Sector as a whole. In addition to the ICB other NHS organisations in Leeds, especially LCH and LYPFT also work directly through the third sector on deliver of a range of important programmes. We recognise that this does not therefore describe the total picture with the level of detail that we would hope to do. We are committed to working with partners across the ICB and in Leeds to present a fuller and more detailed picture going forward.

2.3 Current Picture – ICB Direct Detail

The ICB £20m directly awarded is distributed across 42 separate contracts/grant lines ranging from £28,000 to £7.5million per year. However, there are only 23 providers

directly involved. 12 of these contract lines are worth over £400k per year and in total these 12 largest contracts equate to £14m (60%) of the total direct spend. The £20m is currently distributed: £7.6m to End of Life including hospices, £7.6m to adult mental health including dementia, £1.6m to Children and Young People, £1.6m Social Prescribing and £0.9m to older people (excluding dementia), with a further £0.7m on others.

3. The Priorities 2025-2028

The priorities set out below are to act as a guide and are not meant as a definitive nor exhaustive list. Many of these reflect the Leeds Health & Care Partnership priorities as set out in the Healthy Leeds Plan which all partners including the Third Sector contributed to shaping. They describe the areas where the ICB will be looking to work in partnership with the sector and are thus more likely to present opportunities for colleagues when considering their own strategies and plans. They are presented as those which are "city-wide" and those which are "inequality and neighbourhood" focussed.

The new government set out in their manifesto a number of important pledges. Among them are the following: "Labour's reforms will shift our NHS away from a model geared towards late diagnosis and treatment, to a model where more services are delivered in local communities." "The National Health Service needs to move to a Neighbourhood Health Service, with more care delivered in local communities to spot problems earlier. To achieve this, we must over time shift resources to primary care and community services". The review undertaken by Lord Darzi has emphasised these.

This position statement is intended to signal a significant and deliberate shift of balance away from generic services towards culturally appropriate, neighbourhood level preventative investment and activity. It will also require a deliberate application of proportional universalism if we are to address inequality. This will not happen overnight and will depend not only on NHS policy, both locally and national, but all partners including the Third Sector getting behind this. So, we deliberately focus on Inequality and Neighbourhood first in the section below.

3.1 Inequality and Neighbourhood

The ICB has worked with Leeds Health & Care Partnership to identify a number of priority programmes. These programmes have been developed to improve the lives of

the most deprived in Leeds and in doing so reduce the length of their lives spent in unhealthy life expectancy.

As well as improving the lives of individuals this will also impact on the sustainability of the NHS and Social Care, reducing unplanned care across the NHS and improving independence and thereby reducing demand for social care services. It is good for people and vital for public sector sustainability.

Whilst from an NHS perspective these are in areas that drive costly unplanned care; the actual drivers are found in inequality, inequity of access to care, late identification of risk, late diagnosis and limited preventative care and secondary prevention. Unplanned care is the consequence of poor health outcomes for individuals. The intention of these programme areas therefore is to focus on those communities and among the 26% of people in Leeds living in indices of multiple deprivation (IMD) 1.

When considering the reduction in unplanned care the NHS has traditionally focussed on diversionary schemes in community settings. This has ignored the real drivers hidden in poor health and inequality. The ambition behind the approach this time is to shift the focus to preventative and proactive care based around population health management and value-based healthcare principles and address health risk through socio-medical solutions.

There will be 3 broad features of the ICB approach in this area:

a) Work with a wide range of partners to identify the potential drivers in any given community of the underlying causes of issues identified as priorities, both medical and social.

b) Working with the wider NHS, primary care, Public Health, third sector and communities and predictive analytics to develop culturally appropriate solutions and approaches to address variation in outcome

c) Develop programmes led by people with lived experience recruited to support individuals (and if appropriate families/carers) address issues at community level.

d) Funding approaches that encourage collaboration at locality level (or in some cases among communities of interest) to deliver specified improvement outcomes for their population with an embedded fail-fast and learn mindset.

