Leeds Health & Care Partnership

NHS West Yorkshire Integrated Care Board

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

Wednesday 26th February 2025, 13:15 – 16:00
(Private pre-meet for members 13:00, public meeting 13:15)
St George's Centre, 60 Great George Street, Leeds, LS1 3DL

AGENDA

No.	Item	Lead	Page	BAF Link	Time
LC 65/24	**Welcome, Introductions**	**Rebecca Charlwood** Independent Chair	-	N/A	13:15
LC 66/24	**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	-	N/A	-
LC 67/24	**Minutes of the Previous Meeting** - To approve the minutes of the meeting held 27th November 2024	**Rebecca Charlwood** Independent Chair	4	N/A	-
LC 68/24	**Matters Arising** - To consider any outstanding matter arising from the minutes that is not covered elsewhere on the agenda	**Rebecca Charlwood** Independent Chair	-	N/A	-
LC 69/24	**Action Tracker** - To note any outstanding actions	**Rebecca Charlwood** Independent Chair	12	N/A	-
LC 70/24	**People's Voice** - To received a lived experience of health care services in Leeds	**Healthwatch Leeds Co-Chair**	-	1.1 & 1.3	13:20
LC 71/24	**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	-	N/A	13:30
LC 72/24	**Place Lead Update** - To receive a report from the Place Lead	**Tim Ryley** Place Lead	14	1.1, 1.3, 2.4, 4.1 & 4.2	13:40
ROUTINE REPORTS					

No.	Item	Lead	Page	BAF Link	Time
LC 73/24	**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	60	2.2 & 4.2	13:55
LC 74/24	**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	63	1.1, 2.1 & 2.3	14:00
LC 75/24	**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	65	1.2, 3.1 & 3.2	14:05
BREAK 14:10 -14:20					
FINANCE					
LC 76/24	**Financial Update at Month 9** - To receive an update on the financial position	**Alex Crickmar** Director of Operational Finance	68	3.2	14:20
LC 77/24	**Operational and Financial Planning 2025/26** **a) NHS Planning Guidance Update** - To receive an update on the NHS Planning Guidance **b) Financial Planning Process** - To receive a presentation on the process for financial planning throughout 2025/26 **c) Draft Medium Term Plan** - To receive an update on the draft plans	**Tim Ryley** Place Lead **Alex Crickmar** Director of Operational Finance	80 88	1.2, 3.1, 3.2 & 4.1	14:30
GOVERNANCE / RISK MANAGEMENT					
LC 78/24	**High Level Risk Report: Cycle 4 2024/25 (December 2024 – March 2025)** - To receive and consider the risk management information provided	**Tim Ryley** Place Lead Supported by: **Asma Sacha** Risk Manager	106	All	15:30
LC 79/24	**Proposed Changes to the Leeds Place Sub-Committee Structure from 1st April 2025** - To consider the proposed changes	**Tim Ryley** Place Lead	152	N/A	15:40
FORWARD PLANNING					
LC 80/24	**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	-	N/A	15:55
LC 81/24	**Any Other Business** - To discuss any other business	**Rebecca Charlwood** Independent Chair	-	N/A	16:00

No.	Item	Lead	Page	BAF Link	Time
LC 82/24	**Date and Time of Next Meeting** The next meeting of the Leeds Committee of the WY ICB will be held on 21st May 2025 13:15 – 16:30 (private pre-meet for members 13:00, public meeting 13:15)	**Rebecca Charlwood** Independent Chair	-	N/A	-

Draft Minutes

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

Wednesday 27 November 2024, 1.15pm – 4.30pm

Headingley Enterprise & Arts Centre (HEART), Bennett Rd, Headingley, Leeds LS6 3HN.

Members	Initials	Role
Kashif Ahmed (deputising for CB)	KA	Deputy Director, Integrated Commissioning, Leeds City Council
Dr Ruth Burnett (deputising for SD)	RB	Executive Medical Director, Leeds Community Healthcare NHS Trust
Rebecca Charlwood	RC	Independent Chair, Leeds Committee of the WY ICB
Alex Crickmar	AC	Director of Operational Finance, ICB in Leeds
Victoria Eaton	VE	Director of Public Health, Leeds City Council
Pip Goff	PG	Volition Director, Forum Central
Yasmin Khan	YK	Independent Member – Health Inequalities
Penny McSorley (deputising for JH)	PM	Deputy Director of Nursing, ICB in Leeds
Jonathan Phillips	JP	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, Leeds Teaching Hospitals NHS Trust
In attendance		
Sue Baxter	SB	Head of Partnership Governance, WYICB
Eddie Devine (Item 57 only)	ED	Head of Pathway Integration. ICB in Leeds
Nick Earl (Item 51 only)	NE	Interim Director of Strategy, Planning and Programmes, ICB in Leeds
Harriet Speight	HS	Corporate Governance Manager, WYICB
Apologies		
Caroline Baria	CB	Director of Adults and Health, Leeds City Council
Selina Douglas	SD	Chief Executive, Leeds Community Healthcare NHS Trust
Dr Sarah Forbes	SF	Medical Director, ICB in Leeds
Jo Harding	JH	Director of Nursing and Quality, ICB in Leeds
Cheryl Hobson	CH	Independent Member – Finance and Governance
Julie Longworth	JL	Director of Children and Families, Leeds City Council
Dr Sara Munro	SM	Chief Executive, Leeds and York Partnership Foundation Trust

44 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.

Apologies were noted as above. It was confirmed that the meeting was quorate.

45 APOLOGIES AND DECLARATIONS OF INTEREST

The Chair asked members to declare any interests that might conflict with the business on the meeting agenda. The following interests were declared:

- Item 57 - Consolidating VCSE Mental Health Contracts – PG declared an interest as the representative for the third sector and confirmed that she would leave the room for consideration of the item.
- Item 59 - Urgent Decision: Direct award of new contract for Short-term Community Beds in Leeds – RB, KA, GW and VE declared interests as providers of services considered and confirmed that they would leave the room for consideration of the item.

45 MINUTES OF THE PREVIOUS MEETING

The public minutes of the meeting held 11th September 2024 were approved as an accurate record.

The Leeds Committee of the WY ICB:

- Approved the minutes of the previous meeting held on 11 September 2024.

47 MATTERS ARISING

No matters were raised.

48 ACTION TRACKER

All actions had been completed.

49 PEOPLE'S VOICE

JP introduced the report by Healthwatch Leeds titled 'Communicating Changes - September 2024 Briefing Paper', setting out three significant service changes in Leeds and how they had been communicated to service users. The three service changes related to children's orthodontics providers, audiology providers and the removal of public access to the adult mental health crisis Single Point of Access (SPA) phoneline. JP informed members that in all three cases, Healthwatch had been made aware of the changes after being contacted by members of the public who had reported confusion and worry about the changes. JP advised that mitigating actions had been put in place since, however the

learning gathered informed the development of the recommendations for partners included in the report. JP reflected on items elsewhere on the agenda, including the Place Lead Update reference to the NHS 10 Year Plan consultation, and the opportunity to apply the recommendations to ensure meaningful engagement and communication with members of the public.

Members welcomed the report and recommendations, noting the importance of tangible examples to learn from and recognising that consistency of approach would be key moving forward. It was highlighted that there are defined parameters set by NHS England that limit the ICB's control over communications. It was also noted that some issues experienced had been as a result of private providers breaching contracts, leading to legal issues.

The Committee reflected on how to further embed co-production and early engagement into processes across the partnership. It was agreed that further work would be undertaken to focus on coproduction of responses to smaller scale service changes and reported back to the Committee in due course. Related to this, it was also suggested that partners work together to facilitate public engagement events to seek views to feed into the consultation on the new NHS 10 Year
Plan.

ACTION – To add a communications and engagement update to the forward work plan, focusing on plans for coproduction in relation to changes to services.

PW arrived at 13:40 during discussion of this item.

50 QUESTIONS FROM MEMBERS OF THE PUBLIC

There were no questions submitted on this occasion.

51 POPULATION AND DELIVERY BOARD UPDATE

NE introduced the report setting out the future role and responsibilities of Population Boards to support the reallocation of resources to higher value interventions for their populations. Members were advised that the Population Boards will have a tighter focus on a set of agreed partnership transformation programmes and priorities for their specific population.

It was noted that the work required to transition the Population Boards to the future arrangements will have concluded to enable the Boards to be operating in the new capacity from April 2025.

Members were supportive of the approach taken to date, recognising the importance of simplifying the role of the boards to achieve coordinated change across the system. It was suggested that to support this, and to ensure reduced duplication of work, the Population Boards interconnect other boards and forums across the system as well as with other Population Boards. It was also noted that the transformation resource to facilitate the opportunities identified by the Population Boards would need to be clear from the outset to support the prioritisation process.

In terms of providing further assurance to the Committee, members noted that future reports should be owned by the Boards themselves, building the Boards into the drafting process prior to submission.

The Leeds Committee of the WYICB:

- **NOTED** the shift in focus for Population Boards and implications for the role the partnership in Leeds plays in supporting them.
- **CONSIDERED** 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).

52 PLACE LEAD UPDATE

GW noted for transparency that he worked as a GP in one of the Primary Care Networks (PCNs) included in the chronic kidney disease (CKD) programme detailed in the report.

TR provided an overview of the report, advising members of the emerging changes to priorities nationally, noting that NHS England have written to all ICBs setting out greater clarity on the role of NHSE and ICBs moving forward, advising that ICBs will be responsible for planning services for their population, with an increased focus on integrated neighbourhood health, prevention and addressing inequalities.TR advised that the NHS 10 Year Plan consultation had recently launched and that the Leeds system response to the consultation would be circulated to members in due course.

ACTION – To circulate the Leeds system response submitted to the NHS 10 Year Plan consultation.

TR also provided an update on the Joint Working Agreement (JWA) concentrating on CKD and getting people (a target of 1250) with CKD reviewed and initiated on the NICE recommended TA drugs; SGLT2s, which was approved by the January 2024 Leeds Committee meeting, due to the related prescribing costs. TR advised that it had been proposed that the existing JWA be extended 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). It was confirmed that no additional resources would be required, however TR sought the Committee's support in proceeding with the extension.

Members were advised that the demand for diagnosis in both adult and children's ADHD and Autism remained very challenging. The Leeds and York Partnership NHS Foundation Trust ADHD service for adults had closed for new referrals, and in children's services, families had been made aware of the length of waiting times. It was confirmed that plans to address this were in development and that a further update would be provided to the Committee in due course as part of planning for next year.

There was some discussion on the neighbourhood health focus at a national level and the Leeds response to this. Members were advised that work continues in West Yorkshire to develop an Integrated Neighbourhood Framework, and in Leeds to further develop the neighbourhood model building on the work already undertaken through the Marmot City

programme and Local Care Partnerships. Members agreed that a whole-system approach is required moving forward to build on the successful existing partnerships in the city, built on strong multi-agency relationships and geographical alignment with Primary Care Networks and electoral wards.

The Leeds Committee of the WYICB:

- **NOTED** the contents of the report, giving specific attention to the emerging national context and priorities.
- **SUPPORTED** the extension of the CKD Joint Working Agreement.

53 QUALITY AND PEOPLE'S EXPERIENCE SUB-COMMITTEE ASSURANCE REPORT

The Committee received the AAA report on behalf of the Chair. RC highlighted that there had been many changes in the membership in the last year due to changed job roles, and highlighted the importance of consistency to ensure that the sub-committee remains focused and effective.

The Leeds Committee of the WYICB:

- **NOTED** the report.

54 DELIVERY SUB-COMMITTEE ASSURANCE REPORT

The Committee received the AAA report on behalf of the Chair.

The Leeds Committee of the WYICB:

- **NOTED** the report.

55 FINANCE AND BEST VALUE SUB-COMMITTEE ASSURANCE REPORT

The Committee received the AAA report on behalf of the Chair. It was highlighted that the sub-committee reported positive assurance on the Medium-Term Plan update. It was also highlighted that the sub-committee noted only partial assurance on the effective management of the risks included on the Leeds Place risk register aligned to the sub-committee, due to the volatility of current circumstances as opposed to the quality of mitigations. It was noted that this would be included in the alert section of the AAA report to the WYICB.

The Leeds Committee of the WYICB:

- **NOTED** the report.

56 FINANCE UPDATE AT MONTH 6

AC provided a verbal update on Month 7, which became available after the publication of papers. At Month 7, Leeds Place reported £6.4m behind plan year to date with a likely

mitigated case by year end of £26.2m adverse to plan. There is therefore an increased likelihood of NHS England intervention, and members were advised that finance teams across the WY Places continue to address actions identified by the recent independent review commissioned by the ICB from PwC to mitigate the position. It was noted that work is being undertaken on the medium-term financial plan and planning for next year, which would form part of the upcoming development session for the Leeds Committee on 11 December 2024.

In addition to the partner positions set out within the report, members were advised that that the national insurance cost to third sector had been estimated at £5m in Leeds with additional pressures around accommodating the living wage.

In response to a query regarding the NHS England oversight framework, AC advised that there were not any defined criteria for moving from segment 3 to 4, however that if the organisation continued on the current path, intervention was likely.

The Leeds Committee of the WYICB:

- **NOTED** the Month 6 and 7 positions, specifically the emerging risks and mitigating actions.

57 CONSOLIDATING VCSE MENTAL HEALTH CONTRACTS

PG left the room for discussion of this item (Minute 45 refers.)

ED introduced the report, advising of the intention to consolidate nine current separate ICB held contracts/grant awards with Voluntary, Community and Social Enterprise (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. TR added that the work outlined in the report supported the Third Sector Position Statement attached to the agenda pack as an additional paper for information. In response to a query, ED advised that all current providers had been made aware of the changes proposed.

There was some discussion around the potential for legal challenge. Members were advised that the options had been market tested to reduce the risk of challenge and that the contract team were sufficiently separate as they had been moved to West Yorkshire level as part of the new operating model, allowing for appropriate check and balance.

Opportunities for learning between partners were highlighted, including several similar contracts within the council that would benefit from a similar approach. Partners agreed to discuss further outside of the meeting.

The Leeds Committee of the WYICB:

- **AGREED** 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.

- **NOTED** 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**.**

58 RISK MANAGEMENT AND BOARD ASSURANCE FRAMEWORK REPORT

TR introduced the report, advising that risks are held at different levels of the organisation, with some risks managed across West Yorkshire and then some managed specifically at Leeds place, depending on the population they reflect. TR advised that healthcare providers in Leeds hold their own risk registers and the top three risks from each partner had been included as an appendix to the report for visibility. In addition, TR advised that work is ongoing to review the strategic risks held on the Board Assurance Framework (BAF). TR reflected on whether the risk register reflected the position at Leeds Place suggested that the risk associated with the suspension of Tier 3 Weight Management Services should be added to the risk register.

ACTION – To add the risk associated with the suspension of Tier 3 Weight Management services to the Leeds Place risk register.

The Leeds Committee of the WYICB:

- **RECEIVED** and **NOTED** 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.
- **RECEIVED** and **NOTED** the WY ICB Board Assurance Framework (BAF) Summary and Heat Map.
- **NOTED ASSURANCE** in respect of the effective management of the risks aligned to the Committee and the controls and assurances in place.

59 URGENT DECISION: DIRECT AWARD OF NEW CONTRACT FOR SHORT-TERM COMMUNITY BEDS IN LEEDS

RB, KA, GW and VE left the room for discussion of this item (Minute 45 refers.)

The Chair advised that the report provided detail on the recent decision taken by herself and the Place Lead on 7 November 2024 due to timescales, in line with the terms of reference, in respect of the new contract for the Short-term Community Beds in Leeds.

The Leeds Committee of the WYICB:

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

60 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 worsening financial position and risk of intervention from NHS England
- A summary of the outputs of the discussion around engaging with communities and communicating service changes
- An update on the national focus on neighbourhood health and the approach taken in Leeds
- An update on the neurodiversity risk position
- An update on the work undertaken to refresh the role and remit of the Population Boards

61 FORWARD WORKPLAN

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.

62 ANY OTHER BUSINESS

No other matters were submitted for consideration.

63 DATE AND TIME OF NEXT MEETING

The next meeting of the Leeds Committee of the WY ICB was confirmed as 1.15 pm on Wednesday 26th February 2025.

The meeting closed at 3.55 p.m.

Action Tracker

Leeds Committee of the WY ICB

Action No.	Meeting Date	Item Title	Actions agreed	Lead(s)	Accountable body / board / committee	Status	Update
49/24	**27 November 2024**	**People's Voice**	To add a communications and engagement update to the forward work plan, focusing on plans for coproduction in relation to changes to services.	**HS**	**LCICB**		Added to the workplan.
52/24	**27 November 2024**	**Place Lead Update**	To circulate the Leeds system response submitted to the NHS 10 Year Plan consultation.	**TR/HS**	**LCICB**		Circulated via email 05/12/2024.
58/24	**27 November 2024**	**Risk Management Report**	To add the risk associated with the suspension of Tier 3 Weight Management services to the Leeds Place risk register.	**AS**	**LCICB**		Risk added. Detail provided in the risk management report (26/02/2025).
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

Action No.	Meeting Date	Item Title	Actions agreed	Lead(s)	Accountable body / board / committee	Status	Update
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 (11/09/2024)
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.

Meeting name:	Leeds Committee of the ICB
Agenda item no.	72/24
Meeting date:	26th February 2025
Report title:	Accountable Officer (Leeds) Place Report
Report presented by:	Tim Ryley, Place Lead
Report approved by:	Tim Ryley, Place Lead
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 draws attention to the national context, national and local priorities, including NHS planning guidance and neighbourhood health services, updates on winter pressures, and describes the emerging picture on the NHS operating model.

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.

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. Leeds Place Equality, Diversity and Inclusion Annual Report 2025

Acronyms and Abbreviations explained

1. LTHT – Leeds Teaching Hospitals NHS Trust
2. LCH – Leeds Community Healthcare NHS Trust
3. DHSC – Department of Health and Social Care
4. ICS – Integrated Care System
5. BCF – Better Care Fund
6. CVD – Cardiovascular Disease
7. LHCP – Leeds Health and Care Partnership
8. UTC – Urgent Treatment Centre
9. AAA – Alert, Assure, Advise
10. MDT – Multidisciplinary Team
11. NHSE – NHS England
12. ED – Emergency Departments

What are the implications for?

Residents and Communities	Stronger focus on neighbourhoods
Quality and Safety	
Equality, Diversity and Inclusion	Equalities Report attached
Finances and Use of Resources	National Planning Guidance published
Regulation and Legal Requirements	Changes to Governance
Conflicts of Interest	None noted
Data Protection	None noted
Transformation and Innovation	
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. Introduction and national Context

12.1 I want to start by congratulating Selina Douglas, Chief Executive Officer at LCH, on her appointment to the Chief Executive of the Whittington Hospital NHS Trust. We want to record our thanks to Selina for her contribution to the Leeds health and care system, and leadership of LCH, and wish her the very best going forward.

12.2 Ed Whiting joined Leeds City Council as its Chief Executive Officer at the start of January. We welcome Ed to the city and thank Mariana Pexton for her work as Interim Chief Executive and look forward to working with them on our shared health agenda going forward.

12.3 The ICB in Leeds following personnel changes in the director team over the last year, in part because of the 30% running cost reductions, have seen a number of people move on. We want to record our thanks to Nick Earl for acting up for the past twelve months through a period of considerable change and are now out to recruit permanently a Director of Strategic Programmes and Population Health Management. We expect to be able to announce the successful candidate in March. Helen Lewis is caretaking the new directorate until she starts her partial retirement in the summer. I want to thank Helen for picking this up.

12.4 There remains significant attention and pressure on the NHS nationally. This is both political and operational. A challenging winter, a tight fiscal environment, the late publication of NHS planning guidance and a government pushing reform are prominent features of the current operating context.

12.5 The Department of Health & Social Care (DHSC) have issued their mandate to the NHS. This has been something much less visible over the last few years. It clearly sets a new tone for the relationship between the department and NHS England with a shift of policy and priority setting towards the DHSC. It is also thankfully much shorter than previously. The link to the full document is at: Road to recovery: the government's 2025 mandate to NHS England - GOV.UK

12.6 The priorities in the Mandate are

- Reform to cut waiting times
- Reform to improve primary care access
- Reform to improve urgent and emergency care
- Reform to the Operating Model
- Reform to drive efficiency and productivity.

13. NHS Planning Guidance 2025-2026

13.1 The NHS Planning guidance was published on the 30th of January. Whilst last year the formal date was much later, we did have a lot of detail ahead of publication. This has not been the case this year.

13.2 There will be more detail for the later discussion but the three key messages to note at this stage are:

- An expectation that the NHS will plan to live within its resources with limited new development.
- In line with this there are a small number of priorities: elective waiting times, urgent and emergency care, and primary care access (GP and Dental), and reduced list of national measures from 31 to 18. It should be noted that the Mental Health Investment standard has also been protected.
- There is some preparatory work for the expected NHS Plan due to be published later in the year also required. This includes initial guidance on the development of a neighbourhood health model and an expectation of further clarifying the operating model of the NHS.

13.3 The West Yorkshire Integrated Care System (ICS) is currently in the middle of developing plans, completing the required returns and assessing the key risks with final plans due to be signed-off by the end of March 2025. There are significant challenges in the timeframes and more importantly in developing plans within the very tight financial constraints.

14. Winter

14.1 The NHS has had a particularly challenging winter with higher demand hitting the system earlier than normal and continuing to present significant operational challenges across the whole system, with LTHT in Opel 3 most days and occasionally going into Opel 4. Other providers have also experienced significant pressure.

14.2 The work previously done on HomeFirst has mitigated some of this. However, we have seen a significant increase in people needing to be admitted (though not A&E attendance) and in No Reason to Reside numbers. More positively lost bed days are much reduced from previous years and waits for community care beds are significantly down on what we have seen before, in the main as a result of more active management of flow through them. Most discharge pathways have continued to operate reasonably

effectively with the average length of stay once fit for discharge down from 1.2 days last winter to 0.8 days this winter.