This will become a significant and core part of the ICB's business usual approach.

The priority areas agreed to by the Leeds Health and Care Partnership are described in more detail in the "Healthy Leeds Plan". Importantly the focus is on inequality, and

therefore the focus of each is in the 4 local care partnership (LCP areas) seen as the most deprived. In summary those most related to inequality and neighbourhoods are set out below:

- People at end of life with respiratory Illness.
- Children and young people with respiratory Illness.
- People with three or more long-term conditions plus a serious mental illness (SMI)
- People living with frailty at risk of injuries and fractures.
- Early identification and reduction of hypertension

There is work being undertaken both at a West Yorkshire ICB level and in Leeds to reimagine how neighbourhoods might work in a more integrated way. We will be looking to ensure the Third sector are part of these conversations and how the approach and priorities described above are built into these new models as they emerge over the next few years.

3.2 City Wide Priorities

a) We will continue the investment into the development of a city-wide integrated community mental health service with third sector organisations as an essential component of that in line with the ring fencing of funds. This is an important scheme within the Healthy Leeds Plan. There is a strong inequality dimension to this, and investment will need to reflect this. The national ambition was that 33% of transformation funding went to the Third Sector, which Leeds has achieved. Mental Health is a major factor in health inequality and early mortality, and the sector in Leeds is a valued partner in delivering services and developing culturally appropriate approaches. This is one of the LHCP top priority programmes and will contain a strong focus on early identification and prevention.

b) As well as adult community mental health, and partly in response, we will be looking to review our crisis and talking therapy services across the city. Equity of access will be an important theme of any such review and the sector is well placed to ensure that the approach helps address inequality.

c) Children's mental health, learning disability and neurodiversity are also areas that will need significant attention over the next few years. The existing models of prevention, diagnosis and care are struggling to address demand and be cost efficient as well as adding social value and may require a significant rethink.

d) The ICB in Leeds spends over one hundred million pounds per annum on individual complex packages of care. This is a major factor when considering inequality. Often this is alongside significant spend by colleagues in the local authority. This includes adults and children. It covers people with significant challenges of mental illness, neurodiversity and learning disabilities, children in care and adults living with complex health needs; and it covers those living at home and in residential/nursing settings.

The vast majority of this is provided by independent private providers and sometimes this is provided out of the Leeds area. It has seen significant growth in costs as well as numbers. The ICB is working with the city council to consider new approaches in a number of areas and would welcome an opportunity to work with third sector colleagues in developing alternative models.

e) The need to proactively support vulnerable people at home either to avoid an admission or post admission set out in the LHCP priority programme HomeFirst will continue to be a priority over the next few years, as set out in the Healthy Leeds plan, including building on the successes and learning from the Enhance programme. At the moment quite a lot of the support has been relatively general, and we will be looking to focus this more on specific cohorts and activities.

f) The ICB in Leeds invests £7m into hospices. A joint piece of work between the ICB and the Hospice Collaborative has been undertaken across West Yorkshire to look at hospice funding. This identified and agreed a funding contribution which more accurately reflected the direct contribution to NHS care. All parts of West Yorkshire were below this level and committed to moving towards this over the next few years. Leeds was already closest to the goal and is committed to move in line with West Yorkshire's aim over the next three years (2025-2028).

3.3 Wider Determinants Data

To benefit fully from taking a socio-medical approach to transformation we saw demonstrated by Staten Island the power of bringing together medical data with data on social determinants. We are developing some of this capability through the Leeds Office of Data Analytics and would want to explore how through the development of some common data platforms we might build on this and potentially pay for elements of data collection of this kind.

4. The Third Sector as a Member of the Leeds Health and Care Partnership

A significant proportion of the NHS budget for the city flows through the ICB in Leeds, c£1.5bn per year. We therefore have responsibilities to co-ordinate the city in planning the provision of good quality services and health care for the population, and to do this in a way that addresses inequality, strengthens integration of care and is sustainable and cost effective in both the short and long-term. In fulfilling this role, we have a responsibility for ensuring effective partnership governance is in place across the city.