14.3 Despite immense pressures in the ED departments, LTHT have continued to minimise ambulance turnaround delays enabling a relatively good ambulance performance in West Yorkshire for category 2 response times.

15. Neighbourhood Health and Leeds Priorities.

15.1 Alongside the national priorities for the NHS set out in the planning guidance there is also reference to the development of a neighbourhood health model. In Leeds we have also agreed four areas to prioritise our collective partnership focus and action. These are fully aligned.

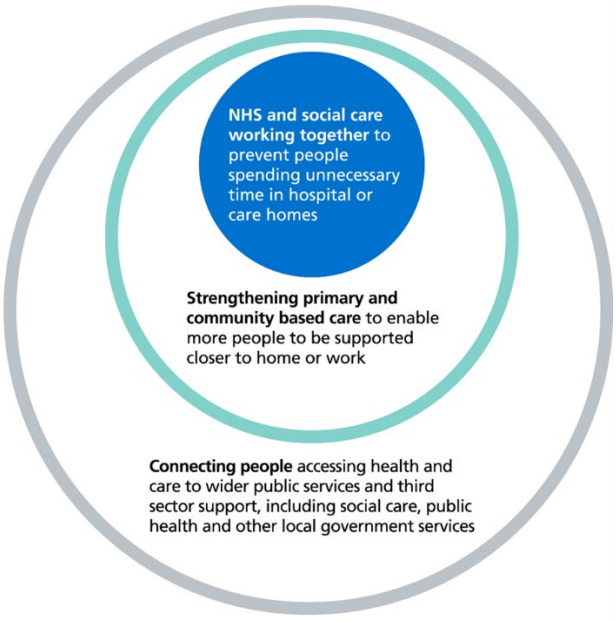
15.2 The four priority areas are set out below with a brief rationale:

- **HomeFirst 2 Targeted Prevention -** the health risks already identified of people who are at the point of high intensity utilisation of health services and significant loss of independence because of frailty, multiple co-morbidities and being at end of life requires significant attention both to improve health outcomes and to support sustainability of the health system. There are a number of pieces or work that require a similar response at a neighbourhood level around this popualtion including MDTs for example.
- **Community Menatl Health Transformation** – whilst progress has been made on delivering this national programme there is still some way to go across what was always a multi-year programme. It is important that we both complete the work and ensure that we are delivering tangible value benefits in experience, outcomes and sustainability.
- **Chilidren with complex needs** – there are significant pieces of work already underway. Currently some of our children and young people (alongside their families) experience significant challenges, poor health outcomes both in their lives today and into adulthood, all the while with growing and high costs to all partners. There is still a bit more work to be done to firm up the detail of this programme.
- **Earlier Identification of CVD risk through Hypertension** - cardiovascular risk in the population once it materialises is a significant driver of poor health exacerbated inequality with multiple demands being placed on individuals, carers and health and care services. Hypertension is an early signal of this risk and a route into improving

health outcomes and reducing risk**.** This is also at the heart of the Core20Plus5 and one of the remaining18 national targets is hypertension.

15.3 A neighbourhood health model is the ***delivery method*** for at least three of our 4 priorities (HomeFirst2, Community Mental Health Transformation, and Cardiovascular). This approach was already part of our planning and work we have already done across for example community mental health, end of life respiratory, and frailty and falls. We will in 2025 as a Leeds Health and Care partnership ramp up our approach to developing a neighbourhood model to secure delivery of our priorities.

15.4 The neighbourhood health model envisaged forms three connected concentric circles. The focus in year one from NHS England is in the inner circle.



15.5 NHS Planning guidance puts the initial emphasis on six expected components:

- Population Health Management including population segmentation. Leeds is in a strong place on this, and it has supported our decisions on our priorities; HomeFirst2, Children, and Cardiovascular Hypertension.
- Modern General Practice. Again, Leeds is in a strong position with 2/3rds of our practices already through this process.
- Standardising Community Health Services. Some integration and common approach, further work to develop.

- Neighbourhood MDT's. Some good examples in Leeds and critical to delivering in particular HomeFirst 2 elements. A key area for development more widely in order to deliver our priorities.
- HomeFirst Approach and link to intermediate care.
- Urgent Neighbourhood Services.

15.6 Whilst these components are primarily focussed on the inner circle, Leeds is in a strong position to move further than this. Our focus on Cardiovascular and Hypertension is very closely aligned to Circle 2. Importantly under the active leadership of Leeds City Council and the work on social determinants in the Marmot programme for example, there is a lot of opportunity to progress the model in circle three as well. PLT is working through the best leadership arrangements to drive both the neighbourhood approach and through that our four priority population groups.

16. NHS Operating Model and Role of Place.

16.1 There have been ongoing conversations within the NHS about the role and responsibilities of Department of Health and Social Care (DHSC), NHS England and ICB's over the last year or so. The emerging picture looks to describe a clearer set of responsibilities, and these will be taken forward over the next 12 months as set out in the mandate from government to the NHS, and in the NHS Planning Guidance.

16.2 The DHSC will take the lead on strategy and policy with NHS England being accountable for the overall service planning and performance. Whilst ICB's will still be involved in performance they will be expected to act as strategic commissioners. There is still a lot of detail being worked through on the implications and guidance is emerging.

16.3 There is also work being done on the role of place and place provider alliances and integrators, with the expectation that ICB's in their strategic commissioning role will be expected to commission in such a way as to enable these alliances to emerge in places. There will be an opportunity for providers to collectively take-on some commissioning functions with delegated resources subject to sufficiently robust integration.

16.4 West Yorkshire ICB in its scale is in a stronger position than some ICB's to undertake this strategic commissioning role. It is also much better positioned than many in its commitment to and delegation to place of both budget and staffing resources. The ICB operating model was deliberately designed to enable this emergence of provider alliances in places without significant further changes.

16.5 However, there are still challenges in articulating a strong rationale, working through practical details, and creating the shift in mindset in both ICB and some providers. Terese Pattern, Chief Officer Bradford District Care Trust is leading the work on this at NHSE, and I am part of the working group on this she has pulled together. Colleagues from NHSE visited Leeds two weeks ago to run thoughts passed some of us. Further guidance and expectations around this are expected shortly.

16.6 Rob Webster asked Anthony Keeley to lead a piece of work to review the effectiveness of the operating model and consider future steps in the development of places. It is broadly in line with the national emerging picture. This is currently being drafted and will be published in the next week or so and will set some goals West Yorkshire by 2026.

17. Changes to ICB Governance

17.1 There have been a number of changes in the ICB governance. In light of the further work on the detail of place arrangements during 2025 ahead of April 2026, it seems sensible to broadly continue with existing arrangements. We are however proposing rationalising the number of sub-committees (See later item).

17.2 There have been a few other changes to the ICB governance also supportive of place delegation as set out below:

Delegation of Powers to Place by NHS West Yorkshire ICB ("WY ICB")

Amendments to the WY ICB Constitution were approved by the WY ICB Board on 17 December 2024. The amendments provide:

- Greater delegation to Place Committees for Better Care Fund submissions.
- Approval of Place-based s65Z5 (joint working and delegation agreements);
- s65Z6 (joint committees and pooled funds); and
- s75 (arrangements between NHS bodies and Local Authorities).

It is anticipated that the application will be submitted to NHSE towards the end of March 2025 following ratification of the minutes of the 17 December 2024 meeting at the WY ICB Board meeting on 18 March 2025.

As the changes had been approved by the ICB on the 17 Dec, an interim approval process in-line with current constitution has been agreed, as follows

(i) NHS WY ICB route for BCF and/or s 75 approval in interim period

- Place assurance committees as appropriate dependent upon content of BCF/s 75
- Place committee to receive the s 75 in full, and with recommendation to ICB Board to approve (with Rob W signature)
- ICB Board to receive the Leeds Committee AAA report with link to s75 in the papers for the meeting, requesting a decision for approval by the ICB Board
- Local authority route will still be through to the Health and Wellbeing Board

Following approval by NHS England of the variance to the Constitution the governance route and decision will be at place, as follows:

(ii) Subsequent to NHS England approval of the constitution variation, route would be:

NHS WY ICB route for BCF and/or s 75

- Place assurance committees as appropriate dependent upon contents of BCF/s 75
- Place committee to receive the s 75 in full, and take decision (with signature of place lead)
- ICB Board notified of approval in triple A with link to s 75 in papers for the meeting

18. Burmantofts Walk- in Centre

18.1 LTHT has been leading the work to change the designation status of the Walk in Centre, based out of Burmantofts Health Centre, to an Urgent Treatment Centre from April 2025. This switch will enable a greater range of urgent/on the day assessment and treatment to be offered (including injuries) and ensure the activity undertaken in the service can be counted towards the 4hr Emergency Care Standard.

18.2 The process to gain NHSE approval requires assurance, including from the ICB, to be provided on how the service can meet all the minimum standards/principles required including offering NHS111 directly bookable appointments plus access to Xray provision. As Accountable Officer for Leeds I have signed-off on the application.

18.3 We are now waiting for NHSE to complete their review and provide feedback on the information provided and confirm if our application has been successful. The Timescales are as set out are as below:

1. LTHT Finance and Performance Board – October 2024
2. ICB/LHCP (ASL Executive Group) –15th Jan 2025
3. ICB Accountable Officer authorisation by mid-January 2025
5. WY ICB send UTC designation submission to NHSE by end January 2025
6. NHSE to confirm designation to ICB & LTHT in March 2025.

19. Leeds Place Equality, Diversity and Inclusion Annual Report 2025

19.1 The ICB in each place has to produce and publish an annual equalities report. This work is led by our Equality Diversity Lead. This has been reviewed by the ICB director team in Leeds and is attached for information.

Recommendations

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

1) Note and comment on the report.

2. Appendices

1) Leeds Place Equality, Diversity and Inclusion Annual Report 2025

Leeds Office of NHS West Yorkshire Integrated Care Board (WYICB)

Our Celebration of Equality, Diversity, and Inclusion 2025

Local population profile, demographic data, and health inequalities

Leeds is an area of great contrasts, including a densely populated inner-city area with associated challenges in relation to poverty and deprivation, as well as a more affluent city centre, and suburban and rural areas with villages and market towns.

The most recent census (2021) indicated that Leeds has a population of 811,953 representing an 8.05% growth since the previous census of 2011. Leeds has a relatively young and dynamic population and is an increasingly diverse city with many ethnic communities including black, Asian, and other ethnically diverse populations representing 22.1% of the total population compared to almost 19% in 2011.

In relation to spoken languages the census 2021 showed that after English (87.83%), the most common spoken languages across Leeds are Polish (1.02%); Arabic (0.59%); Romanian (0.58%); Urdu (0.54%); and Panjabi (0.52%).

The census 2021 showed that 0.05% of the Leeds population use British Sign Language.

In July 2024 our records showed there were 936,625 people registered with General Practitioners (GPs) in Leeds. This data provides us with more up to date information that helps us understand the health and care needs of our population.

The Leeds Health and Wellbeing Strategy 2023 to 2028 sets out a clear commitment that:

“Leeds will be a health and caring city for people of all ages, where those who are poorest improve their health the fastest”.

More information about the Leeds Health and Wellbeing Strategy can be found here:

Leeds Health and Wellbeing Strategy

The role health and social care will play to support achievement of this aim is set out The Healthy Leeds Plan

The Healthy Leeds Plan contains two clear goals, through which we will support delivery of the overall Health and Wellbeing Strategy commitment.

The table below shows how our commitment is driven by action and measured by impact through two system wide goals.

Goal 1 and 2 focus on 26% of the population who live in the 10% most deprived areas nationally.

Goal 1 **Reduce preventable unplanned care utilisation across health settings**	**Goal 2** **Increase early identification and intervention (of both risk factors and actual physical and mental illness)**
Leeds to achieve a 25% reduction in **preventable** unplanned utilisation for those in IMD 1 (people who live in the 10% deprived areas nationally) by 2028, against a 2022 baseline	To be determined However, we know this will have a focus on people who live in the 10% most deprived areas nationally, and for the first year will be delivered with a focus on hypertension and mental health
We will know whether we have achieved this target when we have reduced: • The number of unplanned admissions to hospital (we count the number of days people stay in hospital) • The number of times people used A&E, walk in centres, and Urgent Treatment Centres • The number of times people accessed mental health crisis services • The number of days people stayed as a mental health inpatient We know that some emergencies are unavoidable, and when people need A&E and other same-day services these need to be easily available and accessible. However, we also know that sometimes people end up in hospital in an unplanned way when we could have done something sooner that would have kept them healthier and happier at home or in the community. We want to make sure that people only come into hospital as an emergency when there was no other, better option.	To be determined

We take a person centred and proactive approach by working with people and staff to design solutions together.

Several programmes sit underneath the Healthy Leeds Plan goals, targeting specific groups of people identified through data analysis, to talking to clinicians, our communities, and patients.

We're now going through this process again to work out what to measure and how to set a target for Goal 2, however, we know it will focus on improving the health of the most deprived communities and those facing health inequalities.

The Healthy Leeds Plan has a specific focus on health inequalities. This is because we know that 26% of our population and around a third of all children in Leeds live in neighbourhoods in the 10% most deprived nationally (IMD1).

We know that health and wellbeing is affected by social, economic, and environmental factors that go beyond good healthcare. These are often referred to as the wider determinants of health and include factors such as income, education, access to green spaces and healthy food, employment, and housing.

Inequalities in relation to the wider determinants of health can lead to health inequalities between different populations and therefore addressing these wider socio-economic inequalities is a crucial part of reducing health inequalities for the people in Leeds.

Leeds has also committed to become a Marmot City. Marmot Cities are cities that are committed to reducing health inequality and improving health through improving the wider determinants of health. You can read more about Marmot Cities here, and our initial Leeds report here. Through this programme, Leeds is working in partnership with the Institute of Health Equity to take a strategic, whole-system approach to improving health equity.

Details regarding the population profile, demographics and health inequalities within Leeds can be found in the Leeds Joint Strategic Assessment 2024.

An overview of some of the changing population needs and characteristics identified within the needs assessment include:

- Leeds has a rapidly growing population versus national and regional averages, with growth fastest in inner-city areas where we are also seeing increased density.
- However, the birth rate is continuing to fall, and we are yet to see this level off.
- Population continues to age in line with national patterns, but we are also at peak population size for children and young people with the 'bulge' cohort of the 2010s working through secondary school and into post-16 education.
- The city is much more diverse than a decade ago – minority populations are significantly more likely to experience poverty and inequality, concentrated in inner-city communities.
- The student population is growing year-on-year, but there are early signs it is shifting spatially with growth largely concentrated in the city centre rather than the traditional student communities.

- The proportion of people living with multiple long-term conditions is increasing, with this likely to start earlier in life for people living in the poorest neighbourhoods, creating a need for more adaptable and coordinated services focused on preventing and meeting complex needs.
- The gap in life expectancy in Leeds, could mean that a female living in Harewood can expect to live 11.5 years longer than a female in Hunslet and Riverside, with similar gaps for men.
- Suicide rates are highest among middle-aged men, whilst girls and young women have the highest rates of hospital admissions due to self-harm. Both have higher rates in the city's low-income communities

We have developed a robust population health infrastructure in Leeds designed to put the diverse needs of our population at the heart of everything we do and move decision making closer to the people using our services. Within Leeds we have described the different needs of the population using nine mutually exclusive population segments:

- Children and Young People
- Maternity
- Healthy Adults
- People with a Learning Disability and/or Neurodiversity
- Serious Mental Illness
- Cancer
- Long Term Conditions
- Frailty
- End of Life

By looking at our population in this way, we can better understand what people need to address, the challenges they face and how we as a health and care system can help.

Each population segment has a corresponding Population Board, which brings together experts and representatives from across health and care, the third sector, and Healthwatch to support, inform, and shape decisions that impact their population.

Further information can be found at our website: Population health infrastructure - Leeds Health and Care Partnership (healthandcareleeds.org)

Leeds Health and Care Partnership and equality, diversity, and inclusion

We work together with our partners and the people of Leeds and work as one team, where staff work for Leeds, rather than for individual organisations.

We are committed to sharing resources, ideas, and best practice to improve health outcomes, access, and experience of healthcare and to reduce health inequalities across the city for all our diverse communities.

The vision for Leeds Health and Care Partnership is that Leeds will be a healthy and caring city for all ages, where people who are the poorest improve their health the fastest.

Our vision for Leeds is owned by all partners and delivered through action, using our diverse and unique skills, knowledge, and experiences. We will work together, using our collective resources to create a fairer and healthier Leeds for all.

The Leeds Health and Care Website provides more information:

https://www.healthandcareleeds.org/

As an integrated partnership we continue to work together in the transformation of our healthcare services. In relation to equality, diversity, and inclusion, we ensure that service specifications include the need to have robust policies and processes in place to make sure that the needs of all diverse communities and other health inclusion groups are considered in respect of the delivery of their service and that workforce policies are fair and equitable.

We continue to proactively integrate quality and equality impact assessments and equality impact assessments within all our business processes

Equality analysis and assessment of impact continues to be integrated within all the work our communication, insight and involvement team do.

Equality, diversity and inclusion networks and forums

Our aim is to continually improve equality, diversity, and inclusion (EDI) in relation to being an inclusive employer, reducing health inequalities and removing barriers to accessing healthcare, therefore we continue to work together with our partners and continue to be members of the following:

Leeds NHS Equality Leads Forum

As members of the Leeds NHS Equality Leads Forum, we continue to work in partnership with all NHS organisations in Leeds to ensure that there is a joined-up approach in relation to equality, diversity, and inclusion in relation to our workforce. In addition, we work together to explore inequalities experienced by some of our diverse communities in relation to health outcomes and access to, and experience of healthcare.

For example, we continue to work in partnership to address inequalities experienced by people with sensory impairments in relation to their communication and information needs, specifically in respect of implementation of the Accessible Information Standard; share good practice in relation to all staff networks; continue to work collaboratively in relation to NHS Equality Delivery System 2022; NHS Workforce Race Equality Standard; NHS Workforce Disability Equality Standard; NHSE six High Impact Actions; Patient Carer Race Equality Framework (PCREF).

Leeds Equality Network

During 2024, working in collaboration with Leeds City Council we re-established Leeds Equality Network.

Leeds Equality Network brings together public sector, private sector, education organisations and third sector representation across Leeds. The purpose of the network is:

- To work collectively and collaboratively to contribute to a fair and inclusive society. The network seeks to be more than the sum of its parts, driving meaningful change through partnership working and learning together to make a positive, lasting impact on the city.

- To collectively identify and address inequalities in Leeds, focusing on the protected characteristics under the Equality Act 2010 (age, disability, gender reassignment, marriage/civil partnership, pregnancy/maternity, race, religion or belief, sex, sexual orientation). We will also include Care Experience, Carers and Socio-Economic Inequality and other communities who experience inequalities.

- To deepen our understanding of poverty and deprivation, and the impact they have on inequality across the city, ensuring that these factors are taken into account in our work.

- To maximise the impact of partnership working across member organisations, sharing best practices, promoting events, and sharing intelligence related to equality, diversity, and inclusion. This collective effort will strengthen the city's resources and enhance outcomes for communities

The network is made up of practitioners supporting each other to work more effectively by working in partnership and therefore aim to move beyond a 'compliance' approach, with a commitment to be truly inclusive and work towards the creation of a fair and equitable society where everyone can fulfil their true potential.

To help organisations achieve this, members of the network will agree on annual themes or communities of interest, identifying activities to be developed and delivered collaboratively in relation to these areas.

The areas of focus so far for the network have included protected characteristics and care experience, socio-economic duty, West Yorkshire Integrated Care System "Equity and Justice for Health: A Shared West Yorkshire Vision" Strategy, international days and collaboration and an overview of hate crime.

Communities of Interest Network

We are members of the Communities of Interest Network (COIN) which aims to highlight and address the needs and challenges faced by groups and communities which experience the greatest inequalities, with a focus on health and wellbeing. COIN does this by promoting two-way communication and collaborative working between the Public Sector and Third Sector organisations that represent these communities.

A key focus of the network is to understand and raise awareness of the importance of intersectionality, where people's overlapping social identities may mean they experience disadvantages or discrimination: Communities of Interest - Forum Central

LGBTQIA+ Health and Wellbeing Network

We know that some of us identify as LGBTQIA+. This means we may be lesbian, gay, bisexual, transgender, queer, questioning, intersex, or asexual. Or we may define our gender and sexuality in other ways. Stonewall's glossary lists many more terms.

We are members of Leeds LGBTQIA+ Health and Wellbeing Network, which aims to:

- Improve the health and wellbeing of the LGBTQIA+ population in Leeds by linking services and professionals and sharing best practice.
- Identify potential workstreams and work across service and organisations to progress these workstreams
- Act as a reference group for other groups and organisations who wish to consult with the group
- Act as a forum for debate, discussion, and strategic planning as it relates to the health of LGBTQIA+ people in Leeds.

Leeds NHS Provider Trust's Equality Performance

We continue to work in partnership with our NHS provider trusts in relation to the EDI work we do across the city.

Details of the Leeds NHS provider trust's EDI work and associated reports can be found in the links below:

Leeds Teaching Hospital NHS Trust: https://www.leedsth.nhs.uk/about-us/equality-and-diversity/

Leeds Community Healthcare NHS Trust: https://www.leedscommunityhealthcare.nhs.uk/about-us-new/equality-and-diversity/

Leeds and York Partnership NHS Foundation Trust: https://www.leedsandyorkpft.nhs.uk/about-us/equality-and-diversity/

Insight, communication, and involvement

Our Insight, Communications, and Involvement Team at the ICB (Integrated Care Board) in Leeds is committed to involving people who are protected by the Equality Act 2010, health inclusion groups and other communities who experiences inequalities.

Examples of the ways we are working in Leeds to understand and involve people with differing needs and promote inclusion, include:

The Leeds People's Voices Partnership (PVP)
The PVP brings together senior involvement leads from across the public and voluntary sectors in Leeds. Together we coordinate involvement activities across the city to put the voice of inequalities at the heart of decision-making.

Our joint working includes the Big Leeds Chat, the Leeds Citywide Public Involvement Network, and the development of the Leeds Involvement library. All these projects are focussed on listening and responding to the voice of inequalities.

You can see more about our work with the PVP here: https://healthwatchleeds.co.uk/our-work/pvp/

Listening to local people
Over the last year we have been working with the PVP and our partners across the city to ensure that our boards are hearing from local people, acting on what matters to them and feeding back how their views have shaped our decision. The main part of this work over the past year has involved updating insight reports for our population boards.

The insight reports are written in partnership with public and third sector partners and bring together what we already know about the needs, preferences, and experiences of people in Leeds.

The reports include a section dedicated to highlighting what matters to people with protected characteristics. In addition, we have identified additional communities where we want to focus our involvement. These are people who have experienced; homelessness, deprivation, difficulties accessing digital technology, serving in the forces and people with caring responsibilities.

Working in this way enables us to focus the boards' attention on equality issues so that we can 'improve the health of the poorest, the fastest'. You can view all our insight reports on the Leeds Health and Care Partnership website here: https://www.healthandcareleeds.org/have-your-say/get-involved/populations/

A recent example of this work has been our insight review into the experiences of people using language and British Sign Language (BSL) translation services across West Yorkshire. We worked with our partners across West Yorkshire to identify common patient experience themes over the last few years, which included the following:

- People tell us that we need to support greater use of digital technology but ensure that patients are offered a choice.
- People tell us they would like an option to create an audio recording for feedback.
- People tell us that communication needs to be accessible, and the complaints process should be clear to patients and to carers.

- People tell us there are delays to treatment due to a lack of BSL interpreters.
- People tell us that the information technology system needs to record and flag patients' communication needs.
- People tell us that the quality of professional interpreters used is important and that this is consistent – BSL and language interpreters could be trained in medical terminology.

Involvement input to BSL / Interpreting Services Procurement
We have been working with colleagues to provide input to the recent West Yorkshire wide procurement for BSL and Interpreting services, considering and scoring bidder applications on questions relating to involvement and putting what we know matters to people at the heart of these decision-making processes.

Equality, diversity and inclusion and our Pathway System Integration Team

Examples of our proactive work in relation to EDI and health inclusion include, but not limited to:

Children and Young People

Kooth

Kooth is an anonymous online mental wellbeing community which helps children and young people to feel safe and confident in exploring their concerns and accessing mental health support whenever they need it.

Delivered in partnership with the NHS, Kooth is a free service, 24 hours a day, 365 days a year and is available to anyone between the ages of 11-18, and in some areas, it extends up to age 25.

Kooth does not require a GP or school referral. There are no waiting lists or thresholds to meet. Anyone wishing to access Kooth services just needs to register with an anonymous username and support can be accessed immediately.

Inequalities and Children and Young People's Mental Health

Kooth has been working in partnership with the Centre for Mental Health and recently launched an interactive map and report highlighting the stark disparities in children and young people's mental health in the UK.

Children's chances of having good or poor mental health are shaped by the places they live in and the support available there. This new map tool enables schools, health services and local councils to understand the mental health needs of the children and young people they serve.

Please browse the map, read the full report here.

The new map tool is intended to support the provision of targeted and preventative support, accounting for wider issues linked to poor mental health, such as racism and racialised inequalities and poverty.

In relation to Leeds the map shows:

- Rates of school absence in the UK by local authority - Leeds: Absence among pupils in 2022/23 (% of half days missed): 7.63%
- Rates of mental health and other needs - Leeds: Primary school pupils with social, emotional, and mental health needs as primary Special Educational Needs and Disability category (%): 2.1
- Rate of suicide among children and young people (per 100,000): 6.6 for Leeds. Metric used: Suicide rate per 100,000 10 to 24 year olds in 2018-2022.

Ethnicity Data for children and young people using Kooth in Leeds:

Between 1st November 2023 - end of October 2024, **19.2% of new registrations** (total registrations were 2,237) **were from ethnically diverse service users.**

- **6.2% Asian / Asian British**
- **6% Mixed Ethnicity**
- **4.6% Black & Black British**
- **2.4% Other ethnic groups**
- **5.7% non-stated**

Kooth adapts their engagement and involvement approach to support health inequalities work and seldom heard groups. Health inequalities and Core20+5 is something they always consider and focus on in their engagement work.

For example:

- In relation to schools, they always make sure they are reaching out to those in more deprived areas or with a high percentage of free school meals.
- In recognition that young Muslims are more likely than young people of other faiths to struggle with their mental health due to factors like Islamophobia and stigmas around mental health, Kooth released a brand-new series of articles on kooth.com to support young Muslims, all of which were co-created with a group of young Muslims.
- Kooth hold Talks (webinars / training for professionals and parents / carers) and Kooth Klass (sessions for children and young people) throughout the year on a range of themes such as: Breaking the Mental Health Stigma in the Muslim Community and Why supporting diverse and seldom-heard students is more important than ever.

'Time for Young People, Leeds'

'Time for Young People Leeds' is a new service designed to deliver community-based early emotional and mental health support for children and young people in Leeds, with a particular focus on children and young people aged 11-25 who need support outside of school or NHS services settings.

'Time for Young People, Leeds' is available for children and young adults up to 18 years old, including care leavers and young people with special educational needs and disabilities up to age 25, as well as their parents and carers.

Time for Young People, Leeds, offers evidence-based therapeutic services for a range of common mental health difficulties, including mild to moderate anxiety and depression. These include weekly wellbeing drop ins, one-to-one structured support, group work, wellbeing resources and information, awareness raising and education, and support for professionals working with young people.

Time For Young People Leeds commits to reducing health inequality, through community engagement, while empowering individuals and communities, ensuring that interventions are culturally appropriate, and addressing both the medical and social determinants of health through proactive systems change lens. The service focus is to progress toward closing the gap in health disparities and building healthier, more inclusive communities.

The current top five themes being shared by children and young people accessing the service are: **anxiety, anger, stress, trauma, and sleep.**

Night OWLS

Night OWLS is an overnight listening service which covers the whole of West Yorkshire, including Leeds. It forms part of NHS England's Long-Term Plan, which says that by 2023/24 every single area in England will have a 24 hour, 7 days a week age-appropriate crisis service for children and young people. Night OWLS has been running for over three years now.

Night OWLS aims to offer emotional health and wellbeing support and strategies, and is open to children of any age, young people, and parents/carers. Night OWLS works collaboratively with services in local areas, to offer support as close to home as possible and proactively sign posts into local areas.

Night OWLS embraces the Leeds Survivor-Led Crisis Services ethos, to support children, young people and parents/carers using the Carl Rogers, person centred approach combined with a trauma informed approach.

Over the last six months they have provided emotional support to a small number of children (2%) aged between 5 and 11 who have approached the service.

The Culturally Diverse Groups (CDG) that have been supported by Night OWLS over the last 12 months are:

- Mixed Black/White Caribbean
- Mixed Black/White African
- Mixed Asian/White
- Asian Indian
- Asian Pakistani
- Black Caribbean
- Black African
- Chinese

CDGs are under- represented in relation to using the service and the aim is to encourage more children, young people, parents / carers to reach out and use Night OWLS.

The top five themes being shared by CDG are: anxiety/fear, depression, family issues, lack of support and emotional pain.

#BlackBoyJoy

GIPSIL, a voluntary sector organisation in Leeds was formed in 1992 as “Gipton Supported Independent Living”. GIPSIL works with children, young people, and families in Leeds to realise their potential.

GIPSIL recognised that young people from culturally diverse communities in the most deprived areas of Leeds were disproportionately accessing Social Emotional and Mental Health Support (SEMH) across all GIPSIL services from school-based to outreach provision.

Subsequently GIPSIL began working with Marvina Newton and Black Lives Matter Leeds in 2022 to build on the Speak Up Leeds, Black Boy Joy insight work that had taken place at Carr Manor School. Together, they developed a programme that could be taken to schools across Leeds that provided a platform for Black boys.

Since 2022 they have delivered six groups at Allerton High School, two groups at Co-op Academy Leeds and are starting to work with Leeds City College. During this time, they have also worked with a group of 17-year-old care-leavers and unaccompanied asylum seekers in their supported accommodation.

From February 2024, GIPSIL have been working closely with the school’s senior leaders, identified black allies across the staff team, as well as community leaders, parents, and Black boys, to co-produce and deliver #BlackBoyJoy #SpeakUpLeeds in Co-op Academy Leeds.

The programme aims to empower young black and ethnically diverse students by addressing racial trauma and fostering resilience through creative expression and systemic change. The project utilises a holistic approach, engaging students, educators, and the wider community to co-create a more inclusive and supportive school environment.

Their vision is to create an environment where Black boys can thrive, express their identities, and experience unmitigated joy and success. Their mission is to advance racial equity and build resilience by providing culturally responsive education, mentorship, and community support.

The programme included various co-production sessions with Co-op Academy Leeds. including a workshop with senior leaders, an assembly with 80 black boys, a co-production session with teaching and pastoral staff, identified black allies and a community and parents evening with a presentation, conversations, and cultural food.

Cancer

Prostate Awareness

The North East and Yorkshire region has the highest percentage (20.1%) of men in England who are diagnosed with prostate cancer too late to be cured.

Statistically Black men are twice as likely as those from other ethnicities to be diagnosed with prostate cancer in their lifetime, with one in four black men affected.

Despite this increased risk, work carried out by Unique Improvements on behalf of the Leeds Cancer Population Board showed that awareness of symptoms remains patchy within the black community, and that black men are more likely to be diagnosed with the disease at a later stage and to die of it as a result.

To help tackle this inequality the Cancer Population Board provided additional funding to Unique to help to tackle the barriers to early diagnosis for black men.

As early diagnosis is reliant on primary care, the first stage of the work was to carry out focus groups and insight gathering with the target populations, which shaped the content of a series of webinars for clinical and non-clinical GP staff held in November 2024. These webinars sought to describe the barriers to men accessing GP services when they had symptoms or they were worried about their risk of prostate cancer, and to identify ways in which these barriers could be overcome. For instance, by offering different routes to accessing primary care, by increasing cultural awareness of staff and by myth-busting in relation to diagnostic and treatment pathways.

Following on from this work there is a plan to present findings at GP TARGET events (training events for GPs) in the New Year and then to run a public awareness raising campaign (working title ‘love your prostate’)

Prior to commencing the public campaign there will be engagement to better understand the lived experience of men coming forward for diagnosis, to test existing materials and to provide case studies to support the campaign.

The campaign will take place in Wortley, Armley, Belle Isle and Middleton, and Chapeltown and Harehills. These areas have been selected due to their diverse populations and due to their

differing levels of involvement in previous prostate awareness work, enabling the board to have a clearer idea as to which approaches work best in which circumstances

Complex Needs

Complex Needs - Leeds Small Supports

More than 2,000 people with learning disabilities and/or autism are in inpatient units in England, according to NHS figures.

The Transforming Care programme aims to improve the lives of children, young people, and adults with a learning disability and/or autism who display behaviours that challenge, including those with a mental health condition.

In Leeds we have been creative in identifying bespoke solutions to address this need. Over the last couple of years, we have worked with Leeds City Council to develop small support organisations, creating change in the local market with a new way of commissioning.

The purpose of this model is to provide support to people with a learning disability and autistic people who have experienced long stays in mental health hospital, through a service designed around the person, enabling them to live a healthy and fulfilling life outside of a hospital setting.

Human rights, equality, diversity, and inclusion are the foundation of small supports and as such the organisations stick with the person through good times and difficult times; they build trusting, respectful and reliable relationships with the person they support and with each other.

What are Small Supports?

Small Supports organisations provide support through a service designed around an individual. This bespoke support enables people to have their health needs met as well as their wants and wishes fulfilled.

From the first steps the person (and their chosen family and friends) has as much control as possible and there is a commitment to this control growing.

The starting point to developing great support is the person's aspirations about where they want to live and the life they want to have; conversation about support then follows from this.

Supporters (staff) are recruited by and around the individual. They don't work across services. Staff are not a substitute for friends, community peers, co-workers, and neighbours.

People choose where they live and who, if anyone, they live with. People are the tenant or owner of their own home or perhaps live with family. There is a clear separation of housing and support.

Funding is sustainable and is designed and used around the individual.

Small supports organisations stay with people. Change and challenges are expected so they don't withdraw support or 'sell' services on.

In their work, leadership, recruitment and actions, small supports organisations are rooted in their local community.

The organisations stay relatively small. Knowing each person well means not growing by more than three to five people a year and finding a natural size where people are known and valued, and the organisation is financially sustainable.

Small supports organisations are developed around these practices. Taking some of these practices and making them aspirations within large, segregated services will not deliver the desired outcomes.

The link below is to a film tells the story of Mark, who was supported by Leeds small support provider, Unique Support Solutions, to return to community to live a rich and fulfilling life after many years in hospital.

NHS England » Homes not hospitals

Long Term Conditions

Access to dementia diagnosis

NHS England monitors dementia diagnosis rates for all NHS Integrated Care Boards and areas. Using this information, our work in Leeds includes an annual check on whether the population diagnosed with dementia reflects the ethnic diversity of the Leeds older population.

We also have a contract with Touchstone Leeds, a voluntary sector organisation, which includes the co-ordination of the Leeds Black and Minority Ethnic (BME) Dementia Forum, and dedicated support to people and carers of diverse south Asian origins.

Since this community-focused work started in 2012, Leeds has seen more ethnically diverse people diagnosed with dementia. The diagnosis rate did reduce during the COVID pandemic, however our monitoring shows that the increase in the diagnosis rate since 2021 has included people from diverse ethnicities across Leeds.

A level of variation expected in relation to dementia diagnosis, because some ethnically diverse populations are younger, when compared the White population and because health inequalities affect dementia prevalence across different population groups.

Ethnicity data, following work that took place during 2023/24 shows that Leeds has improved the coding of ethnicity in primary care, with fewer 'unknown / not stated'

The data we have does show that people of Chinese origins are one of the population groups perhaps underrepresented in the diagnosed population.

The Memory Support Workers (Alzheimers Society service, commissioned by the ICB in Leeds and Leeds and York Partnership NHS Foundation Trust) report significant progress with the "Lychee Red" Chinese Elders' group, which meets at Beeston Village Community Centre.

There are now local service leaflets translated into Hong Kong Chinese, and one of the Memory Support Workers has attended several meetings and presented in both English and Chinese with one of the group volunteers translating.

Frailty - Injuries and falls

Our injuries and falls programme linked to frailty is a priority programme for us in Leeds.

Following a review of data on falls and frailty in the city analysis indicated that falls rates were higher in more deprived areas of Leeds with Armley, York Road, Burmontofts, Harehills and Richmond Hill identified as areas with a high rate of admissions for falls and injuries.

Working with Local Care Partnerships several workshops were held in Armley, York Road and Burmantofts, Harehills and Richmond Hill areas working with local communities with the aim of reducing falls in the older population.

The project has a specific focus on inclusive access to services and social activities in the community; aiming to support older people to feel stronger and more confident and improve health and wellbeing.

The initial focus of the work has been in the Armley, and York Road areas and the programme has brought people and local organisations together within these communities from across the local care partnership including from local third sector organisations, neighbourhood networks, primary care, community health care, adult social care, housing, and local community groups.

This work is ongoing and takes a life course approach and will report in Spring 2025 with several areas identified for more targeted work and support, including:

- Supporting increased access to transport to attend falls, strength and balance classes, activity programmes and local lunch and social clubs.
- Increase number of/and access to reviews of medication and bone health assessment.
- Increase menopause education and awareness - impact on bone health
- Support around have better access to funding for housing adaptations:
- Increase awareness and support around alcohol harm reduction and hoarding.
- Work together to provide more consistent pathways of support from hospital to community
- Increased awareness of falls pathways within primary and community care.
- Improved support to care homes - a trial of care home risk assessment guidelines is underway which will inform the development of a standard training offer to care homes to support falls risk assessment, prevention and management.

Further work with people with lived experience and the local community is planned to inform a more targeted approach within these communities to inform an implementation plan during 2024/25.

Pulmonary Rehabilitation and Cardiac Rehabilitation Reducing Health Inequalities

Our programme of work supports the West Yorkshire approach to long term health conditions and personalised care. The robust partnership working arrangements between Leeds Community Healthcare NHS Trust (LCH) and Active Leeds, hosted by Leeds City Council, has enabled both a home exercise programme and targeted community programme to actively promote that people can remain as independent as possible with access to a menu of personalised interventions, which includes knowledge, skills, and confidence to help manage their needs/ symptoms more effectively.

Work that has been in development over the last two years has focused on reducing health inequalities and aligns with the Leeds city's ambition where, "Leeds will be a healthy and caring city for all ages where people who are the poorest improve their health the fastest."

This ambition is outlined in the Healthy Leeds Plan and these programmes align with Goal 1: "preventable unplanned care utilisation across health settings."

Pulmonary Rehabilitation

LCH have an established Pulmonary Rehabilitation (PR) programme run by specialist healthcare professionals. Classes are currently held at four venues across the city and have a virtual offer of PR for those patients unable to access the venues and promote self-management by promoting the use of the MYCOPD app.

Active Leeds works with LCH and jointly delivers Pulmonary Rehabilitation with the Physiotherapy Team in four venues across Leeds. In addition, Active Leeds offers free structured lower-level intervention classes (Targeted Community Programme) via a health coaching programme across eight leisure centres in Leeds with a wide menu of activities across local communities.

The Targeted Community Programme is delivered in areas where there are gaps in provision across the city. In some circumstances, the gaps are in areas of high deprivation in areas such as Beeston, Bramley, Chapeltown and Seacroft.

By delivering activities in these areas and where possible ensuring they are culturally sensitive, this will improve access to people with those communities, especially those from underrepresented populations such as those from diverse cultural backgrounds and females.

Cardiac Rehabilitation

Our programme of work aims to increase uptake and accessibility to cardiac rehabilitation in Leeds, striving towards the 85% target set by NHS England.

Home Exercise Programme (HEP)

Active Leeds became involved in this piece of work, early 2024. An Active Leeds Exercise Specialist delivers a HEP two days per week as a part of their duties. LCH have trained two staff from Active Leeds to deliver home visits as a part of HEP. There currently have been 131 patients seen at home by the Active Leeds Team. This has increased the capacity of the Physiotherapists to work on more complex patients. From those patients visited by Active Leeds 32 have built their confidence to start the 12-week activity programme delivered in Active Leeds venues and another 5 have started the Active Leeds Strength and Balance Programme as a part of their rehabilitation.

Cardiac rehabilitation is also part of the Targeted Community Programme. There are parts of the city where there are gaps in provision especially in the more deprived communities and there has been much collaboration with system partners to further understand how interventions can be offered to address people's needs. Areas include Beeston, Bramley, Seacroft and Chapeltown as with PR. There is also a Wharfedale Cardiac Club (peer support group) run by people with lived experience with a system partnership approach to share knowledge and learning.

The Home Exercise Programme provides people who are unable to get out of their homes or with mobility issues to access cardiac rehabilitation in their own home. This is a city wider offer but provides a service to those with the greatest need that otherwise would be excluded from any face-to-face offer.

Data for both the heart and lung programme 12-week programme over the last five months shows:

- Just under 400 people have been part of the programmes
- Double the number of men have participated in the programmes compared to women
- The programmes are most popular with people in the 65-74 age group.

The Targeted Community Programme is aiming to improve and increase access from underrepresented populations and will continue to do this as the programme develops in the areas highlighted. Furthermore, interventions have shown that there is a growing number of people receiving interventions in IMD areas 1 and 2.

Overall, the benefits for both the PR and CR programmes, creates more capacity within the Leeds Community Healthcare Physiotherapy Team to focus their work on more complex and complicated patients who would otherwise have a much longer wait to be seen, improving the outcome for the patient. There is also an opportunity to share learning (have access to shared records and other joint resources) across the services and to be fed into the Leeds/ West Yorkshire Health and Care Partnership and learning shared nationally.

The programmes continue to develop the targeted community offers that are co-produced with local communities and voluntary sector to ensure the activities support local people and are culturally sensitive.

For further information regarding impact, please see Current evaluation for the service –

Healthy Adults

Basis Leeds

Basis Yorkshire, based in Leeds, is a specialised organisation that provides outreach support women and non-binary individuals working in the sex industry. The organisation's primary goal is to empower these individuals to make safer and healthier choices by offering information, support, and options, and advocacy.

Key Services and Approaches

Support Services: Basis Yorkshire offers safety information and support to female and trans+ sex workers in Leeds, as well as girls and young women experiencing sexual exploitation.

Health Services: They provide advocacy and access to sexual health services, as well as support for physical and mental health needs.

Housing Assistance: The organisation supports service users with housing-related issues by connecting them with the relevant housing services.

Training and Education: Basis Yorkshire produces educational materials and offers accredited training, workshops, and events for professionals working in related fields.

Impact on Service Users

The impact of Basis Yorkshire on its service users is multifaceted:

- **Empowerment:** By providing information and support, Basis Yorkshire empowers individuals to make safer and healthier choices
- **Stigma Reduction:** The organisation works to challenge stigma and inequality of access to services for all their service users.
- **Advocacy:** Basis Yorkshire advocates for women's right to work more safely, while also supporting those who are sexually exploited to be safer and free from harm.
- **Tailored Support:** Their services are designed and delivered in close collaboration with the women and young people they serve, ensuring that their voices and experiences are at the centre of their work.
- **Holistic Care:** By addressing all aspects of their service users' lives - from sexual health to housing and mental wellbeing - Basis Yorkshire provides comprehensive support.
- **Safety Enhancement**: Through their work, they aim to create a safer environment for sex workers and those at risk of sexual exploitation

By focusing on these areas, Basis Yorkshire strives to make a significant positive impact on the lives of vulnerable individuals in Leeds, helping them to navigate challenges, access necessary services, and work towards safer and healthier futures.