The ICB remains committed to ensuring the Third Sector remains an important member of this broader partnership. Currently at least one representative of the Third Sector sits on all the key decision-building and strategic decision-taking bodies across the Health System including among others the Leeds Committee of the ICB and its sub-committees, the Health & Wellbeing Board, the Partnership Leadership Team (Formally PEG), Various Population and Care Delivery Boards and a wide range of enabler and advisory groups. There is currently work underway to further deepen and simplify the LHCP arrangements and the sector through Forum Central is an important voice in shaping this.

This involvement has been essential in developing for example the "**Health & Wellbeing Strategy**" and agreeing the health priorities set out in the "**Healthy Leeds Plan**". These joint priorities are those areas where the Leeds Health & Care Partnership and, within that broader partnership, the relationship between the Third Sector and ICB will focus.

Given the enormous variety and scale of the Third Sector in Leeds ensuring effective representation and engagement of the sector in the Leeds Health & Care Partnership requires considerable co-ordination. Leeds City Council and the ICB have jointly funded Forum Central to undertake this role (among other functions) on our and the sectors behalf. The ICB remains committed to funding the infrastructure necessary to enable active and effective participation of the Third Sector in the wider partnership.

Given the financial challenges and scarce resources of all the partners in this arrangement it will be important that we keep these arrangements under review so that the Leeds Health & Care Partnership remains a truly effective partnership of all. The ICB will look to work with Leeds City Council, Forum Central and the Third Sector as a whole to review the existing arrangements. It will be important for the sector as a whole to

consider how the excellent leadership more generally across the Third Sector plays an active role in the broader partnership prioritisation and decision building and taking.

5. Procurement and Contractual Approach

5.1 Partnership

The previous sections have sought to articulate the overarching principles and ambition alongside the strategic priorities at the heart of the partnership we are looking to build. However, it is important given the particular role of the ICB in acting as a funder that we also set out our intentions for how the practical mechanics of contract and grants will be made. These are important factors in the sustainability of organisations and in helping them in planning.

The ICB will continue to play its role in co-ordinating the system, ensuring value for public money and in the distribution of resources through contracts and grants. However, the way this works is evolving and through the auspices of the Leeds Health & Care partnership it will be important that all providers including those in the Third Sector work as partners with a degree of flexibility and openness to adjust within agreements which in turn then enables longer and more flexible contracting arrangements.

5.2 The Provider Section Regime

Use of provider selection regime: The "Provider Selection Regime" (PSR) came into force at the start of 2024. It has been designed to introduce a flexible and proportionate process for selecting who should be providing health care services and a framework that allows collaboration to flourish whilst not losing sight of the people we serve or the taxpayer.

As well the existing competitive process there are two further options: direct award (three sub processes) and most suitable provider. The table describes the range of options and highlights those in yellow which we are most likely to use when working with the sector.

Direct Award Processes (for existing services)			The Most Suitable Provider Process	The Competitive Process
A	B	C		
No realistic alternative to the existing provider.	People have a choice of providers, and the number of providers is not restricted by the relevant authority.	The existing provider is satisfying the existing contract and will likely satisfy the proposed new contract, and the contract is not changing considerably.	Allows the relevant authority to make a judgement on which provider is most suitable based on consideration of the key criteria. Award without competitive tender.	Where the relevant authority cannot use any of the other processes or wishes to run a competitive exercise.

Whilst the new regulations undoubtedly present opportunities they do also come with risks and specific legal requirements (See Appendix 2 for more detail). The ICB will use this new regulatory regime to maximise the benefits and minimise those risks. An important example is that whilst longer contracts are understandably favoured by providers the length of contracts offered are legally curtailed under Direct Award Option C if they breach the lifetime value thresholds set by the regulations.

Most Suitable Provider processes offer us greater opportunity to award longer term contracts that offer stability to the sector however the ICB would have to prove that no other provider could and if challenged there is a risk that a competitive process would then be needed.