Solace Leeds

Solace is a Leeds-based charity that provides specialised and tailored support and services to refugees and asylum seekers in Leeds (and Yorkshire). Their work focuses on improving the mental health and wellbeing of individuals who have often experienced trauma, persecution, and exile.

Key Services:

Therapeutic Support: Solace offers a range of therapies, including:

- Individual psychotherapy
- Group stress management sessions
- Pain management programs
- Family therapy

Cross-Cultural Approach: Their therapeutic work is cross-cultural and often involves the use of interpreters to ensure effective communication,

Expertise Sharing: Solace has developed e-learning courses to share their knowledge with professionals working with refugees and asylum seekers across the UK.

Impact on Service Users

- **Mental Health Improvement:** Solace provides over 3,000 hours of therapy to more than 250 people annually, helping alleviate suffering and improve emotional wellbeing
- **Empowerment:** Their services empower clients to navigate the challenges of adapting to a new cultural context while dealing with the UK asylum process
- **Reduced Isolation:** During challenging times like the COVID-19 pandemic, Solace's support has been described as a "lifeline" for many clients, helping to combat feelings of isolation and abandonment.
- **Increased Understanding:** Solace's work helps clients better understand their situations and rights, reducing anxiety stemming from lack of information or language barriers.
- **Wider Impact**: Through their e-learning initiatives, Solace has reached over 1,700 professionals across various sectors, enhancing the capacity of other organisations to support refugees and asylum seekers effectively.
- **Advocacy**: Solace advocates for their clients' needs, including supporting with housing and welfare appeal processes when necessary.

By providing these comprehensive services, Solace plays a crucial role in supporting some of the most vulnerable individuals in society, helping them to heal from past traumas and build more stable lives in their new communities.

The West Yorkshire Community Chaplaincy Project (WYCCP):

WYCCP is an organisation that focuses on supporting individuals who have been in prison, aiming to support them as they transition back into the community and addressing the other factors that impact on health inequalities.

Services Provided

Mentoring and Resettlement Support: WYCCP offers mentoring and resettlement support for people leaving prison and their families.

Transition Assistance: The team acts as a "scaffolding" that supports service users through the transition from prison to stability in the community. This support can be adjusted based on the individual's progress or problems.

Practical Help: Community chaplains assist ex-offenders with various practical needs, including:

- Securing accommodation
- Managing money
- Obtaining benefits
- Accessing foodbank vouchers
- Acquiring furniture and clothing
- Accompanying them to appointments

Impact on Service Users

- **Addressing Immediate Needs:** WYCCP helps address pressing concerns of ex-offenders, such as housing, mental health issues, and substance abuse problems, access to primary care services.
- **Preventing Re-offending:** By providing comprehensive support, the project aims to prevent re-offending and help ex-offenders reintegrate into society
- **Emotional Support:** Community chaplains offer crucial emotional support during the challenging transition period from prison to community life.
- **Holistic Approach:** The project takes a holistic approach to supporting ex-offenders, addressing various aspects of their lives to promote successful reintegration.

In summary, the West Yorkshire Community Chaplaincy Project provides crucial support to ex-offenders, helping them navigate the challenges of reintegrating into society and working towards reducing recidivism through practical assistance, mentoring, and emotional support.

Leeds GATE

Leeds GATE (Gypsy and Traveller Exchange) is an organisation that provides targeted support for the mental health and wellbeing of Gypsy and Traveller communities in Leeds and West Yorkshire.

Key Services

Mental Health Support:

- One-to-one targeted mental health support
- Caseload management for individuals with mental health needs
- Expanded services to cover West Yorkshire with support from the West Yorkshire Integrated Care Board

Holistic Approach:

- Address various aspects of wellbeing, including practical needs like accommodation and benefits
- Offer emotional support and advocacy
- Provide spaces for community members to share skills and build confidence

Cultural Competence:

- Services designed by and for Gypsy and Traveller communities
- Staff with lived experience of the community, enhancing trust and engagement

Impact on Service Users

- **Improved Mental Health:** The targeted support has helps community members manage and recover from mild to moderate mental health issues.
- **Increased Awareness:** Work has been done to reduce stigma around mental health within the community and increase understanding of available support.
- **Enhanced Access**: By providing culturally competent services, Leeds GATE has improved access to mental health support for a community that often faces barriers to mainstream services.
- **Holistic Support:** Addressing various aspects of wellbeing has helped service users manage multiple challenges simultaneously.
- **Community Trust:** The use of staff from the community has built trust and encouraged more people to seek help.
- **Expanded Reach:** The extension of services across West Yorkshire has allowed more community members to access support.
- **Visibility of Issues:** The project has helped make the mental health challenges faced by Gypsy and Traveller communities more visible to the ICB and wider region.
- **Hope and Compassion:** Service users have reported feeling a sense of hope and experiencing compassion, which are crucial for engagement and recovery.
- **System Change**: Leeds GATE's work is not only supporting individuals but also working to change systems to better serve Gypsy and Traveller communities in the long term.

Leeds GATE's work in health and wellbeing is addressing critical needs within a community that faces significant health inequalities. Their culturally sensitive approach and focus on both individual

support and systemic change are having a meaningful impact on the mental health and overall wellbeing of Gypsy and Traveller communities in the region.

Mental Health

Transformation of Community Mental Health Services

As we continue the Transformation of Community Mental Health services, equality diversity and inclusion continue to be at the heart of all considerations across the whole Mental Health programme. Some recent examples include:

- Transformation has seen the emergence of Community Mental Health hubs. These hubs aim to enable access close to people's communities, they are aligned to local care partnerships (LCPs) and are designed to meet bespoke local population needs. Targeted new investment into Voluntary, Community and Social Enterprise (VCSE) organisations, and particularly grassroots organisations/groups, has been an underpinning strategic investment approach to reaching previously underserved communities. This approach aims to improve provision of bespoke and culturally competent care and support offers within communities, to improve equalities in access, experience, and outcomes.
- Leeds Community Foundation and Forum Central have partnered with the ICB in Leeds to deliver the Transforming Mental Health Grants programme, engaging local Community Organisations in Leeds. Guidance to underpin the delivery and targeting of the transformation grants funding has been developed. This has been directly informed through lived experience involvement and activity, and engagement with 109 third sector organisations/ community groups in Leeds to understand how we can better serve people within the scope of Community Mental Health Transformation. People with lived experience have additionally been directly involved in the decision-making process and represented through the grants award process as panel members. At a celebration event stakeholders heard the immense impact on people with complex needs through strengths-based approaches - this will be captured through the end of grant reports, a toolkit for organisations and a film.
- People with complex and enduring mental health need are one of the plus groups within the national Core20PLUS5 programme to reduce health inequalities. Improving access to Physical health checks is one of the identified clinical areas within the Core20PLUS5 programme that require accelerated improvement and is also a key requirement within the community mental health transformation programme. This is in response to the significant inequality of premature mortality for people with serious mental illness. Leeds continues to perform well on the NHS England requirement. We have increased and tested more targeted support for those not accessing physical health checks, including introducing pilots of primary care-based roles and outreach provision. We have undertaken an evaluation of the pilots tested which concluded key recommendations for targeting resources to areas with higher population cohorts with severe mental illness, utilising a range of personalised communication and contact methods, longer appointment times, and ensuring tailored approaches to health checks including availability of home visiting options. These will be taken forward in further mobilising the new model of care.

SYSTEM FLOW

High Intensity Use Service (BARCA Outreach Support Team)

Barca Outreach Support Team (BOST) started in November 2015 to support people who are having frequent contact and presentations to urgent and emergency healthcare services. The team works with people who are 'high users' to identify the impetus behind their attendances and to support them with these aspects. BOST use a navigator model, providing flexible, intensive support.

The main aim of the service is to support and improve the wellbeing of these identified individuals, working with them to create a parity between the self-management of their physical and mental health needs. The majority of people supported by the service live within the most deprived parts of our city.

Navigators visit people in their home or in the community where they may feel most comfortable exploring the underlying reasons behind their frequent emergency visits. This assessment aims to explore the biopsychosocial aspects such as living environment, social isolation, financial situation, substance misuse or unmanaged mental or physical health, which may be contributing to their frequent use of service.

This approach helps to strengthen and build a therapeutic support relationship, providing a trauma-informed response to the person's needs. This is particularly important when working with people who may have been supported by several different services and organisations during their lives and can sometimes feel let down by the support that they have previously been offered.

Taking the time to focus on establishing and building trust in the support provided is a vital element of the BOST model.

The team ensure that the focus of support is not always on the challenges that people may be experiencing, but also on wellbeing and enjoyment. This is an important aspect in broadening the person's identity and developing the therapeutic support.

Developing a person's health literacy is a crucial part of the team's work. Using a strengths-based practice they support people to self-manage care of their physical and mental health, educating about the health and social care system helping them to navigate and engage with appropriate primary and secondary health care services, and discuss other specialist providers and organisations in Leeds.

With the consent of the individual, BOST then works with them and other relevant organisations across Leeds to support any identified unmet needs. This includes services such as: primary and secondary care, addiction services, community mental health support, housing support, welfare and benefits services, support for people who are sex working, peer support and other groups to reduce social isolation, and other specialist organisations.

Equality, diversity and inclusion and our Primary Care Team

Our primary care team continue to promote EDI, health inclusion and initiatives.

People with a hearing loss or impairment:

Our primary care team have continued to work with the DEAForum to understand what changes they would like to see put in place in GP practices to improve their experience of engaging with primary care services. We are also working with BID Services to better understand the needs of and provide support to Deaf patients.

BID is a voluntary sector organisation that provides a range of specialist services for Leeds residents who are d/Deaf, hard of hearing, sight impaired, severely sight impaired or deafblind and their family/ carers.

In order to effect positive change, we:

- have streamlined the scheduled booking services provided by Language Empire making booking an interpreter easier for practice staff. This has included raising awareness of the services available.
- are developing NHS App training with BSL interpretation

Translation and Interpretation

The commissioning of interpretation services within primary care (GP Practices) has been identified as an opportunity to collaborate at scale across places at West Yorkshire to reduce duplication, maximise funding and provide consistency.

The identified benefits of this include:

- Demonstrates joint commissioning across West Yorkshire – potentially paving the way for further collaboration of services/with other providers
- Opportunity to collectively improve service provision and address patient and provider feedback re service delivery
- Fewer providers to access on behalf of their patients
- Reduce duplication in service provision
- Provides opportunity for working at scale
- Provides opportunity to access wider range of providers

Over the last year primary care commissioning, contracting, communication and engagement colleagues have worked together to explore and progress a joint procurement of interpretation services.

Involvement and Engagement Leads across all places produced an insight report pulling together an understanding of the experiences, needs and preferences of patients and carers accessing interpretation services across West Yorkshire. A West Yorkshire wide Equality Impact Assessment

was also completed. Both documents were used to heavily influence the development of the service specification and evaluation questions that have been used in the procurement.

In addition, input into the service specification and evaluation questions was received from clinicians, Health Improvement and the West Yorkshire Healthwatch colleagues who have all provided valued feedback which to further shape the service specification. This involvement will continue throughout the procurement process and mobilisation.

The tender closes on 11 November and the new provider of services will be awarded the contract in January ahead of go-live on 1 April 2025.

Adaptive Action Workshop (Healthy Communities Together) (HCT)) Accessing Interpreting and Translation services in Primary Care.

The workshop focused on the needs of asylum seekers and refugees who experience some of the most severe health inequalities and therefore the poorest health outcomes long term.

The session aimed to take a whole systems view, to see where the strongest partnerships can be formed and make lasting change. The purpose of the session was to explore the experiences of different stakeholders in accessing interpreting and translation services in a primary care setting and to gain a greater understanding about the issues being faced by our communities, with a view to how we can commission and deploy language support more effectively.

Extended Access

GP practices are required to deliver services during their core hours of 8.00am– 6.30pm Monday to Friday. From 1st October 2022, Primary Care Networks were required to deliver an Enhanced Access Service over and above core hours. At minimum a PCN must provide enhanced access between the hours of 6.30pm and 8pm Mondays to Fridays and between 9am and 5pm on Saturdays. The Practices work together to provide a wide variety of services. This Enhanced Access offer contributes to the improvement of patient access to primary care.

In Leeds 16 of our 19 PCNs continue to sub-contract the Enhanced Access service to the Leeds GP Confederation. Three PCNs provide this service themselves. These services are tailored to population need and offer a combination of virtual and face to face services.

Each PCN also offer a proportion of planned and same day service responses as part of this access model. PCNs deliver services working in collaboration with providers including Physiotherapy, Mental Health, Medicine Optimisation, Social Prescribing to review and hone their models of service to meet health needs of their population.

Advancement in service provision ensures the PCNs work with the Leeds GP Confederation to provide proactive care preventative care. This includes offering NHS Health Checks, the successful integration of Cervical Screening in 17 PCNs and LARC (Long-Acting Reversible

Contraception) to service models in 11 PCNs. In addition, childhood vaccination and immunisations have been piloted in one PCN.

This recognises that members of the population cannot always attend for preventative and screening care during traditional core hours and opens a wider menu of choice to enable attendance opportunities.

Working with refugees, asylum seekers and migrant communities

Our primary care team work closely with colleagues in Leeds City Council to support families residing in hotels following their arrival in the UK. During 2024/25 this work has continued, and the following information provides an update on the services being implemented throughout the year

In relation to the Interim Hotel Accommodation Service, Bevan Healthcare continue to provide bespoke health services to individuals and families residing hotels following their arrival in the UK.

In respect of mental health and wellbeing, Solace, who provide free counselling, psychotherapy and advocacy in the Yorkshire and Humber region to the survivors of persecution and exile, provides 1:1 intervention and family interventions and a range of services through 2 practitioners within the hotels, including group sessions, gender specific groups and individual support.

Solace also developed additional support materials, for example, audio and video tools to offer direct support to individuals and families in managing stress and other low level mental health issues and translated audio and video psycho education tools for refugees and asylum seekers who arrive in Leeds and West Yorkshire.

WYICB is in the process of completing mapping exercise of current mental health provision for asylum seekers and refugees across all places, to facilitate improvements in meeting the mental health and wellbeing needs of vulnerable migrants, and to understand what support or additionality could be provided by West Yorkshire Inclusion Health Unit.

The mapping exercise aim to improve the promotion of good mental health and wellbeing, prevention of mental health issues occurring as well as putting in place interventions for those requiring more specialist support for their mental health.

General Practice Outcomes Programme

Across Leeds we have a local enhanced service entitled “General Practice Outcomes Programme (GPOP) which aims to deliver specific outcomes for our populations. Our GPOP contributes to our work in relation to health inclusion.

Our Primary Care Health Inequalities Scheme (now included in General Practice Outcomes Programme (GPOP) has improvement targets for all practices:

- Smoking - Record Smoking Status

- Smoking – Offer Brief Advice
- Smoking – Refer to Stop Smoking Service
- Alcohol – Increased number of AUDIT-C Screening.
- Alcohol – Offer Brief Advice
- Increase Number of Carers Registered
- Record Ethnicity of 95% of Registered Patients
- Record First Language of 95% of Registered Patients

Safer Surgeries

Safe Surgeries aim to remove barriers faced by many in relation to accessing healthcare and ensure inclusive general practice for communities.

We have asked all practices to be signed up to Safer Surgeries by April 2025.

Our current position is:

- 66 Practices have signed up Safer Surgeries and we are aiming for all practices to be signed up by the end of the 24-25 year.
- 100% of PCNs across Leeds have at least one practice that is accredited by the Royal College of General Practitioners to be Veteran Friendly
- Overall, 60% practices who are veteran friendly
- 24 Practices noted as Pride in Practice accredited on the Pride in Practice Website

Cervical Screening

With the aim of improving cervical screening across all the diverse communities in Leeds, cervical screening letters have been translated (audio and written) into several languages. These include Romanian, Polish, Urdu, Portuguese, Arabic, Tigrinya, Kurdish, Punjabi, Bengali, Czech, French, Spanish, Lithuanian, Italian, Slovak and the BSL video with English subtitles.

Gypsy, Traveller, Roma communities

Following merger of Fountain Medical Centre and Morley Health Centre we are carrying out a mapping exercise to ensure patients still have choice in relation to registering with a GP practice and to ensure that there is equity of access for the traveller community in that area.

Accessible Information Standard (AIS) and Reasonable Adjustments (RA) Digital Flag

Our Data Quality Team are working on clinical system templates for AIS, RA and Digital Inclusion, to make them more user-friendly for Practice staff, to include flagging, pop-ups, reporting for review communication preferences, referral letters etc.

In early 2025, NHS England is launching a refreshed version of Accessible Information Standard (AIS). Along with this, they are introducing a self-assessment framework to help organisations

evaluate their progress and plan improvement regarding AIS. Leeds has been selected as a pilot area, giving a unique opportunity to test this framework and provide feedback on its effectiveness.

Healthwatch Leeds is leading on the project to review, input and offer feedback on the framework. Colleagues across the ICB in Leeds, along with other stakeholders in Leeds, has been invited to take part in the pilot project for the AIS Self-Assessment Framework.

Primary Care Network (PCN) Projects

All PCNs continue to work on various schemes and projects to improve equality, diversity, and inclusion.

The following information provides a brief overview of the work in Burmantofts, Harehills and Richmond Hill (BHR) PCN as an example of multiple projects that are taking place:

- **Severe Mental Illness (SMI)-** working in collaboration with Touchstone and the recovery team from LYFPT we provide a gym session twice week dedicated to SMI patients only.
- **Physical Health Checks** - all practices continue to prioritise physical health checks for people with a learning disability and people with SMI with continued improvement in the overall number of checks undertaken.
- **SMI non-engagers** - the Population Health Management Hub (HPMH) Team provide an outreach service for SMI annual reviews. For patients not engaging we will do a home visit to check contact details and if patient consents, we do an annual review. If no answer, then a letter is left asking patients to contact practice to make an appointment and update contact details.
- **Public Health Mental Health Team -** run and/or attend community events/venues, for example women's health events, Bevan asylum seeker monthly events and provide hypertension case finding. The team also run hypertension educational sessions

Equality, diversity and inclusion and our NHS Continuing Care Service

Choice and Equity Commissioning Policy Improving our Approach to Best Value Care

The All Age Continuing Care Service (AACC) service has a statutory duty to break-even financially. Therefore, when making decisions about commissioning services, it must balance a range of factors including individual choice and preferences, quality, safety, and value for money.

Throughout this process, the service must recognise the need to achieve best value in its use of financial resources, in order that it can share limited NHS resources equitably across all patients for whom it has commissioning responsibility. It can do this through carefully considering the offer that is made available to each person.

The Choice and Equity Commissioning Policy when used with the Commissioning Principles aims to support the AACC Services in each of the five places of the West Yorkshire ICB to deliver fair and efficient use of public money and to support places to commission safe, affordable, and high-quality local provision working with partners across the ICB and the local authority.

In addition, it will assist in ensuring that the information we provide is clear, accessible, and up to date, that staff have clear direction, policies and standards underpinning the service and the service has robust governance arrangements.

Of key importance is that all people being assessed receive equitable and comparable, high quality, consistent experience regardless of their age, sex, ethnicity, gender identity, religion or belief, sexual orientation, or disability.

The underpinning commissioning principles which will be used by staff and published on our website with translation available in multiple languages. An Easy Read version is in development for the New Year.

Key indicators are being developed by the ICB to ensure that the impact of the policy is measurable and equitable across all areas and these measures will form part of the quarterly reporting. In addition to this we are working with system providers to ensure that the equality monitoring is captured at point of referral to enable accurate reporting of key indicators.

Equality, diversity and inclusion and our Medicines Optimisation Team

Stopping the overmedication of people with learning disabilities or autism or both

'STOMP' is an acronym for Stopping over Medication of People with a learning disability, autism, or both with psychotropic medicines. (These are prescribed drugs that affect the mind, emotions, and behaviour by changing how the brain works).

A national health campaign was introduced in 2016 to stop the over-use of psychotropic medication to manage people's behaviour and has been identified as a priority in the NHS long term plan. The STOMP programme aims to improve the quality of life of people with a learning disability (LD) and autism or a learning disability alone by reducing the potential harm of inappropriate psychotropic drugs by having a specific STOMP medication review.

Psychotropic medicines are used to treat mental health conditions. It is estimated that on an average day in England between 30,000 and 35,000 people with a learning disability, autism or both are taking prescribed psychotropic medication without appropriate clinical justification. This is medication which results in alterations to perception, mood or consciousness. Long-term use of these medicines puts people at unnecessary risk of a wide range of side effects including weight gain, organ failure and even premature death.

A six-month pilot which started in August 2024 across two primary care networks (PCN), West Leeds and Seacroft is being collaboratively led by the Leeds and York Partnership NHS

Foundation Trust (LYPFT) Mental Health Pharmacy Team and LYPFT Community Learning Disability Team (CLDT).

The ICB in Leeds is providing medicines optimisation expertise for the project to facilitate integration into primary care. Phase 1 for the PCN pharmacy team will focus on those patients who are currently on a psychotropic drug without a documented indication on their medical record to ensure the appropriateness of the drug. A STOMP template was created on the GP systems for the STOMP review to take place was created and allows pharmacists to send advice guidance to LYPFT requests for further help and advice.

Chronic Kidney Disease (CKD) Project – PCN led approach

Kidney disease does not affect everyone equally in the UK. There is a complex and unequal distribution of risk factors across people's life course and across stages of kidney disease.

Social deprivation, ethnic background, gender, mental health, age, and geography are all factors that affect the risk of developing kidney disease, how the disease progresses, treatments and outcomes. These factors often interact with each other, and it can be difficult to untangle the association between them. The research summary is presented in the infographic (source). These research findings support targeted approaches in population health management of kidney health.

Two of the selected four PCNs include areas of IMD1 (Source). Seacroft and Burmantofts/Harehills/Richmond Hill (BHR) PCNs have Index Multiple Deprivation (IMD) decile score of 1, and where prevalence and or complications of CKD are higher and connect to the ICB's Leeds place-based multimorbidity work.