Social Value: Procurement regulations require us to consider social value as part of all tender processes with a minimum weighting of 10% for competitive procurements. The new government has indicated that they will be putting a greater emphasis on this and ensuring decisions do not increase inequality. We welcome this as an opportunity to support our commitment to "Keeping It Local" and addressing inequality.

We will work with other partners and the sector to develop a "Social Value" statement within all procurements that reinforces these commitments and an approach to scoring bids that ensures that this is a strong feature in decision making. We would expect these to be developed and a feature of our approach ahead of 2025-26.

5.3 Joint Commissioning and Commissioning Consortia Approaches

We recognise that third sector organisations at times face the added challenge of providing a range of services or outcomes to multiple commissioners. This creates considerable bureaucracy often with varying expectations.

We have been working with Leeds City Council Adults and Health directorate through the auspices of the Better Care Fund (BCF) and Section 256 agreements. We are committed to developing this further with Leeds City Council as a whole and with local NHS partners, where possible, to agree single contracts operating under similar contractual arrangements. This will not happen overnight but across the three years of this strategy we hope to make significant progress in streamlining this further.

We intend to reduce the total number of contracts and grants (not the value) and will work with the sector to do this over the next few years. We have seen the benefit of working with community anchors and existing infrastructure organisations in work that has been done in the city through "Community Mental Health Transformation", and "Enhance" in bringing smaller and more community-based organisations into the system without them having to create all the necessary infrastructure. We intend this to be a growing feature of our approach.

5.4 Procurement and Contractual Principles

Length of Contracts / Grant allocations: The ICB in Leeds will move away from one-year contracts and grants at next renewal towards three and five-year awards as the norm. Where there is a strong rationale for varying from this (longer or shorter) this will be set out clearly. Contracts and grants will become more focussed on outputs and outcomes than inputs and look to allow for mutually agreed variation within the contractual period.

Uplifts and Efficiency: The NHS sets out nationally proposed uplifts for NHS providers and Primary Care. It then offsets this **uplift** with an **efficiency** requirement. So, for example, it may say that there is a 2% contract uplift value to cover wages and inflation and then offset this with a 1.6% efficiency ask leaving a 0.4% actual increase. These uplifts published and prescribed as part of the annual planning round are not uniform and do not usually include non-NHS providers. The ICB Team in Leeds will apply the net average of all prescribed uplifts and efficiency asks to Third Sector grants and contracts annually.

Notice Periods. The ICB will normally give a minimum of six-month's notice for the termination of a contract or grant, or material change in contract value and/or service specification. The caveats to this will be:

- A mutual agreement between the ICB and an organisation to end a contract or make changes within it, in a shorter time period. We would expect as the partnership further matures this would become a more common feature.
- A breach of contract by a provider that could lead to harm or non-delivery of a service.
- Where the ICB in Leeds is instructed to by NHS England or West Yorkshire ICB.

Outcome Based and Data Requirements. The ICB is keen to rationalise contractual data requirements to be more proportionate to the scale of the contracts. The focus will shift over time as contracts are renewed and other arrangements described here are put in place. There will also be a stronger emphasis on outcomes and outputs that are the remit of the agreement, and much less on inputs and process measures as part of the commitment to support innovation and shift power towards community-based solutions.

Non-Recurrent Funding. The NHS frequently identifies short-term non-recurrent funding. This has caused considerable difficulties for the ICB and Third Sector Partners in the past; the ICB often not being in a position to make funding recurrent and therefore disappoint partners, and for the third sector developing capacity and capability rapidly with no guarantee of income in the medium-term. However, given stretched resources it would feel unhelpful to not consider how these might be used. The ICB approach going forward will be to:

- Campaign to reduce short-term funding of this kind.
- When it is made available to us, we will only seek to apply for it for one of three uses:
- To fund limited non-recurrent one-off activity such as a training course or pieces of digital infrastructure.
- To fund surge activity in a given year, perhaps to support winter or reduce a backlog.
- To bring forward an already existing planned investment in a priority area.
- Outside of this act as a pass-through organisation where partners wish to apply outside of these priorities. This will be subject to a formal written commitment that the provider(s) concerned will not ask for recurrent support.

As such we will always look for this to be in the form of a variation to an existing contract or grant, and we will rarely use new contracts or grants as the basis for distributing short-term resources.

6. Opportunities for a Broader Contribution

6.1 The ICB in Leeds as an Anchor Organisation

The ICB Team in Leeds is not an 'Anchor Organisation' in the traditional sense given it is a relatively small team employing only about 250 people and forming part of a wider West Yorkshire organisation of about 1,100 people. It owns no estate. However, unlike many other small organisations it has responsibility for an extremely large budget of about £1.6bn per annum. There are therefore ways in which it can play an important role in terms of contributing more broadly to wider societal value.

6.2 Strategic Influence

Leeds is already influential regionally and nationally. We expect this to continue. We will look to build on this and work with the sector along with other partners in the city recognising that our ability to influence will be different and that all partners will have different opportunities and levers. We will continue to use the existing collective partnership meetings to discuss these issues and work to strengthen how we utilise the various opportunities that different sectors have.

6.3 Additional Features of Its Approach

The ICB through the Integrated Digital Service (IDS) and the Office of Data Analytics (ODA) jointly invest with Leeds City Council to support integrated digital and data solutions. We have already articulated how we are looking to streamline contractual data collection and to explore opportunities to collect data related to social determinants of health. There is already some work underway to connect some larger organisations to the Leeds Care Record and we also jointly fund a team working on digital inclusion who work closely with a number of community organisations. We remain committed to these pieces of work and looking to see how we can build on this going forward.

Specifically, the ICB in Leeds will work with Third Sector organisations to ensure that:

- There is a clear understanding of the approach and associated operational models employed by the ICB in Leeds to deliver any given initiative. This might include sharing of appropriate electronic resources, access to documentation, identification of requirements to access specific technical platforms or systems, processes for sharing data, and/ or steps required to (access and) provide consistent and timely insights regarding progress.

- The people employed by the Third Sector (either paid or voluntary) can make a valuable contribution by accessing learning resources that are required to deliver any given initiative. This might include identification of, and access to, materials and/ or digital training necessary to deliver activity as required. Plus, this will include clear signposting of how to access support if needed.
- Third Sector organisations have access to the systems specific to the activity being delivered. This might include support in accessing the Leeds Care Record (or equivalent), appropriate care plans, appointments or rostering solutions and tracking applications.
- Third Sector organisations have access to insights required to help shape any given initiative, or to track progress against targets, or to predict the impact of change. This might include shared access to any analytical reports and dashboards developed by the Office of Data Analytics, or it might include access to recording systems to allow organisations to share progress towards specific objectives.

The ICB will continue with other statutory partners fund both the Leeds Health & Care Workforce Academy and the Leeds Academic Health Partnership (LAHP). The Workforce Academy already has strong Third Sector engagement and is creating a range of opportunities to involve the sector. We envision this continuing to evolve. The Third Sector has a whole may want to explore whether there are benefits the academy could play and how they might collectively contribute. The LAHP has a strong focus on inequality, and we would look to see how as a partnership further opportunity for research might be developed.

The ICB team in Leeds has reduced the number of fixed meeting rooms that it directly leases. It therefore requires the regular use of larger meeting spaces both for its own internal operations and also in order to effectively play its role as an integrator in the city bringing partners together. As a principle of "how we operate" where there are not rooms of sufficient size available in our two bases, we will always look first to secure meeting rooms in Third Sector venues across the city. On an annual basis we anticipate this will be worth c£10-20,000.

6.4 Further Areas to Explore

We will work to encourage the wider ICB to take a similar approach to selection of venues for Board meetings and other work and to adopt the Leeds principles.