Reducing unwarranted kidney health inequalities must become everyone's responsibility. To achieve this, clinicians, renal services, the wider renal community in the UK and policymakers need to think disruptively and create their own opportunities to change the system.

This joint working initiative with Astra Zeneca, aims to reduce progression of chronic kidney disease (CKD) and adverse cardiovascular outcomes for people living with CKD (with or without Type 2 diabetes). The pilot project focuses on people living in most deprived areas of Leeds who are culturally diverse, specifically those whose genetic and diet predispose them to higher risks of diabetes, CKD and cardiovascular events, where traditional access to health system is a barrier.

Kidney disease is more likely, progresses faster, and is associated with earlier death amongst people from more deprived backgrounds. It also progresses faster in people from Black, Asian and UK minority ethnic populations, who are also less likely to receive a transplant. Women are more likely to get kidney disease, but men are more likely to start dialysis. Older people are less likely to receive a transplant.

The project recognises the disparities and is trying to address some of these inequalities. It is piloting an integrated approach to care, focusing on delivering better care closer to home.

The aim is to upskill PCN pharmacists and nurses in CKD management, in order to improve diagnosis and self-management, to optimise standard care, including the addition of the SGLT2-inhibitor drug (dapagliflozin). The project team has sourced wide range of information in foreign languages to support the work.

The PCNs are being supported by the PCN diabetes specialist pharmacists, and consultant nephrologist as well as a kidney nurse to help with education, guidelines, and more complex patients.

Optimal Lipid Management

This is one of the five key clinical areas in relation to health inequalities. In 2024, we continued our Soar Beyond project and System Transformation Fund (STF) Lipid Optimisation Project, both of which started in 2023.

The main goal to upskill primary care colleagues to transform lipid optimisation in GP practices and PCNs. Our data suggested that there was a higher proportion of patients with cardiovascular disease (CVD) and non-optimised lipids levels from the most deprived areas compared to the least deprived areas (CVDPrevent, 2022).

CVDPrevent is a national primary care audit that automatically extracts routinely held GP data covering diagnosis and management of six high risk conditions that cause stroke, heart attack and dementia.

In line with the CORE20PLUS5 approach, both projects engaged GP practices and PCNs from Leeds in areas with IMD score of 1.

Soar Beyond project was funded through a successful bid with NHS England's National Lipid Programme Workforce Support. Six PCNs in Leeds were involved (Burmantofts, Harehills and Richmond Hill; Beeston; Middleton and Hunslet; Seacroft; Cross Gates; West Leeds).

The evaluation of this nine-month project was completed by Soar Beyond in August 2024 with following results:

- It increased lipids competencies of the PCN workforce (80% compared to 58% at baseline).
- It improved patient access to clinical pharmacy lipid appointments (343 targeted review appointments per week).
- It alleviated GP pressure in respect of the Addition Roles Reimbursement Scheme (ARRS), which is a program in the NHS that funds new roles in primary care to improve access to general practice. (100% of PCNs had local lipid protocol in place compared to 17% at baseline).
- 100% of PCN adopted national lipid pathway and improved access to new lipid lowering therapies.

The STF Lipid Optimisation Project was another successful bid with NHS England, led by Leeds Place for West Yorkshire ICB between March 2023 to August 2024. An integrated lipid

multidisciplinary team service (primary and secondary care clinicians) was set up by Leeds Teaching Hospitals NHS Trust to support participating PCNs through clinical leadership and a new electronic advice and guidance pathway. In Leeds, the participating PCNs were Burmantofts, Harehills and Richmond Hill; Beeston; Middleton and Hunslet; Seacroft; Bramley, Wortley, and Middleton.

According to CVDPrevent CVDP007CHOL indicator, which measures the percentage of patients with CVD and a blood cholesterol level that meets target in the previous 12 months, for Leeds most deprived area, the percentage of patients with cardiovascular disease (CVD) treated to lipid target increased by 10.79%.

Chronic Obstructive Pulmonary Disease (COPD) Project

COPD is highlighted as a key clinical area in the CORE20PLUS5 approach. We are working with Interface Clinical Services through the donations and grants route via Glaxo Smith Klein Plc. to implement care optimisation in COPD by pharmacist-led COPD clinical reviews across all practices in Leeds (April 2024 to March 2025).

The project targets high-risk COPD patients to help reduce clinical complications or unplanned admissions; to assess and proactively manage patients with COPD through optimisations of pharmacological and non-pharmacological therapies, including referrals to smoking cessation, vaccination and pulmonary rehabilitation programmes.

Leeds Scabies Case Study – Leeds Health Protection

In April 2023, a scabies outbreak was detected in Leeds, particularly affecting families in deprived areas with high health inequality, such as Harehills, Burmantofts, and Richmond Hill.

Primary Care data and surveillance reports confirmed an increase in cases in these areas. A response was coordinated with local partners to overcome barriers related to healthcare access, limited awareness, and socioeconomic challenges. This included:

- Expanding the Leeds minor ailments scheme (Pharmacy First) to include scabies treatment for unregistered patients.
- Coordinating with NHS England and Department of Health and Social Care to address stock shortages.
- Providing training to 51 local professionals to improve community awareness and access to care.
- Sharing communications with local stakeholders, including third-sector organisations, to boost awareness.
- Supporting families with laundry facilities and essentials to help control infection spread.

The team continues to monitor scabies cases, support care homes with treatment guidance, hold regular review meetings, and update primary care prescribing data every six months to ensure

proactive response to potential outbreaks. Additionally, there is a focus on broader pest issues such as bed bugs and head lice, identified as ongoing community concerns.

Equality, diversity and inclusion and our Safeguarding Business Unit

An example of our proactive work in relation to EDI and health inclusion include:

Our Safeguarding Team works together with many organisations across Leeds to contribute to improving outcomes for children, young people, and adults at risk.

This year our Safeguarding Team has supported both the citywide self-neglect and serious youth violence consultations. Including professionals, service users, and their families was a primary focus of the consultations to provide the opportunity to hear the views of all our diverse communities.

Our Safeguarding Team actively promoted the serious youth violence **"share your voice"** consultation, led by the West Yorkshire Violence Reduction Partnership (VRP) across the Leeds health economy.

The consultation included a variety of inclusive approaches to encourage engagement and during the three-month consultation views were sought from people who lived in communities experiencing serious violence, people with lived experience of serious violence including victim and or survivors, and parents and carers, as well as the views front-line staff.

National data shows that black and mixed heritage boys are more likely to acquire a criminal record, have interrupted education training and employment, and potential disruption to the wider family.

The Designated Nurse for Safeguarding Children represents the health economy at the Leeds City Council Serious Violence and Organised Crime Board (SVOC) ensuring health economy engagement. SVOC Board activity this year has included the identification of and strategy planning to address racial disproportionality and serious youth violence in the city.

Additionally, each of the Population Health Boards is linked to a member of the safeguarding team to support the Leeds Health and Wellbeing Strategy ambition for Leeds to be a 'healthy and caring city for all ages, where people who are the poorest improve their health the fastest'.

NHS Equality Delivery System 2022 (EDS22)

The link below provides detailed information about EDS22:

https://www.england.nhs.uk/about/equality/equality-hub/patient-equalities-programme/equality-frameworks-and-information-standards/eds/

Leeds NHS organisations continue to work in partnership in relation to the EDS22 Domain 1: Commissioned or provided services and we continue to provide peer support for Domain 2: Workforce Health and Wellbeing; and Domain 3: Inclusive Leadership.

We use EDS22 across Leeds and the wider West Yorkshire Integrated Care System to:

- Assess our performance in addressing our equality, diversity, and inclusion (EDI) priorities.
- Provide opportunities for stakeholders to analyse our performance data and input into that assessment.
- Assist with identifying our EDI priorities for the future.
- Provide opportunities to work in partnership to deliver and assess those priorities consistently

In relation to Domain 1, which assesses equality performance for commissioned or provided services, WYICB and NHS providers are required to engage, assess, develop, and deliver an improvement plan for three services each.

In 2024 across West Yorkshire, it was agreed each place would take a partnership approach to focus improvements on specific clinical pathways:

- Palliative and End of Life Care
- Cancer (Early Diagnosis)
- Suicide Prevention

In collaboration with Leeds NHS providers, we chose to review services around Palliative and End of Life Care (PEoLC) to:

- Respond to recent findings from local and national patient and carer feedback including West Yorkshire Healthwatch and Parliamentary and Health Service Ombudsman
- Support EDI improvement work with Leeds Palliative Care Network

It should be noted that the EDS22 is a review of a sample of services delivering care within the pathway, not a review of the whole pathway.

Within the PEoLC pathway, the following services have been sampled across Leeds in our EDS22 assessment for 2024:

- Respiratory EoLC (ICB in Leeds)
- Children's Community Nursing (LCH)
- Homeless Health Inclusion Team (LCH)
- Neighbourhood Nights (LCH)
- Cancer Service (LTHT)
- In-hospital Palliative Care Team (LTHT)
- Dementia Wards (LYPFT)
- Care Homes Team (LYPFT)
- LTHT Easy Read material in the Learning Disability Team
- LYPFT Functional Ward

An initial peer review was held in November where we were joined by representatives from Leeds NHS provide trusts, third sector and Leeds Palliative Care Network to review the service-specific self-assessments and to consider previous patient, carer, and community insight alongside provider and population data to identify what is already known about the EDS22 outcomes in PEoLC and what gaps/improvements these identified.

The EDS22 process and scoring so far has evidenced that there are many strengths in the way PEoLC is delivered to marginalised groups at risk of inequity. The peer review identified opportunities for learning across services and partners to embed these strengths more consistently.

The EDS22 process has also helped the NHS in Leeds to identify the several areas for improvement and subsequent actions across the PEoLC pathway. Whilst recognising all the suggested actions are key to addressing the areas for improvement that have been identified, a collective proposal, across the NHS in Leeds, has been reached to prioritise the following actions for 2025:

- Improving data collation and analysis
- Cultural competence, building on the 2023 focus in relation to Children and Young People Mental Health Services and Maternity Services.
- Increasing and using feedback from groups and communities who experience inequalities, barriers to accessing services and are seldom heard.

Leeds NHS organisations are currently undergoing a period of further engagement with partners and communities to identify:

- any other strengths or gaps that groups were aware of
- whether the initial peer review fits with their knowledge of the palliative and PEoLC pathway for groups at risk of inequalities
- what the priority actions should be and how the proposed priorities fit with their work/priorities for the next year
- how we would continue to engage with those groups and coordinate any shared work

Leeds NHS engagement with partners and communities will be completed by the end of January 2025, which will enable us to finalise our priority areas for improvement in relation to PEoLC and subsequently meet the mandatory requirements associated with EDS22. This means we must publish our evidence and priorities/objectives on WYICB website and submit them to NHS England by 28th February 2025.

Committee Escalation and Assurance Report – Alert, Advise, Assure

Report from: Leeds Quality & People's Experience Sub-Committee (QPEC)

Date of meeting: 15 January 2025

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

Date of meeting reported to: 26 February 2025

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:
ICB in Leeds Quality Highlight Report The sub-committee was updated on recent pressures on maternity and neonatal services staff in Leeds. In addition to the services undergoing Care Quality Commission (CQC) inspection in December and January 2025, there had been media interest centred on a number of serious incidences. Leeds Teaching Hospitals NHS Trust (LTHT) staff had been required to correct a number of factual inaccuracies in the journalist's findings. Staff had also provided data and information following a report by the Maternity and Newborn Safety Investigations (MNSI) programme to NHS England (NHSE) which had raised concerns regarding how staffing levels were being reported. As a result of the MNSI intervention, a risk summit would be held by the end of January 2025. The sub-committee was updated on delays in pathology results that had occurred during the recent transfer and new pathology building implementation programme. Concern was expressed regarding the impact of the incident on Primary Care, both in terms of clinical risk and impact on GPs' Quality Outcome Frameworks. Members were assured that, while GPs had been requested to report any significant incidents via a dedicated email address, no significant harms had been identified to date. Assurance was given that incidents were being tracked and uncoded results would be addressed in batches.
Advise:
Leeds System Safeguarding Governance Arrangements The sub-committee received a report detailing the safeguarding arrangements for the WY ICB, the Leeds Safeguarding Children Partnership (LSCP) and the Leeds Safeguarding Adults Board (LSAB). The annual reports of the WY ICB, LSAB and LSCP were also received. The sub-committee was assured of the multi-agency safeguarding arrangements in place for safeguarding children and adults at risk in Leeds and across West Yorkshire. QPEC remained the sub-committee in Leeds with delegated assurance responsibilities for safeguarding, escalating to the Leeds Committee as appropriate.

Independent Review: Action Plan Update
The sub-committee was updated on actions being taken following the independent investigation and recommendations into the care of a young person in Leeds. Progress was noted against most of the recommendation groupings. The sub-committee requested further assurance regarding how well established processes for escalation were for complex needs cases which involved a number of partner organisations. The sub-committee agreed it would continue to receive updates on the action plan at each meeting until all actions had been completed.

Assure:

Care Home Commissioning – Joint Work with ICB to Improve Quality of Care in Residential and Nursing Homes
A Care Home Commissioning report detailing joint work between Leeds City Council (LCC) and the ICB to improve the quality of care in residential and nursing homes was presented to the sub-committee. As of June 2024, 79.9% of care homes were rated by CQC as "Good" or "Outstanding". Overall occupancy was 83% for residential/nursing care homes. There was a recognised need to increase provision specifically for nursing dementia beds and for some higher-level need residents. Members were assured that a coordinated approach to quality improvement (QI), including joint visits and audits, continued to help maintain and improve standards.

The sub-committee noted that financial sustainability remained a concern, particularly for smaller providers or those rated "Requires Improvement" by CQC.

How People's Experiences Have Shaped the HomeFirst Programme
The sub-committee received a report from the HomeFirst Programme. Positive outcomes from the programme included 969 fewer adults being admitted to hospital each year and 573 more people being discharged directly to their homes after their stay in hospital, instead of moving to a bedded setting. The sub-committee was assured of the positive outcomes of the programme, both in terms of staff and patient feedback as well as corresponding Best Value in healthcare.

People's Voice
The sub-committee was presented with a video of Abdul from Harehills speaking positively about his experience of healthcare services in Leeds following a stroke and how his cultural needs were addressed by staff. Members welcomed Abdul's positive comments about the quality of care he received in hospital and his aftercare support via the HomeFirst Programme. Members noted the importance of providing a supportive environment for staff to develop further understanding of cultural beliefs.

Risk Management Report (Leeds Place Risk 2024)
The sub-committee received the Leeds place risk report for risk cycle 4 of 2024/25. Five risks were aligned to the QPEC Sub-Committee and shared with the Leeds Delivery Sub-Committee. While there had been no change to the risk scores, a number of changes had been made to key controls and assurance. All five risks were high scoring 12+ risks.
There was a discussion regarding risk 2024 - risk of not meeting legislative responsibilities in relation to community deprivation of liberty (DoLs) for fully funded

Continuing Healthcare (CHC) cases – which was not aligned to any of the Leeds sub-committees. Assurance was given that the aligning of the risk would be agreed with the WY Mental Health Transformation Programme Lead.

Committee Escalation and Assurance Report – Alert, Advise, Assure

Report from: Leeds Delivery Sub-Committee

Date of meeting: 29 January 2025

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

Date of meeting reported to: 26 February 2025

Report completed by: Harriet Speight, Corporate Governance Manager, WY ICB on behalf of Yasmin Khan, Independent Member and Chair of Delivery Sub-Committee

Key escalation and discussion points from the meeting
Alert:
Proposed Changes to the Leeds Place Sub-Committee Structure from 1st April 2025 The sub-committee was presented with a proposal to move from three to two assurance sub-committees, effectively dissolving the Delivery Sub-Committee and reassigning its responsibilities to the Finance and Best Value Sub-Committee and the Leeds Committee. In summary, it was proposed that the Finance and Best Value Sub-Committee be renamed as the Finance, Value and Performance Sub-Committee and that the new sub-committee should take on performance management assurance responsibilities, and that the Leeds Committee would monitor health inequalities reporting moving forwards. Members reiterated that despite the realignment of this assurance responsibility, health inequalities should remain integral to the wider work of the partnership and be embedded in the work of both remaining sub-committees. The sub-committee supported the proposed changes to the Leeds sub-committee structure and recommended to the Leeds Committee that they be implemented from 1 April 2025. The sub-committee wished to highlight the importance of input from Leeds Committee members in the development of the membership of the new Finance, Value and Performance Sub-Committee to ensure appropriate representation from across the partnership.
Advise:
Health Inequalities Update The sub-committee received the report, noting that future reports would be submitted to the Leeds Committee subject to approval of the sub-committee restructure. Members were provided with an overview of the partnership approach to tackling health inequalities within Leeds, including data tools developed over the last 6-12 months that enable reporting from multiple health inequality perspectives to

understand performance and inform targeted data driven approach in identifying priorities. Members were also presented with the Terms of Reference for the recently reestablished Leeds Healthcare Inequalities Oversight Group.

Performance Management Report

The sub-committee noted reasonable assurance against local and national metrics, however recognised that increasingly challenging circumstances pose a clear risk to future delivery and outcomes. Members highlighted the challenge associated with lagged data from WY against national metrics, recognising the pressures associated with providing additional more timely data sets, however agreed that within future reports, there should be continued commitment to providing WY sets of data to support understanding of variation between WY Places, alongside more local, intuitive data sets that reflect place-based priorities and plans.

Risk Management Report

Members agreed that they were only partially assured that risks presented were being mitigated and managed. Members agreed that this reflected the volatility of circumstances as opposed to the quality of mitigations.

Health and Growth Accelerator Trials

Members received the Health and Growth Accelerator Trials Report with an outline of the proposed Government funding, including a £2.9m allocation to Leeds. Members were supportive of the programme of work set out and the expected benefits, however highlighted potential risks relating to sustainability of funding, excess human resources (after the project) and managing the exit strategy. The sub-committee therefore highlighted the need for potential risks for each project to be communicated with partners at the outset. It was noted that future updates would be submitted to the Leeds Committee.

Assure:

People's Voice

The sub-committee watched a 'how does it feel for me?' video depicting Abdul's story, as part of the Healthwatch Report on Older People update. The video outlined Abdul's evaluation of health services for the older people and highlighted the need for health service providers to consider and address patient's personal, cultural, and religious circumstances in meeting their individual expectations. The sub-committee noted that it was important to capture and acknowledge the brilliant work of the staff in the hospital and homecare teams, as described by Abdul.

Committee Escalation and Assurance Report – Alert, Advise, Assure

Report from: Leeds Finance and Best Value Sub-Committee

Date of meeting: 22 January 2025

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

Date of meeting reported to: 26 February 2025

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 9 The sub-committee was informed that the Leeds Health and Care Partnership (LCHP) position was reporting on plan year to date with a forecast year end position also showing delivery of plan. The Leeds Teaching Hospitals Trust (LTHT) position was cited as a key risk. The introduction of a national cap on the Elective Recovery Fund (ERF) had increased the risk in the LTHT and ICB in Leeds position. Leeds City Council (LCC) had reported a forecast year end deficit of c£20m with pressures in Adults and Children's Services. There was additional risk to the financial position of the ICB in Leeds following increased spend in prescribing and complex care packages. Increased demand for neurodevelopmental (ND) assessments via Right To Choose (RTC) at £4.5m above plan and weight management services at £0.5m had also placed more risk on the financial position. The sub-committee wished to alert the Leeds Committee of its concern regarding the balance of mutual accountability in the WY Integrated Care System (ICS) and the impact on the Leeds population. **Proposed Changes to the Leeds Place Sub-Committee Structure from 1st April 2025** The sub-committee was presented with a proposal to move from three to two assurance sub-committees, effectively dissolving the Delivery Sub-Committee and reassigning its responsibilities to the Finance and Best Value Sub-Committee (to be renamed the Finance, Value and Performance Sub-Committee) and the Leeds Committee. The sub-committee supported the proposed changes to the Leeds sub-committee structure and recommended to the Leeds Committee that they be implemented from 1 April 2025.
Advise:
Medium Term Financial Plan

The sub-committee received the Medium Term Financial Plan (MTFP) update. Current MTFP modelling showed a £435m deficit for LHCP before efficiencies at the end of the five year period, with a £169m gap for 2025/26. The signed off MTFP would subsequently form the baseline plan for 2025/26 planning. The sub-committee noted the significant financial challenge in a c£7% efficiency requirement in 2025/26.

2025/26 Financial Planning Update
The sub-committee received the 2025/26 Financial Planning update which reported that the ICB in Leeds had a gap of £30-40m entering 2025/26. The indicative collective financial gap for 2025/26 was £170m distributed across the four NHS bodies in Leeds which would need to be addressed through a combination of efficiencies, waste reduction, transformation and potential disinvestments. Although NHS England (NHSE) planning guidance had not been received, the forecast indicated a real term reduction in funding with a 4% productivity improvement being required. Focus would continue to be on 18 week performance in elective recovery and protecting emergency care.

The sub-committee recognised the challenge posed to the Leeds health and care system in achieving a balanced plan and wished to advise the Leeds Committee that the 2025/26 Financial Plan would need to be taken to the Leeds Committee meeting on 21 May 2025.

Assure:

People's Voice
The sub-committee was presented with a video of Abdul from Harehills speaking about his experience of healthcare services in Leeds following a stroke and how his cultural needs were addressed by staff. Members welcomed Abdul's positive comments and the work that had been undertaken at LTHT in embedding the 3Cs of communication, coordination and compassion.

Risk Management Report (Leeds Place Risks 2413, 2414)
Members received a report providing an update on the Risk Register and the risks aligned to the Finance and Best Value Sub-Committee, one of which was also aligned to the Delivery Sub-Committee.

With regard to risk 2413 – risk that the financial position across the Leeds system will not achieve financial balance – the risk score of 20 had remained static despite a comprehensive review being undertaken into high cost care packages. Following discussion regarding the risk of the financial position and in the context of further significant cost reduction and efficiency requirements in 2025/26, the sub-committee agreed it remained **partially assured** of the effective management of the risks and the controls in place.

Value-Based Health and Care
The sub-committee discussed value-based health and care, focussing on the shift from activity-based systems to outcomes-based systems. Members discussed the evolutionary process of moving towards value-based health and care by increasing integration of services, data, financial risk and decision making. Population health management and early intervention were identified as key features of the approach.

While the current financial position remained challenging partnership working offered opportunities to make incremental changes.

Meeting name:	Leeds Committee of the West Yorkshire Integrated Care Board
Agenda item no.	76/24
Meeting date:	26 February 2025
Report title:	Financial Update at Month 9
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 paper is to provide an update on the month 9 financial position for the ICB in Leeds, Leeds Place and West Yorkshire.

Overall, the reported Leeds Health and Care Partnership position at Month 9 is on plan year to date. The ICB in Leeds, LYPFT and LCH are reporting a slightly favourable variance against plan at Month 9 with LTHT reporting a £2.4m adverse variance against plan.

Overall, the Leeds place position is forecasting it is on track to deliver its financial plan with a forecast c£1m favourable variance to plan at year end based on the latest forecast positions.

However there remains a number of significant financial risks to delivery of the forecast position. This includes the introduction of an ERF cap by NHSE which has recently been announced which caps the level of elective payment (impacts on LTHT and ICB), delivery of waste reduction plans, non-elective and other demand pressures (e.g. OAPs, ND, weight management etc).

The West Yorkshire ICS position is forecast to be c£29.5m adverse to plan made up of the adverse variances mainly across 2 Provider Trusts (Airedale and Mid Yorks) with all other areas delivering plan or better. However, this position is subject to confirmation that the impact of ERF cap will be addressed by NHSE which if not could worsen the position.

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

☐ Improve healthcare outcomes for residents in their system

☐ Tackle inequalities in access, experience and outcomes

☒ Enhance productivity and value for money

☐ Support broader social and economic development
Recommendation(s)
The Leeds Committee of the West Yorkshire Integrated Care Board is asked to: 1. Review and comment on the month 9 position. 2. Note the emerging and ongoing risks to delivery of the 24/25 financial plan and mitigating actions being taken
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
1. Month 9 Update - PowerPoint slides
Acronyms and Abbreviations explained
1. WY ICB – West Yorkshire Integrated Care Board 2. QIPP – Quality, Innovation, Productivity and Prevention (Commissioner terminology for efficiencies) 3. CIP – Cost Improvement Programme (Provider terminology for efficiencies) 4. NHSE – NHS England 5. LTHT – Leeds Teaching Hospitals NHS Trust 6. LCH – Leeds Community Healthcare NHS Trust 7. LYPFT – Leeds and York Partnership Foundation NHS Trust

What are the implications for?

Residents and Communities	Service provision
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	Continued scrutiny on value for money
Citizen and Stakeholder Engagement	

Proud to be part of West Yorkshire
Health and Care Partnership

Appendix 1

NHS West Yorkshire
Integrated Care Board

NHS West Yorkshire ICB

Month 9 Financial Position

Context and Background

NHS West Yorkshire
Integrated Care Board

The purpose of this paper is to provide an update on the month 9 financial position for the ICB in Leeds, Leeds Place and West Yorkshire.

Nationally the message continues to be the NHS expected to deliver the plans it has committed to. There is still no expectation of additional funding this year with any announcements made in the budget already committed.

Due to the timing of month end closure, the month 10 financial position will be verbally updated on at the Committee meeting.

Leeds Month 9 Position

Organisation	YEAR TO DATE - M09 I&E reported Month 09 24/25			FORECAST - M01 to M12 I&E forecast		
	Plan £m	Surplus / (Deficit) £m	Reported Variance £m	FOT Plan £m	FOT Surplus / (Deficit) £m	FOT Variance £m
Leeds ICB	(9.2)	(8.1)	1.1	(12.3)	(12.3)	0.0
Leeds and York Partnership NHS Foundation Trust	(0.6)	0.3	0.8	1.0	1.0	0.0
Leeds Community Healthcare NHS Trust	0.8	1.3	0.5	1.0	1.9	0.9
Leeds Teaching Hospitals NHS Trust	(14.5)	(17.0)	(2.4)	2.1	2.1	0.0
Leeds Place Total	**(23.5)**	**(23.5)**	**0.0**	**(8.2)**	**(8.2)**	**0.9**

- Overall, the reported Leeds Health and Care Partnership position at Month 9 is **on plan year to date**. The ICB in Leeds, LYPFT and LCH are reporting a slightly favourable variance against plan at Month 9 with LTHT reporting a £2.4m adverse variance against plan.
- Overall, the Leeds place position is forecasting it is on track to deliver its financial plan with a **forecast c£1m favourable variance to plan at year end** based on the latest forecast positions.
- However there remains a number of significant financial risks to delivery of the forecast position. This includes the introduction of an ERF cap by NHSE which has recently been announced which caps the level of elective payment (impacts on LTHT and ICB), delivery of waste reduction plans, non-elective and other demand pressures (e.g. OAPs, ND, weight management etc).

ICB in Leeds Month 9 Financial Position

NHS West Yorkshire Integrated Care Board

As at Month 9	YTD Plan	YTD Spend	YTD variance	Annual Plan	Forecast Spend	Annual Variance
	£000	£000	£000	£000	£000	£000
RESOURCE						
Allocation - Programme	1,253,334	1,253,334	0	1,646,036	1,646,036	0
Allocation - Primary Care Co-Commissioning	126,169	126,169	0	164,123	164,123	0
Allocation - Running Costs	4,567	4,567	0	6,090	6,090	0
TOTAL RESOURCE	**1,384,070**	**1,384,070**	**0**	**1,816,249**	**1,816,249**	**0**
SPEND						
Acute	691,658	689,841	1,817	900,206	898,883	1,324
Mental Health	190,287	194,201	(3,914)	253,818	258,330	(4,512)
Community	174,500	173,906	594	233,690	232,825	865
Continuing Care Services	62,952	64,880	(1,928)	83,936	86,520	(2,584)
Prescribing and Primary Care	129,864	127,006	2,857	173,026	169,651	3,374
Primary Care Co-Commissioning	134,511	134,617	(106)	175,246	175,405	(159)
Other	5,061	4,978	84	6,749	6,600	149
Programme Reserves	(105)	(929)	824	(4,211)	(4,989)	778
Subtotal Programme spend	**1,388,728**	**1,388,500**	**227**	**1,822,459**	**1,823,225**	**(765)**
Running Costs	4,567	3,716	852	6,090	5,281	809
TOTAL SPEND	**1,393,295**	**1,392,216**	**1,079**	**1,828,549**	**1,828,506**	**43**

ICB in Leeds Month 9 Financial Position

NHS West Yorkshire
Integrated Care Board

At month 9 the ICB in Leeds is forecasting a **break-even position against plan (£12.3m deficit).** In year the main overspending areas continue to be within Mental health (MH) and Continuing Health Care (CHC) services.

- MH is forecasting a £4.5m overtrade due to rehab placements, Neurodiversity (ND) referrals and S117 costs. Within CHC there is a forecast £2.5m overspend driven by a historic case issue (c.£0.6m) along with under-delivery of efficiency plans (£0.9m forecast vs £2.2m plan).
- These are both primarily being offset by a forecast underspend within the Prescribing budget by c.£2.3m based on October data. However, it is expected this underspend will reduce in future months based on the latest data which indicates a potential risk of c£1-2m risk to the position.
- Other key risks to the year-end forecast position include:
    - Weight management
    - Neurodiversity spend
    - New high-cost packages in Q4
    - Impact of ERF cap on available funding to be received from NHSE.

ICB in Leeds Month 9 Financial Position

NHS West Yorkshire
Integrated Care Board

To minimise these risks the ICB is taking a number of actions including:

- Continue implementation of pay and non-pay controls
- Delay/defer uncommitted spend and not incur new expenditure in year
- Complex/high-cost packages efficiency recovery plan
- Maximise efficiency opportunities including prescribing and ERF
- Review all technical opportunities e.g. accruals

WY ICS Month 9 Financial Position

Leeds Health & Care Partnership

Organisation	YEAR TO DATE - M09			FORECAST - M01 to M12					
	I&E reported Month 05 24/25			I&E forecast			Scenarios - Organisation 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 (Mitigated) £m	Worse Case Variance £m
Bradford ICB	(5.8)	(12.9)	(7.1)	(7.8)	(16.4)	(8.6)	(3.0)	(8.6)	(22.6)
Calderdale ICB	(0.0)	1.7	1.7	0.0	1.4	1.4	3.1	1.4	(0.7)
Kirklees ICB	(0.0)	1.5	1.5	(0.0)	0.2	0.2	4.0	0.2	(4.7)
Leeds ICB	(9.2)	(8.1)	1.1	(12.3)	(12.3)	0.0	2.0	0.0	(10.3)
Wakefield ICB	(0.0)	0.2	0.2	0.0	(0.1)	(0.1)	0.5	(0.1)	(8.6)
WY ICB	30.9	33.6	2.7	41.5	48.5	7.1	4.4	3.9	(15.5)
West Yorkshire ICB Total	**15.8**	**15.8**	**(0.0)**	**21.4**	**21.4**	**(0.0)**	**11.0**	**(3.2)**	**(62.5)**
Airedale NHS Foundation Trust	(4.1)	(11.3)	(7.2)	(6.9)	(6.9)	0.0	0.0	(10.3)	(16.8)
Bradford District Care NHS Foundation Trust	(0.7)	(0.6)	0.0	0.0	0.0	0.0	0.0	0.0	(0.6)
Bradford Teaching Hospitals NHS Foundation Trust	(13.3)	(17.5)	(4.2)	(14.0)	(14.0)	0.0	0.0	(4.6)	(15.4)
Calderdale And Huddersfield NHS Foundation Trust	(3.2)	(4.1)	(0.8)	(1.3)	(1.3)	(0.0)	0.0	(3.5)	(10.6)
Leeds and York Partnership NHS Foundation Trust	(0.6)	0.3	0.8	1.0	1.0	0.0	1.0	0.0	0.0
Leeds Community Healthcare NHS Trust	0.8	1.3	0.5	1.0	1.0	(0.0)	1.0	1.0	0.0
Leeds Teaching Hospitals NHS Trust	(14.5)	(17.0)	(2.4)	2.1	2.1	0.0	0.0	(21.0)	(42.2)
Mid Yorkshire Hospitals NHS Trust	(2.5)	(20.0)	(17.5)	(3.4)	(3.4)	0.0	0.0	(26.9)	(37.6)
South West Yorkshire Partnership NHS FT	0.2	(0.9)	(1.1)	0.0	0.0	0.0	0.0	0.0	(4.0)
Yorkshire Ambulance Service NHS Trust	0.4	(0.5)	(0.9)	0.0	0.0	0.0	0.0	0.0	(4.8)
West Yorkshire Provider Total	**(37.5)**	**(70.3)**	**(32.8)**	**(21.4)**	**(21.4)**	**(0.0)**	**2.0**	**(65.3)**	**(132.0)**
West Yorkshire ICS Total	**(21.7)**	**(54.5)**	**(32.8)**	**(0.0)**	**(0.0)**	**(0.0)**	**13.0**	**(68.5)**	**(194.5)**

WY System Overview

NHS West Yorkshire
Integrated Care Board

Month 9 update on the ICS financial position is as follows

- The month 9 year to date position for the ICS was a £54.5m deficit against a planned £21.7m deficit; a shortfall/adverse variance against plan of £32.8m.
- The month 9 adverse variance of £32.8m has worsened from the adverse variance at month 8 of £26.7m, a deterioration of £6.1m.
- The main reasons for the month 9 adverse variance continue to be 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.
- Scenario analysis at Month 9 suggested a potential risk of up to £68.5m to plan. However, the current risk is closer to **c£29.5m** made up of the adverse variances mainly across 2 Provider Trusts (Airedale and Mid Yorks) with all other areas delivering plan or better. However, this position is subject to confirmation that the impact of ERF cap will be addressed by NHSE which if not could worsen the position.

Financial Sustainability - Month 9 Update

NHS West Yorkshire
Integrated Care Board

Summary of Financial Sustainability Savings to date as at December 2024

Original Planning Assumption	£38,532,000
Month 8 Forecast	£40,089,890* *4x new schemes identified
Expected Variance (Table Below)	£1,557,890* *Includes unidentified and known slippage
Scheme forecasting to deliver but awaiting data	(£4,929,083)
Risks (Next Slide)	(£1,390,000)
Worse Case	(£4,761,193)

	Plan 24/25	Forecast 24/25	Variance
Technical Finance led schemes	£20,243,000	£20,027,000	(£216,000)
Pathway and System Integration	£6,589,000	£7,294,400^	£705,400
Prescribing (Medicines Optimisation)	£9,000,000	£11,050,490^	£2,050,490
CHC	£2,200,000	£910,000	(£1,290,000)
Unidentified	£500,000	£808,000^	£308,000
Total	£38,532,000	£40,089,890	£1,557.890

^It is to be noted, we are performing better than expected in these areas , which is mitigating some of our planned areas that are underperforming.

Recommendations

NHS West Yorkshire
Integrated Care Board

The Committee is asked to:

- Review and comment on the month 9 position.
- Note the emerging and ongoing risks to delivery of the 24/25 financial plan and mitigating actions being taken

Meeting name:	Leeds Committee of the West Yorkshire ICB
Agenda item no.	77a/24
Meeting date:	26th February 2025
Report title:	NHS Planning Guidance Update
Report presented by:	Tim Ryley, Place Lead
Report approved by:	Tim Ryley, Place Lead
Report prepared by:	Tim Ryley, Nicola Nicholson, Jo Howard

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

Previous considerations:

Leeds ICB Directors Meetings
Ongoing City wide conversations on particular elements

Executive summary and points for discussion:

The paper describes the headlines of the NHS Planning Guidance for 2024 2025, the work currently underway to respond to this and the timelines, constraints and processes by which this is being done. Given the timeframes and requirements more detail will be available at the 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. Note and consider the content, expectations and constraints of the planning guidance and associate timescales.
2. Provide strategic direction on key issues and priorities.
3. Note submission timescales and Accountable Officer (Leeds) responsibilities.

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. Planning Guidance Summary
Acronyms and Abbreviations explained
1. None

What are the implications for?

Residents and Communities	Sets out the priorities for the NHS for the coming 12 months.
Quality and Safety	Retains a focus on securing safe services
Equality, Diversity and Inclusion	Core20Plus5 is noted
Finances and Use of Resources	The NHS is expected to live within its means in 2025-26. This will require further significant productivity improvements by all parts of the system.
Regulation and Legal Requirements	The Planning Guidance and associated submissions are a legally required response to the government mandate.
Conflicts of Interest	All NHS partners and partners in receipt of NHS funding are conflicted on financial allocation. However, no decisions are being made in the meeting.
Data Protection	N/A
Transformation and Innovation	N/A
Environmental and Climate Change	N/A
Future Decisions and Policy Making	The guidance does contain elements that point to the forthcoming 10 year plan.
Citizen and Stakeholder Engagement	The paper does not set out any specific changes that at this stage require consultation. Any proposals in final planning submissions where such engagement is required will be subject too appropriate involvement.

1. Introduction

1.1 The NHS Operational Planning guidance was published on 30th January 2025. This paper provides an overview of this year's planning guidance, links to the key supporting documents, and an overview of our approach and timelines.

1.2 The timeframes required by NHS England and West Yorkshire require a very fast turnaround of the activity and financial detail and do not align well with the meetings of the Leeds Committee of the ICB. This paper therefore only sets out the headline requirements and the process. More detail will be presented to colleagues at the meeting.

1.3 Final submissions will take place ahead of our next meeting in April. Committee members are therefore invited to provide a strategic steer of where priorities should focus as the detailed work is undertaken by teams over the next four weeks.

2. NHS National Planning Guidance 2025/26

2.1. The 2025/26 planning guidance recognises the current challenges across the health and care sector, and seeks to address these, whilst continuing to build momentum towards long-term solutions. The guidance aims to provide a springboard to reimagine services as part of the 10 Year Health Plan (due to be published late spring 2025). The guidance indicates systems will have greater financial flexibility to manage constrained budgets through increased proportion funding and minimised ringfencing.

2.2. The national priorities are much more focused, reducing from 31 objectives in 2024/25 to 18 success measures aligned to the 7 key priorities. The 7 priorities are:

1. Reducing elective care waits
2. Improving A&E waiting times and ambulance response times
3. Improve patient's access to general practice and urgent dental care
4. Improve patient flow through mental health crisis and acute pathways and improve access to children and young people's mental health services
5. Drive reform that will support delivery of immediate priorities and ensure the NHS is fit for the future (focus on neighbourhood health, digital tools, addressing health inequalities and shift towards secondary prevention)
6. Live within budget allocation, reduce waste and improve productivity
7. Maintain focus on overall quality and safety of our services

2.3. The financial allocation is very tight. The financial guidance accompanying the planning guidance is very clear that the NHS is expected to live within its allocation. Given the likely outturn at West Yorkshire ICS level of a deficit of c£75-£80m deficit (of which Leeds is c£8m), NHS England is providing c£49m transitional non-recurrent funding in addition to the overall allocation. The distribution of this is still under discussion.

2.4. The attached guide produced by Carnal Farrar provides a further useful quick reference guide.

3. Supporting documents.

3.1 Alongside the publication of the NHS Operational Planning guidance over 35 supporting documents and guidelines were published, which included numerous finance and contracting guidelines. However, a number of key documents that may be useful for Committee members have been summarised and are listed below:

3.2 **Community Health Service Standardisation:** This is the first publication which provides an overview of the core community health services that ICBs, service providers and partners should consider when designing, commissioning and delivering community health services, including neighbourhood health.

3.3 **Neighbourhood Health Guidance:** Throughout the documents published to support this year's planning guidance, the government mandate and the development of the 10 Year Health Plan, there is a strong emphasis on neighbourhood health. The full vision for the health system will be set out in the 10 Year Health Plan, including proposals to help make this emerging vision for neighbourhood health a reality. The guidance sets out the expectations for systems to continue to progress neighbourhood health in advance of the publication of the 10 Year Health Plan.

3.4 **The Better Care Fund policy framework 2025-26**: The objectives of this year's BCF reflect the government's commitment to reform via a shift from sickness to prevention and from hospital to home. These shifts are also consistent with the commitment to reform by developing a neighbourhood health service based on more responsive, preventative and coordinated care in people's homes and local communities. The BCF objectives which are in line with our existing approach:

1. **Reform to support the shift from sickness to prevention:** local plans to help people remain independent for longer and prevent escalation of health and care needs, including:
    - timely, proactive and joined up support for people with more complex health and care needs,

- use of home adaptations and technology
- support for unpaid carers

2. **Reform to support people living independently and the shift from hospital to home**: local plans must
    - Help prevent avoidable hospital admissions
    - Achieve more timely and effective discharge from acute, community and mental health hospital settings, supporting people to recover in their own homes (or other usual place of residence)
    - Reduce the proportion of people who need long-term residential or nursing home care

3.5 **Reforming Elective care for patients:** This document sets out plans to meet the NHS constitutional standard of 92% of patients should wait no longer than 18 weeks from referral to treatment by March 2029, and includes improving performance against the cancer waiting times standards.

3.6 **Joint Forward Plan (JFP):** ICBs and partner trusts have a duty to prepare a plan setting out how they propose to exercise their functions. This is coordinated at a West Yorkshire level and the contribution towards that plan is the Healthy Leeds Plan. Given the anticipated publication of the 10 Year Health Plan in the spring and a multi-year financial settlement for the public sector as part of the Spending Review 2025, there will be no refresh to the JFP. NHSE is currently drafting a set of expectations and timetable for a subsequent more extensive revision of JFPs aligned to wider reform of nationally coordinated NHS planning processes. This will include a shift from single to multi-year operational and financial planning.

4. Approach to the NHS Planning round 2025/26

4.1 We are working closely with the West Yorkshire Planning and Performance team to ensure that our approach is joined up and as efficient as possible, avoiding duplication where possible. There is also a strong emphasis on ensuring that the three elements of planning (activity and performance, finance, and workforce) are developed together.

5. High level timeline for submission - Activity and planning:

Date	Milestone
30th January	Publication of 2025/26 priorities and planning guidance and linked documents
18/02/2025	Headline submissions from Providers to Leeds Place Planning Team
19/02/2025	Leeds Place Sign approval headline submission at ICB Directors Team
20/02/2025	Leeds Headline submission sent to WY Planning Team
25/02/2025	Place based meeting with WY Planning Team
26/02/2025	Strategic Insight and Steer at Leeds Committee
14/03/2025	Final Submissions from Providers to Leeds Place Planning Team (estimated)
19/03/2025	Review and Leeds Place Sign approval final submission at Directors Team
20/03/2025	Final submission to WY planning team
27/03/2025	Final submission to NHSE
02/04/2025	Update to Leeds Committee of the ICB

6. Headline Planning Submission

6.1 The headline submission is being developed by ICB and provider colleagues and requires sign off ***through each sovereign NHS organisation*** prior to submission to West Yorkshire. Therefore, due to the short timescales, it has not been possible to include a copy of the completed headline submission with this cover report. More information will be available at the committee.