We are aware that some Third Sector organisations find it difficult to attract Trustees to their organisations with the appropriate skill set and that being a trustee is a great

leadership development opportunity for those individuals, gaining governance, finance, people management and service delivery opportunities as well as broadening system knowledge and empathy. We will promote any opportunities and encourage all colleagues in the ICB Team in Leeds to consider putting themselves forward (alongside a number that already do). To further encourage this, we will work with wider ICB colleagues to explore whether we could look to include this, say ½ day per month pro-rata, within their work time.

We are also interested in exploring potential developmental opportunities for our colleagues and colleagues in the third sector in exploring staffing exchanges / secondments to strengthen relationships and understanding between the statutory and third sector.

7. Summary of Commitments and Opportunities

7.1 Commitments

This document sets out 12 commitments that the ICB in Leeds is making in developing the partnership ***subject to the caveats at section 1.5.***

1: We will include a review with the sector of progress against the commitments and approach and update the statement annually to provide a clearer and wider breakdown of existing spending in future iterations and reflect latest priorities.

2: The Third Sector will continue to be a valued member of the Leeds Health & Care Partnership and we will review with the sector and other partners the infrastructure arrangements to ensure it can continue to contribute effectively.

3: The level of funding to the Third Sector via the ICB in Leeds will at least keep pace with the growth in the NHS allocation from 2025.

4: Within the overall allocation to the third sector there will be a stronger emphasis on addressing inequality and preventative and proactive care.

5: There will be a common statement and strong emphasis on wider social value as part of all procurements to strengthen our commitment to the principles set out in “Keeping it Local.”

6: The norm for contract lengths and grants will be between three and five years, with written justifications for lower or higher contract lengths. Direct award processes will be one example of a legally constraining limit.

7: We will give six months' notice if terminating any contract or ending any grant, subject to the caveats at Section 5.3.

8: There will be a reduction in the overall number of contracts and grants with a move away from short-term non-recurrent funding and greater use of community anchors/alliance and partnership models of delivery.

9. There will be an increasing focus on supporting community partners including the third sector at locality level to develop solutions and deliver outcomes including streamlining and resourcing data collection.

10. We will continue to work with Leeds City Council, other NHS partners in Leeds and across the ICB to look where possible to streamline processes and increase the level of consistency of approach whilst recognising principles of organisational sovereignty and subsidiarity.

11. We will develop with the Third sector our approach to digital integration to include the Sector as appropriate.

12. We will continue to use our position in the city and wider ICB to look at additional ways in which we can advocate with the sector and use our anchor role to consider social value in a broader context.

7.2 Partnership

If we are to mature the partnership to be the strong and purposeful one which we are all seeking, then alongside these commitments from the ICB we will be looking for a partnership response from Third Sector colleagues. We recognise that given the very different scale of organisations that the approach and responses will need to vary.

We would therefore welcome partners to be actively involved in both shaping and informing the specific health improvement priorities as set out by the Leeds Health & Care Partnership, and then as partners it will be important that we all recognise that NHS spending in the city and work will be strongly shaped by those commonly agreed and jointly owned priorities. It will be important that the sector contributes to the review of how infrastructure organisations work going forward to strengthen their contribution to this process.

We will be looking for some parts of the sector to further look at how they bring their resources, leadership, and access to different funding models to the table in supporting implementation of shared priorities.

The strong and purposeful partnership we envisage is not just a description of the relationship between the ICB and the Third Sector, but we hope will foster a further strengthening of partnerships within the sector itself and this will be something we will be actively looking for in the way schemes are designed.

In the undoubted challenges we will face going forward it is important that in a mature partnership, the roles, limits and constraints under which different partners operate under are mutually acknowledged and respected.

Fundamentally we need to move out of the language of commissioner and provider to one of partnership. This will require ongoing work and changes in culture and relationships from all of us, beyond words in documents. The ICB team in Leeds is committed to this within the constraints described elsewhere.

Appendices

A. West Yorkshire Commissioning Principles

The ICB Board led by work done by the Third sector across west Yorkshire agreed to adopt seven principles in the way that the ICB works with the Third sector. These 7 principles agreed in May 2024 are set out below alongside a summary of how the statement takes these forward in Leeds.