6.2 The headline submission consists of 3 elements for each NHS provider and the ICB in Leeds to complete:

1. **Productivity and opportunity**
   For the ICB four areas of productivity have been identified for the ICB to consider. These include continuing healthcare, primary care prescribing, demand moderation and non-acute efficiency system opportunities. To support this productivity packs have been developed for all providers and systems by NHSE. A summary of the ICB productivity pack can be found here: productivity data jan 2025 v2.pptx

2. **Narrative headlines**
   For the ICB, four areas of focus to support delivery of our plans have been identified, this includes:
   - Urgent and emergency care
   - Ambulance
   - Mental health
   - Primary care

3. **Targets for 2025/26 against key metrics**
   For the ICB, a number of key performance metrics have been identified with planned activity for 25/26 required, these include:
   - A&E non acute trusts
   - Average length of stay adult acute MH beds
   - Access to CYP MH services
   - Reliance on MH inpatient care for adults with a learning disability
   - Reliance on MH inpatient care for autistic adults

7. Recommendations

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

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

1. Note and consider the content, expectations and constraints of the planning guidance and timescales
2. Provide strategic direction on key issues and priorities for Leeds
3. Note submission timescales and Accountable Officer (Leeds) responsibilities.

8. Appendices

1) Carnal Farrar Summary of Guidance

Appendix 1

NHS England Priorities and Operational Guidance 2025/26

The **NHS Planning Guidance** is a strategic document issued annually by NHS England that sets priorities and operational expectations for the NHS. It provides **national priorities, financial management and performance targets** to guide Integrated Care Systems (ICSs), NHS Trusts, and other healthcare providers.

Lord Darzi's 2024 investigation highlighted that despite the dedication of NHS staff, the **health system in England is struggling to meet the growing demands of an ageing population**, with more people living in poor health and facing delays in care. This year's priorities have been published to drive essential reforms and address these challenges.

Financial flexibility and funding plans

- Under the 2025/26 Planning Guidance, NHS England has reduced the number of national priorities, giving local systems **greater financial flexibility in how funding is deployed**
- The additional funding provided in the October budget must cover pay settlements, increased employer national insurance contributions, faster improvement on the elective waiting list, and new treatments mandated by NICE
- NHS organisations need to **reduce their cost base by at least 1%** and **achieve a 4% improvement in productivity** to manage demand growth as well as addressing new local cost pressures and 2024/25 non recurrent savings
- NHS England will move towards a devolved system and **increase local autonomy** by transferring a **higher proportion of funding directly to local systems** and **minimising funding ring fences**

National priorities for 2025/26

Reduce the time people wait for elective care

- **Improve the percentage of patients waiting <18 weeks for treatment to 65%** and for **first appointment to 72% nationally**, with every trust delivering a minimum 5% point improvement
- **Reduce the proportion of people waiting >52 weeks for treatment to less than 1%** of the total waiting list
- **Improve performance against 62-day cancer standard to 75% and 28-day faster access standard to 80%**

Improve A&E waiting times and ambulance response times

- Reach **minimum of 78% patients admitted, discharged and transferred from ED within 4 hours**
- Improve **Category 2 ambulance response times to an average of 30 minutes** across 2025/26
- Reduce avoidable ambulance conveyances and handover delays by **delivering hospital handovers within 15 minutes** and improving access to **urgent care services at home or in the community**
- Improve and standardise urgent care by using the principles of **same day emergency care (SDEC)**

Improve patients' access to general practice (GPs) and urgent dental care

- **Improve patient experience of access to GPs** as measured by the ONS Health Insights survey
- Improve access to urgent dental care, **providing 700,000 additional urgent dental appointments**
- Put in place action plans by June 2025 to **improve contract oversight, commissioning and transformation for GPs to tackle unwarranted variation**

Improve mental health and learning disability care

- **Improve patient flow through mental health crisis and acute pathways**, reducing average length of stay in adult acute mental health beds
- **Improve access to children and young people's (CYP) mental health services** to achieve the national ambition of 345,000 additional CYP aged 0-25 receiving support compared to 2019
- **Reduce reliance on mental health inpatient care** for people with learning disabilities and autism, delivering a minimum 10% reduction

Key actions for delivery

Live within our means

- **Deliver a balanced system financial position**
- **Reduce spend on temporary staffing and support functions** (incl. 30% reduction on agency; 10% reduction on bank spend)
- Improve **procurement, contract management and prescribing**
- Drive improvements in **operational and clinical productivity**, including stopping lower-value activity

Digital transformation

- Make **full use of digital tools to drive the shift from analogue to digital**
- Providers proactively offering **NHS App-first communications** to patients
- GPs enabling all core NHS App capabilities
- Systems adhering to the **'Federated Data Platform (FDP) First' policy**
- Systems completing planned **EPR system procurements and upgrades**

Focus on prevention and address inequalities

- Set foundations for **the neighbourhood health model**, taking a **population health management approach**
- **Address leading causes of morbidity and mortality** (e.g. prevent cardiovascular events by targeting blood pressure and lipid levels)
- **Reduce inequalities in line with the Core20PLUS5** approach for adults and CYP

Quality and safety

- Maintain **focus on the overall quality and safety of services**
- **Focus on challenged and fragile services**, including maternity and neonatal services
- **Deliver the key actions of 'Three year delivery plan'** and continue to address variation in access, experience and outcomes

Meeting name:	Leeds Committee of the West Yorkshire ICB
Agenda item no.	LC77c/24
Meeting date:	26/02/2025
Report title:	Draft Medium Term Financial Plan
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			
Executive summary and points for discussion:			

The purpose of this paper is to provide an update on the development of the medium-term financial plan to the Leeds Committee of the WY Integrated Care Board (ICB).

Work has been ongoing across the Leeds system over the last few months on the development of the medium-term financial plan (MTFP). This work has been linked in with the wider work being undertaken by the West Yorkshire Integrated Care System (ICS) on the system medium term financial plan. This is in part to ensure consistency of approach/assumptions.

Key points:

- The current medium term financial plan modelling shows for the Leeds and Health Care Partnership a £435m deficit before efficiencies at the end of the 5-year period, with a £169m gap for 2025/26
- This is a significant financial challenge that can't be underestimated and is c7% efficiency requirement in 25/26. The numbers presented should be caveated that Providers are yet sign off plans, therefore there may be further adjustments including the impact of 25/26 planning guidance is not included.

Next steps:

- MTFP will be updated post 2025/26 planning, and the national spending review which is focussed on the medium/long term. This will give us a better indication of the position moving forwards.

- Development of medium-term plan will be a continuous development and needs to link to the strategy of the Partnership:

  - Review of funding flows and how we use this to support the delivery of the Healthy Leeds Plan aligned to value based healthcare. This includes discussion of how we use our available resources to support 'left shift' to manage population health risk in line with our risk appetite.

  - Look to implement aligned incentive arrangements and innovative approaches to risk and reward models with partners including Primary Care

  - Understand and model the impact of interventions proposed by the priorities within the Health Leeds Plan and driven by the Population Boards as they are worked up.

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

☐ Improve healthcare outcomes for residents in their system

☐ Tackle inequalities in access, experience and outcomes

☒ Enhance productivity and value for money

☐ Support broader social and economic development

Recommendation(s)

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

1. Review and comment on the Medium Term Financial Plan
2. Note the next steps as detailed in the report.

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 impact on risk to financial deliver in the future.

Appendices

1) Medium Term Financial Plan Update – PowerPoint slides

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 medium term 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	

Draft Medium Term Financial Plan Update

Leeds Committee of the West Yorkshire Integrated Care Board

26 February 2025

Purpose, Context, Approach

Purpose and Context

NHS West Yorkshire Integrated Care Board

- The purpose of this report is to provide an update to the Committee on the progress on the development of the medium-term financial plan for Leeds Place.

- Work has been ongoing across the Leeds system over the last few months on the development of the medium-term financial plan (MTFP). This work has been linked in with the wider work being undertaken by the West Yorkshire ICS on the system medium term financial plan. This is in part to ensure consistency of approach/assumptions.

Approach

NHS West Yorkshire Integrated Care Board

1. Use 24/25 financial plans as starting point
2. Understand 2024/25 underlying position – consistent approach across WY for identification of non-recurrent items
3. Apply consistent income and expenditure uplifts for 2025/26 onwards
4. Agree assumptions for income sources in future (e.g. ERF, Covid etc)
5. Agree expected efficiency requirement and develop efficiency and productivity opportunities to address planning deficits in future years.

A later phase of the medium-term plan for Leeds will also need be the development of the medium-term financial strategy which will need to consider items such as the impact of national policy and direction of travel around use of resources e.g. ‘left shift’.

Stage 1: Underlying Financial Position

Underlying Financial Position

NHS West Yorkshire Integrated Care Board

1. The underlying position has also been developed in conjunction with other regional ICB colleagues, with draft principles around allocations being proposed/agreed.

2. The draft underlying position for each organisation in Leeds Place is set out in the table on the following page. Key assumptions for development of underlying position:

    - Starting point = 2024/25 submitted financial plan
    - Remove non-recurrent technical flexibility
    - Remove other non-recurrent income
    - Remove other non-recurrent expenditure
    - Adjustment for non-recurrent efficiencies

It should be noted this position is draft and is subject to further work/review by each organisation and across Place and is not signed off at this point.

Stage 1 output – Underlying Position - £67.7m deficit

NHS West Yorkshire Integrated Care Board

Organisation	24/25 Plan	NR Technical Flexibility	Other NR Income	Exp. Incurred NR	FYE Recurrent Only	Change in Recurrent Run Rate	Underlying Position
Leeds And York Partnership	1.0	0.0	(6.3)	2.4	0.0	(3.5)	**(6.4)**
Leeds Community Healthcare	1.0	0.0	(1.2)	0.0	0.0	(4.8)	**(5.0)**
Leeds Teaching Hospitals	2.1	(12.0)	(1.8)	1.4	(4.9)	(26.4)	**(41.6)**
ICB in Leeds	(12.3)	(0.4)	0.0	0.6	0.4	(3.0)	**(14.7)**
Total Leeds Health and Care Partnership	**(8.2)**	**(12.4)**	**(9.3)**	**4.4**	**(4.5)**	**(37.7)**	**(67.7)**

Stage 2: Medium Term Financial Plan Pre-Efficiencies

Medium Term Financial Plan Pre-Efficiencies

NHS West Yorkshire Integrated Care Board

- Starting point – underlying position output from Stage 1
- Stage 2: Application of national and local assumptions:
  - Providers – Tariff uplifts (CUF), apply assumed national efficiency %, apply assumed convergence %, national expenditure inflation assumptions
  - ICB – assume standard level of allocation growth each year, and application of CUF uplifts to providers (equal to provider assumptions)

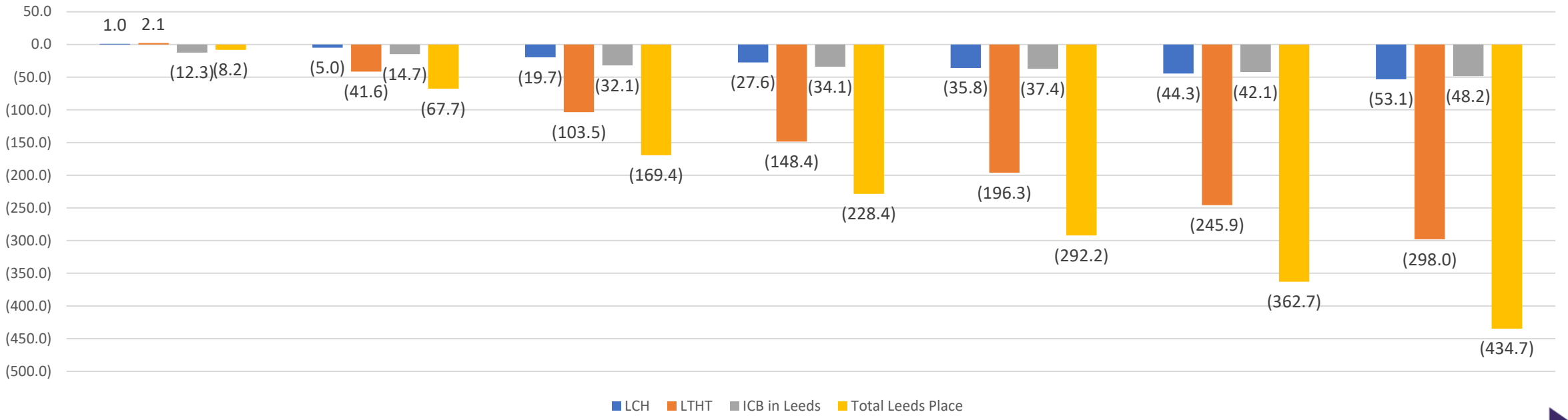
Category	25/26	26/27	27/28	28/29	29/30
Pay	2.1%	2.1%	2.1%	2.1%	2.1%
Drugs	0.5%	0.6%	0.7%	0.7%	0.8%
Other Operating Costs	1.3%	1.7%	1.9%	1.9%	2.3%
Capital	1.3%	1.7%	1.9%	1.9%	2.3%
Cost Uplift Factor	**1.9%**	**2.0%**	**2.0%**	**2.0%**	**2.1%**
Efficiency Factor	-1.1%	-1.1%	-1.1%	-1.1%	-1.1%
Net Cost Uplift Factor	**0.8%**	**0.9%**	**0.9%**	**0.9%**	**1.0%**
CNST	*10.0%*	*10.0%*	*10.0%*	*10.0%*	*10.0%*

	25/26	26/27	27/28	28/29	29/30
Allocation Growth - Core	3.0	3.1	3.1	3.1	3.2
Convergence - Core	- 1.0	-	-	-	-
Continuing Care	10.0	10.0	10.0	10.0	10.0
Prescribing	5.0	5.0	5.0	5.0	5.0
Primary Care	3.2	3.2	3.2	3.2	3.2
Running Costs	2.1	2.1	2.1	2.1	2.1
Acute Services	0.2	1.3	1.3	1.3	1.4
Mental Health Services	0.2	1.3	1.3	1.3	1.4
Community Health Services	0.2	1.3	1.3	1.3	1.4
BCF	5.7	5.7	5.7	5.7	5.7

Medium Term Financial Plan Pre-Efficiencies

NHS West Yorkshire Integrated Care Board

MTFP before efficiences	24/25 Plan £m	24/25 Underlying Position £m	25/26 £m	26/27 £m	27/28 £m	28/29 £m	29/30 £m
LYPFT	1.0	(6.4)	(14.1)	(18.3)	(22.8)	(30.4)	(35.3)
LCH	1.0	(5.0)	(19.7)	(27.6)	(35.8)	(44.3)	(53.1)
LTHT	2.1	(41.6)	(103.5)	(148.4)	(196.3)	(245.9)	(298.0)
ICB in Leeds	(12.3)	(14.7)	(32.1)	(34.1)	(37.4)	(42.1)	(48.2)
Total Leeds Place	**(8.2)**	**(67.7)**	**(169.4)**	**(228.4)**	**(292.2)**	**(362.7)**	**(434.7)**



Stage 2: Medium Term Financial Plan Post-Efficiencies

Medium Term Financial Plan Post-Efficiencies

NHS West Yorkshire Integrated Care Board

- WY have modelled the MTFP using indicative efficiencies provided by Providers and an assumed 3% recurrent efficiency for each ICB area.

MTFP after efficiences	24/25 Plan £m	24/25 Underlying Position £m	25/26 £m	26/27 £m	27/28 £m	28/29 £m	29/30 £m
LYPFT	1.0	(6.4)	(6.7)	(3.4)	(0.2)	0.2	3.5
LCH	1.0	(5.0)	(13.8)	(17.6)	(23.1)	(28.8)	(34.7)
LTHT	2.1	(41.6)	0.0	8.0	8.0	8.0	8.0
ICB in Leeds	(12.3)	(14.7)	(14.5)	1.6	16.9	31.4	45.2
Total Leeds Place	**(8.2)**	**(67.7)**	**(35.0)**	**(11.4)**	**1.7**	**10.8**	**22.0**

Efficiencies	25/26 £m	26/27 £m	27/28 £m	28/29 £m	29/30 £m
LYPFT	7.4	7.4	7.4	7.5	7.6
LCH	5.9	4.0	2.5	2.5	2.6
LTHT	103.5	50.6	44.3	45.1	46.1
ICB in Leeds	17.5	18.1	18.7	19.2	19.8
Total Leeds Place	**134.3**	**80.0**	**72.9**	**74.3**	**76.1**

Conclusion and Next Steps

Conclusion

NHS West Yorkshire Integrated Care Board

- This current medium term financial plan modelling shows for the Leeds and Care Partnership a £435m deficit before efficiencies at the end of the 5-year period, with a £169m gap for 25/26.

- This is a significant financial challenge that can't be underestimated and is c7% efficiency requirement in 25/26.

- The numbers presented should be caveated that Providers are yet sign off plans therefore there may be further adjustments including the impact of 25/26 planning guidance is not included.

Next Steps

NHS West Yorkshire Integrated Care Board

- MTFP will be updated post 2025/26 planning, and the national spending review which is focussed on the medium/long term. This will give us a better indication of the position moving forwards.
- Development of medium-term plan will be a continuous development and needs to link to the strategy of the Partnership:
    - Review of funding flows and how we use this to support the delivery of the Healthy Leeds Plan aligned to value based healthcare. This includes discussion of how we use our available resources to support ‘left shift’ to manage population health risk in line with our risk appetite.
    - Look to implement aligned incentive arrangements and innovative approaches to risk and reward models with partners including Primary Care
    - Understand and model the impact of interventions proposed by the priorities within the Health Leeds Plan and driven by the Population Boards as they are worked up.

Meeting name:	Leeds Committee of the West Yorkshire Integrated Care Board
Agenda item number:	78/24
Meeting date:	26 February 2025
Report title:	High Level Risk Report: Cycle 4 2024/25 (December 2024 – March 2025)
Report presented by:	Asma Sacha, Risk Manager (WY ICB)
Report approved by:	Aimee Willett, Head of Corporate Governance (WY ICB)
Report prepared by:	Asma Sacha, Risk Manager (WY ICB)

Purpose and Action:			
Assurance ☒	Decision ☐ (approve/recommend/ support/ratify)	Action ☒ (review/consider/com-ment/discuss/escalate	Information ☐

Previous considerations:

Quality and People's experience Sub-Committee – 15 January 2025
ICB in Leeds Director's Team Meeting – 22 January 2025
Finance and Best Value Sub-Committee – 22 January 2025
Delivery Sub-Committee – 29 January 2025

Executive summary and points for discussion:

This report presents the Leeds Place High Level Risk Reports, Risk Log and Risk on a Page Report as at the end of the current risk review cycle (Cycle 4, 2024/25).

Following review of individual risks by the Risk Owner and the allocated Senior Manager, all risks on the Leeds Place Risk Register were reviewed by the Leeds Senior Managers and then by the Quality and People's experience Sub-Committee, the Finance and Best Value Sub-Committee, and the Delivery Sub-Committee.

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

The paper includes the Board Assurance Framework (BAF) for all five places which is attached at **Appendix 2.** The BAF provides the ICB with a method for the effective and focused management of the principal risks and assurances to meet 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.

With which purpose(s) of an Integrated Care System does this report align?

☒ 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 ICB Committee is asked to **RECEIVE** and **NOTE** the High Level Risk Report, Risk Log and Risk on a Page Report as an accurate representation of the Leeds place risk position, following any recommendations from the relevant sub-committees.
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 details of all risks on the Leeds Place Risk Register. The various ICB Risk Registers support and underpin the BAF, and relevant links are drawn between risks on each.
Appendices:
Appendix 1: Leeds place risk register Appendix 2: Board Assurance Framework Cycle 4 2024/25 Appendix 3: Risk on a Page Report Cycle 4 2024/25 Appendix 4: Leeds Health and Care Partnership Top Risks - February 2025
Acronyms and abbreviations explained:
In Appendix 1: • Static – 'x' archives – risk score has been unchanged for 'x' risk cycles • Static description – neither the risk score nor its description has changed since the previous cycle • Reached tolerance – current risk score has reduced to target score so risk may be closed 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 Registers
Quality and Safety	Any implications relating to individual risks are outlined in the Risk Registers
Equality, Diversity and Inclusion	Any implications relating to individual risks are outlined in the Risk Registers
Finances and Use of Resources	Any implications relating to individual risks are outlined in the Risk Registers
Regulation and Legal Requirements	Any implications relating to individual risks are outlined in the Risk Registers

Conflicts of Interest	None identified.
Data Protection	Any implications relating to individual risks are outlined in the Risk Registers
Transformation and Innovation	Any implications relating to individual risks are outlined in the Risk Registers
Environmental and Climate Change	Any implications relating to individual risks are outlined in the Risk Registers
Future Decisions and Policy Making	Any implications relating to individual risks are outlined in the Risk Registers
Citizen and Stakeholder Engagement	Any implications relating to individual risks are outlined in the Risk Registers

1. **Introduction**

1.1 The Leeds ICB Committee via the West Yorkshire Integrated Care Board (WY ICB - as a publicly accountable organisation), needs to take many informed, transparent and complex decisions and manage the risks associated with these decisions. As part of this risk management arrangement, the Committee therefore needs to engage with this overarching approach and thereby ensure that the Committee has a sound system of internal control.

1.2 Effective risk management processes are central to providing assurance that all required activities are taking place to ensure the delivery of the Partnership's priorities and compliance with all legislation, regulatory frameworks and risk management standards.

1.3 The report sets out the process for review of the Leeds Place risks during the current review cycle (Cycle 4 of 2024/25) which commenced on 18 December 2024 and ends after the West Yorkshire ICB Board (WY ICB) meeting on 18 March 2025.

1.4 The report shows all high-scoring risks (scoring 15 and above) recorded on the Leeds Place risk register. Details of all Leeds Place risks are provided in **Appendix 1.**

1.5 The report includes the Board Assurance Framework (BAF) which was reviewed during Cycle 4 2024/25, this is attached at **Appendix 2.**

1.6 The risk on a page/ heat map is attached at **Appendix 3.**

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

2.2 Please see pages 15 – 26 of the of the West Yorkshire ICB Risk Report 17 December 2024 for the Corporate Risk Register.

2.3 The West Yorkshire Risk Management Policy and Framework was approved at the West Yorkshire ICB Board on 21 March 2023 which details the risk management process including the risk scoring matrix.

2.4 All high scoring place risks and all risks common to more than one place are reported to the WY ICB Board.

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.