West Yorkshire Principles		**Summary of Response**
1	Develop a Place level picture of health & care VCSE sector investment	Section 3 describes this at a basic ICB level, but there is a recognition that there is further work to do to describe the totality of investment across the NHS and Leeds City council as a whole (See commitment 1).
2	Develop and agree principles for a risk-based approach that moves away from short-term contracts to longer term sustainable investment to enable innovation and transformation and prioritises social value.	Section 3 references a commitment to total funding and section 5 describes a commitment to a longer norm for contracts and grant awards of three to five years. There will be a social value statement and strong emphasis on social value in procurements.
3	Develop an action plan to mitigate against the risk to diverse grass roots VCSE organisations which may be disproportionately affected by financial pressures but are carrying out essential health inequalities and health creation work including reviewing local mechanisms to ensure funding is reaching these areas.	The paper as a whole articulates a number of features that are designed to do this including a greater emphasis on collaborative commissioning, length of contracts and grants, commitment to social value and the prioritising of neighbourhood and locality level solutions to priority areas.

4	Develop and agree principles for strategy to shift investment closer to communities including to communities themselves to support early help and prevention.	The priorities and approach to inequalities and communities set out in this paper in Section 4.2 as well as the commitment to look at use of community anchors etc. will underpin our approach to a move toward community and secondary prevention.
5	Provide greater flexibility in use of funding already allocated to VCSE organisations and consider grant/contract renegotiation in the light of a lack of uplifts	See Section 5.3
6	Minimise re-tendering processes where possible – saving staff time to focus on delivery; and	Both the move to fewer more consolidated contracts and longer contract lengths should support this as set out in Section 5.
7	Plan and communicate regarding re-commissioning services and explore contract extension.	Section 4 sets out the priorities alongside a commitment to an annual refresh and update should strengthen this. Section 6 describing longer contract lengths with more built-in flexibilities will also support more certainty and continuity.

Appendix B: Provider Selection Regime

The Provider Selection Regime (PSR) came into force on 1 January 2024 and replaces the:

- Public Contract Regulations (PCR) 2015, when procuring healthcare services
- National Health Service (Procurement, Patient Choice and Competition) Regulations 2013

The PSR has been designed to:

- introduce a flexible and proportionate process for deciding who should provide health care services
- provide a framework that allows collaboration to flourish across systems
- ensure that all decisions are made in the best interest of patients and service users.

The PSR has introduced three provider selection processes that relevant authorities can follow to award contracts for health care services. These are the:

- Direct award processes (A, B, and C).
- Most suitable provider process.
- Competitive process

Decision-Making Circumstances (Healthcare Services Only)

Direct Award Processes (for existing services)			The Most Suitable Provider Process	The Competitive Process
A	B	C		
No realistic alternative to the existing provider.	People have a choice of providers, and the number of providers is not restricted by the relevant authority.	The existing provider is satisfying the existing contract and will likely satisfy the proposed new contract, and the contract is not changing considerably.	Allows the relevant authority to make a judgement on which provider is most suitable based on consideration of the key criteria. Award without competitive tender.	Where the relevant authority cannot use any of the other processes or wishes to run a competitive exercise.

When assessing providers under the Provider Selection Regime; direct award process C, the most suitable provider process, or the competitive process there are five criteria that must be considered;

- Quality and innovation
- Value
- Integration, collaboration and service sustainability
- Improving access, reducing health inequalities, and facilitating choice
- Social value

In addition, the following basic selection criteria are to be taken into consideration;

- The provider's ability to pursue a particular activity i.e. a provider's ability to pursue a particular activity, e.g., a requirement to hold a specific authorisation or membership or a professional organisation
- Economic and financial standing i.e. necessary economic and financial standing, e.g. a minimum annual turnover, holder indemnity insurance
- Technical and professional ability i.e. necessary technical and professional ability, e.g. a certain level of experience, not having conflicting interests