2.6 This cycle work has been undertaken with risk owners to update their risks, review the risk score and ensure that additional information is complete. This more focused and supportive approach will continue.

2.7 The Place Risk Register will not capture risks which are owned by Leeds Health and Care 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 4. Partners are also consulted when populating and managing the Population and Care Board risk registers.

2.8 There are currently **11 risks** on the Leeds Place Risk Register, this includes the two new risks.

3. **High scoring Risks**

3.1. There are seven high scoring risks (15+) in Cycle 4 2024/25;

Risk ID	Risk Rating	Principal Risk	Risk Status
2413	20	There is a risk that the financial position across the Leeds system will not achieve financial balance due to the combination of undelivered QIPP and new cost pressures in 2024 – 25. This could result in the system as a whole not meeting its statutory duties to break even.	Static – 3 cycles Aligned to Finance and Best Value Committee. Monthly financial sustainability meetings with overspending functions have brought the year end forecast back in line with planned

			position at Month 8, the ICB in Leeds has been given a further £2m stretch target to achieve. High-cost packages programme Board set up to ensure longer term control over these cost areas. Continued communications to be sent to ensure the whole teams understand the position and review of all uncommitted budgets to identify further opportunities
2480	16	There is a risk that our current commissioned Tier 3 weight management service not being sufficient to meet demand due to limited local budget and workforce and the introduction of new drugs for weight management and associated NICE technology appraisals increasing demand and legal obligation. This could result in an increased number of referrals to right to choose providers and associated expenditure and potential detrimental impact on the quality and suitability of services for the population in Leeds.	New Recovery and efficiency plans are in place. Awaiting advice from NHSE and the WY core team. This is being reviewed via the Leeds Long-term Conditions Population Board with updates to the Leeds Scrutiny Committee.
2415	16	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.	Static – 3 cycles There has been no further update to this risk.
2414	16	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	Static – 3 cycles Leeds City Council are reporting a c.£20m forecast year end deficit at Month 8 with

		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 adverse variances to plan) and the management of winter pressures.	overspends of £13.8m in Adults and £18.8m in Children's service based on the achievement of significant efficiencies. Regular 25/26 financial planning meetings have been established to ensure consistent approach going forward.
2019	16	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.	Static – 7 cycles Key controls are in place responding to a high level of demand, but current controls are still not sufficient to reduce the risk score.
2354	15	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 could lead to poor patient outcome and significant financial impact.	Static – 7 cycles Key controls have been updated.
2301	15	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	Static – 8 cycles A letter was sent to all families on the waiting list to signpost to additional resources that will offer support.

		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.	

4. **New Risks this Cycle**

4.1. There are two new risks added to the Leeds place Risk Register in Cycle 4 2024/25;

Risk ID	Risk Rating	Principal Risk	Risk Status
2480	16 (I4 x L4)	There is a risk that our current commissioned Tier 3 weight management service not being sufficient to meet demand due to limited local budget and workforce and the introduction of new drugs for weight management and associated NICE technology appraisals increasing demand and legal obligation. This could result in an increased number of referrals to right to choose providers and associated expenditure and potential detrimental impact on the quality and suitability of services for the population in Leeds.	New Aligned to the Quality and People's experience Sub-Committee. Recovery and efficiency plans are in place. Awaiting advice from NHSE and the WY core team. This is being reviewed via the Leeds Long-term Conditions Population Board with updates to the Leeds Scrutiny Committee.
2487	9 (I3 x L3)	There is a risk of additional service pressure, across the Leeds place caused through the immediate recovery actions Adult Hospices in Leeds may need to implement, due to the current financial deficit (shortfall in annual funding). This will result in additional service pressures on other health and care partners across Leeds place, including primary care, acute hospitals and community services impacting on hospital admissions, delayed discharges and an increase in social care demands.	New Aligned to the Quality and People's experience Sub-Committee. There is a risk in relation to shortfall in finding over the next financial year and the impact this

			will have to services and the system. WY ICB is working with the hospices on developing on a sustainable funding model for Adult Hospice care.

5. **Emerging Risks this Cycle**

There are no emerging risks in Cycle 4 2024/25.

6. **Board Assurance Framework (BAF)**

6.1 The BAF provides the ICB with a method for the effective and focused management of the principal risks and assurances to meet 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. These risks are owned by members of the Executive Management Team.

6.2 The BAF will be reviewed during risk cycles 2 and 4 by Place risk owners following which the assurance will be provided to Place Committees and the quarterly West Yorkshire Integrated Care Board meetings. The WY ICB Executive Management Team will review the BAF during risk cycles 1 and 3.

6.3 The Board Assurance Framework reviewed in Cycle 4 2024/25 is attached at **Appendix 2.**

6.4 The table below shows key changes which has been made to the BAF following review by Leeds senior managers during Cycle 4 2024/25;

BAF risk	**Cycle 3 2024/25 score**	**Cycle 4 2024/25 score**	**Reason for change**
2.3 There is a risk that we cannot measure and assess performance across the system in a timely and meaningful way, which impacts our ability to respond quickly as issues arise.	9	6	The likelihood has been reduced from 3 to 2, reducing the risk score from 9 to 6. There is reasonable oversight already of activity, capacity and performance via excellent place-based relationships and working arrangements. The likelihood has reduced from 3 to 2 because of the fast turnaround (timely and

			automated) and wide availability of data.

7. **Next steps**

7.1 The risks will be carried forward to the next risk review cycle which will commence after the WY ICB Board meeting on 18 March 2025. The next risk cycle will be Cycle 1, 2025/26.

8. **Recommendations**

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

1. **RECEIVE** and **NOTE** the High Level Risk Report, Risk Log and Risk on a Page Report as an accurate representation of the Leeds place risk position, following any recommendations from the relevant sub-committees.
2. **CONSIDER** whether it is assured in respect of the effective management of the risks and the controls and assurances in place.
3. **RECEIVE** and **NOTE** the Board Assurance Framework for Cycle 4 2024/25.

Appendix 1

Risk ID	Date Created	Risk Type	Strategic Objective	Risk Rating	Risk Score Components	Target Risk Rating	Target Score Components	Risk Owner	Senior Manager	Principal Risk	Key Controls	Key Control Gaps	Assurance Controls	Positive Assurance	Assurance Gaps	Risk Status
2413	20/03/2024	Finance and Best Value Committee	Enhance productivity and value for money	20	(4xL5)	6	(3xL2)	Matthew Turner	Alex Crickmar	There is a risk that the financial position across the Leeds system will not achieve financial balance due to the combination of undelivered QIPP and new cost pressures in 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 Additional financial controls around all new expenditure - above £50k for healthcare and £10k for non-healthcare	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 Additional financial controls around all new expenditure - above £50k for healthcare and £10k for non-healthcare reviewed by Leeds DTM and WY investments panels.	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 - 3 Archive(s)
2480	14/01/2025	Both Delivery and Quality and People's Experience	Improve healthcare outcomes for residents	12	(4xL4)	9	(3xL3)	Lindsay Mcfarlane	Helen Lewis	There is a risk that our current commissioned Tier 3 weight management service not being sufficient to meet demand due to limited local budget and workforce and the introduction of new drugs for weight management and associated NICE technology appraisals increasing demand and legal obligation. This could result in an increased number of referrals to right to choose providers and associated expenditure and potential detrimental impact on the quality and suitability of services for the population in Leeds.	1. Revised contract and specifications to help future planning facilitated by funding (ICB Leeds) 2. Recovery plans and efficiency plans in place 3. Plan to be open to new referrals in July 2024 4. Ongoing work to develop new model delivery 5. NICE TA medicines policy and funding variation 6. Right to choose monitoring	1. Awaiting guidance from NHSE 2. Awaiting guidance and support from WY core team 3. Lack of ability to mitigate referral to Right to Choose 4. Media influence and public demand 5. No local governance contract mechanisms with national right to choose provider(s)	1. Currently discussed and reviewed via Leeds long term conditions population board with updates to Leeds Scrutiny committee 2. Local service offer in place in Leeds 3. Quality measures in place of the local offer	See above	1. Not receiving quality data from right to choose (only referral numbers received) 2. Gaps in data from Leeds data model	New - Open
2415	21/03/2024	Delivery Committee	Tackle inequalities in access, experience, outcome	12	(4xL4)	9	(3xL3)	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. West Yorkshire ICB Board approved 7 Principles	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 - 3 Archive(s)
2414	20/03/2024	Both Delivery and Finance and Best Value	Enhance productivity and value for money	12	(4xL4)	6	(3xL2)	Matthew Turner	Alex Crickmar	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 adverse variances to plan) and the management of winter pressures.	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 - 3 Archive(s)
2019	30/06/2022	Both Delivery and Quality and People's Experience	Improve healthcare outcomes for residents	12	(4xL4)	9	(3xL3)	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. Improved capacity for Same Day Emergency Care at St James's and virtual ward capacity significant improvements in waiting time for rehab beds driven by major	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 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 doesn't 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 context 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 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 - 7 Archive(s)
2354	14/08/2023	Both Delivery and Quality and People's Experience	Tackle inequalities in access, experience, outcome	15	(3xL5)	9	(3xL3)	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 could lead to poor patient outcome and significant financial impact.	ADHD service (LYPFT) has closed to routine referrals temporarily due to the demand for assessment and treatment leading to waiting times of over 10 years. The ICB have commissioned a provider under an urgent award to deliver a support team 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 support team is reporting positive feedback and outcomes for patients. The support team calls are identifying patients who do not need to be on the waiting list and/or providing support/validation so that they no longer need to seek an assessment. Funding is in place to support the waiting list until March 2025. Review of progress in early 2025; Learning from this work is being used to develop a new ADHD front door proposal for new referrals aiming to reduce the number of ADHD assessment referrals. Leeds Autism Diagnostic Service has improved pathway efficiency and waiting times. The increased number of people diagnosed is putting strain on post-diagnostic offer. ICB Place resource is also 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. 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. A neurodiversity working group has been established as part of the CMH Transformation programme to improve access to mental health services for people who are neurodivergent. This will help people who are on the diagnostic waiting lists to have their needs met - to 'wait well'. A third sector organisation has been successful in a grant bid for a project to support autistic people to access the new hubs.	Right To Choose referrals for non-urgent assessments will increase due to the local NHS ADHD service pause. Spend in this area needs to be monitored and is an area of unknown/risk. WY accredited provider list will help with the quality assurance oversight of RTC providers and provide consistent tariffs. The WY accredited provider list is awaiting sign off and providers to express interest. An "ADHD front door" is being developed to support patients meet needs before they enter the assessment pathway. Investment and funding to be explored as part of the proposal It is unknown when the Trust ADHD service will reopen to new referrals to non-urgent assessment referrals. The future of the ADHD pathway will be influenced by the NHSE ADHD taskforce however it is unclear how quickly guidance will be shared. Some guidance on clinical prioritisation for assessment is needed. . The WY programme and clinical colleagues are linked in. Leeds system will be exploring options for developing the ADHD pathway for assessment and medication pathways. There is no ring-fenced investment/funding into ADHD development. Autism referral rates to Leeds NHS pathway have reduced, RTC referrals for autism need to be investigated. Seeking funding/grants to support pre- and post diagnostic support offer.	WY ND programme guidance and resources 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 - 7 Archive(s)
2301	16/05/2023	Both Delivery and Quality and People's Experience	Tackle inequalities in access, experience, outcome	15	(3xL5)	6	(3xL2)	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. Further workshop in February 2025 with Education to see how best we can support schools to manage the needs of people who are neurodivergent and reduce dependency on diagnosis. Needs led support needs to be offered earlier in the pathways. 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 2024. 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. 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) LCH has been able to restart assessments for under 5s and has simplified and tiered its offer to increase speed of diagnosis - also moving to a more needs led support offer alongside diagnosis ICB looking at local options to deliver 'Choice' assessments across Leeds	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 - 8 Archive(s)

2024	30/06/2022	Quality and People's Experience Committee	Improve healthcare outcomes for residents	12	(4x L3)	1	(1x L1)	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 reviewing moved to Continuing Care Service to free up HCM capacity	Please add actions in addition to the controls listed to reduce risk to target - with date for completion- see guidance p4. The following have been copied from Datix: Liberty Protection Safeguards LPS has been delayed in its implementation indefinitely. There is insufficient budget and resource at place to undertake preparatory work for all potential cases of DoL or to engage legal representation in order to progress all cases to the court of protection. The court has raised concerns on a number of occasions about the use of family members as appropriate rule 1.2 representatives, this requires additional legal support and HCM work.	LCH provide performance reports, highlighting the current position. The ICB Mental Capacity Act Lead meets with LCH quality Leads and Beachcroft solicitors quarterly to track progress and unpick any delays or performance issues	Regular meetings with the HCM Managers to ensure issue remains in focus. Mental Capacity Act Lead is working both at 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 - 8 Archive(s)
2018	29/06/2022	Both Delivery and Quality and People's Experience	Tackle inequalities in access, experience, outcome	12	(4x L3)	9	(3x L3)	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- work to reduce the waiting list for access to step 3 CBT in NHS talking therapies has impacted significant improvements with many people now able to commence high intensity therapy within 4 months and waiting list greatly improved	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 Access to housing remains significantly challenging (both for supported and general needs housing), impacting on flow	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, achieving a reduction in OOA placements just above the planned trajectory.	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 - 2 Archive(s)
2016	29/06/2022	Both Delivery and Quality and People's Experience	Tackle inequalities in access, experience, outcome	12	(4x L3)	12	(4x L3)	Lindsay Mcfarlane	Helen Lewis	There is a risk that 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). However, capacity in pressured specialties in limited 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 meetings, at which progress on reducing lists of long waiters are shared, risks assessed and appropriately escalated, and mitigating actions agreed (covers cancer and planned care)	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 Network 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.	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 - 9 Archive(s)
2487	27/01/2025	Quality and People's Experience Committee	Improve healthcare outcomes for residents	9	(3x L3)	6	(3x L2)	Helen Smith	Tim Ryley	There is a risk of additional service pressure, across the Leeds place caused through the immediate recovery actions Adult Hospices in Leeds may need to implement, due to the current financial deficit (shortfall in annual funding). This will result in additional service pressures on other health and care partners across Leeds place, including primary care, acute hospitals and community services impacting on hospital admissions, delayed discharges and an increase in social care demands.	1. Funding uplift: Explore funding uplift allocations to all Hospices to mirror NHS statutory organisations 2. Funding reallocation: To explore options to reassess and reallocate funding to prioritise essential services and mitigate the impact of increased costs 3. Collaboration with stakeholders: Engage with local stakeholders to seek additional funding or support 4. Cost saving measures: Explore efficiency strategies, such as streamlining operations to reduce overhead costs 5. Fundraising campaigns: Support Hospices and local authorities to launch targeted campaigns to increase donations and secure new funding streams 6. Potential government funding for end of life pathways.	1. Limited flexibility in funding reallocation due to existing financial pressures across the system, making it difficult to reallocate funds without compromising essential services 2. Limited opportunity for further efficiency improvements without negatively impacting service quality and staff wellbeing 3. Over-reliance on public donations, which may not bridge the funding gap 4. Potential that the government funding does not materialise and that the allocation is not passed through.	1. Financial audits: Work with finance teams to monitor and evaluate the impact of the tax increase on Hospice finances and assess the effectiveness of mitigation measures 2. Hospice performance reviews: Reviews of service delivery metrics to ensure patient care and service standards are maintained 3. Collect feedback from patients, families, carers and staff 4. End of Life Population Care Board: Regular reporting to ensure governance and accountability in managing the risk 5. Regular reporting to the group Quality sub committee 7. West Yorkshire Palliative End of Life Care Steering Group: Regular reporting to the group	See above	None identified at this stage.	New - Open

West Yorkshire Integrated Care Board - Board Assurance Framework - Guidance notes for completion *(version Feb 1.4 March 2024)*

The following information is taken from the WYICB's *Risk Management Policy and Framework (v1.0)* to provide guidance to those completing the Board Assurance Framework (BAF) on behalf of the ICB and place partnerships. The full document can be accessed here:

https://www.wypartnership.co.uk/application/files/9816/5893/1635/West_Yorkshire_ICB_Risk_Management_policy_and_framework_v1.0_26.07.22.pdf

The ICB operates the principle of subsidiarity. As the statutory body, the ICB is accountable for delivery of its priorities, but delegates responsibility for delivery to the five places (Bradford District and Craven, Calderdale, Kirklees, Leeds and Wakefield). Risks associated with delivery at Place will be managed at Place unless it is agreed to manage centrally.

Currently, fifteen strategic risks, linked with the mission of the ICB, have been identified following a series of development sessions held during summer 2022. These were ratified at the meeting of the ICB Board held on 20 September 2022.

The **Board Assurance Framework** summarises how the Board knows that the controls it has in place are effectively managing the principal (strategic) risks, together with references to documentary evidence/assurances and current mitigation action plans. The ICB and the Place Partnership Committee of each of the five places will maintain an Assurance Framework and Corporate Risk Register through which risk management activities are prioritised and managed.

Risk appetite refers to the level of risk that an organisation is willing to tolerate or expose itself to when controlling risks as they arise or when embarking on new projects. An organisation may accept different levels of risk appetite for different types of risk, or in relation to different projects. The organisation's risk appetite ensures that risks are considered in terms of both opportunities and threats. Risk appetite *(which is a description, not a score)* informs the risk tolerance levels, which are considered for individual risks. Based on the risk appetite, a target risk score is set for individual risks. This is the level to which the risk is to be managed.

PLEASE NOTE: The worksheets titled 'Summary' and 'Heat map' will be completed by the ICB governance team. The worksheets 1.1 to 4.3 inclusive should be completed by the ICB lead director / board lead (blue section) and all the worksheets **except** 3.4 and 4.3 should be completed by the Place leads (or their nominees) as follows: Bradford District and Craven (peach section); Calderdale (orange section); Kirklees (green section); Leeds (purple section); Wakefield (pink section). Please do not change any formatting within this document.

Controls describe the available systems and processes *(the specific things we are doing)* which help to minimise and/or manage the risk.
Assurance is the *(source)* information used to ascertain whether the controls are effective.
Mitigating actions describe what else we are doing to control the risk and/or provide additional assurance.

ICB and Place leads are asked to describe three key controls - each requiring linked assurance(s) - relevant to the strategic risk.

A risk score is obtained, using a 5 x 5 matrix, (impact x likelihood), which determines whether the risk is ranked as low, moderate, high, serious or critical. The following tables are provided to inform the target and current risk scores.

Definitions of impact:

Risk impact	Insignificant	Minor	Moderate	Major	Catastrophic
	1	2	3	4	5
Purpose					
Achievement of the ICB mission	A decision affecting contracts finance, collaborations, quality or governance has no impact on the ICB mission.	A decision affecting contracts finance, collaborations, quality or governance does not support the ICB mission.	A decision affecting contracts finance, collaborations, quality or governance delays the achievement of the ICB mission.	A decision affecting contracts finance, collaborations, quality or governance impedes or significantly delays the achievement of the ICB mission.	A decision affecting contracts finance, collaborations, quality or governance majorly impedes and/or delays the achievement of the ICB mission.
Health outcomes and life expectancy	Marginal reduction to health outcomes and/or life expectancy for >5% of a given population.	Minor reduction to health outcomes and/or life expectancy for >15% of a given population.	Moderate reduction in health outcomes and/or life expectancy for >30% of a given population.	Significant reduction in health outcomes and/or life expectancy for > 50% of a given population.	Major reduction in health outcomes and/or life expectancy for >75% of a given population.
Health inequalities	Marginal increase in the health inequality gap in up to all six of most deprived Local Care/Community Partnerships (PCNs)	Minor increase in the health inequality gap in up to all of the six most deprived Local Care/Community Partnerships (PCNs) and / or a minor increase in the number of deprived Local Care/Community Partnerships (PCNs)	Moderate increase in the health inequality gap in up to all of the six most deprived Local Care/Community Partnerships (PCNs) and / or a moderate increase in the number of deprived Local Care/Community Partnerships (PCNs)	Significant increase in the health inequality gap in up to all of the six most deprived Local Care/Community Partnerships (PCNs) and / or a significant increase in the number of deprived Local Care/Community Partnerships (PCNs)	Major increase in the health inequality gap in up to all of the six most deprived Local Care/Community Partnerships (PCNs) and / or a major increase in the number of deprived Local Care/Community Partnerships (PCNs)
Service quality and performance (includes patient experience, safety and clinical effectiveness)	Informal complaint	Formal complaint Local resolution	Investigation by Health Service Ombudsman Minor out-of-court settlement	Multiple complaints Judicial review Litigation expected Civil action – no defence	Litigation certain Criminal prosecution
	Negligible effect on quality of clinical care	Noticeable effect on quality of care Single failure to meet internal standards Minor implications for patient safety if unresolved	Significant effect on quality of care / significantly reduced effectiveness Repeated failure to meet internal standards Major patient safety implications of findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved.	Totally unacceptable level or quality of treatment / service Gross failure of patient safety if findings not acted on Gross failure to meet national standards
	Commissioned local or national targets not achievable – single episode	Commissioned local or national targets not achievable – 1-3 episodes	Repeated failure to meet commissioned local or national targets > 3 episodes	Commissioned national targets not achieved resulting in involvement of external bodies / regulator	Commissioned national targets not achieved resulting in special measures
Financial efficiency	Small loss	Loss of 0.1–0.25 per cent of budget	Loss of 0.25–0.5 per cent of budget	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget	Non-delivery of key objective/ Loss of >1 per cent of budget
Capability					
	Negligible injury or ill health requiring no absence from work.	Minor injury or ill health requiring up to 2 days absence from work.	Moderate injury or illness resulting in the submission of a RIDDOR report.	Single fatality.	Multiple fatalities

	Negligible damage to equipment or property.	Minor damage to equipment or property.	Moderate damage to equipment or property.	HSE improvement notice received.	HSE or police investigation resulting in imprisonment of Chief Executive or other implicated staff
Compliance (includes H&S and other legal or governance factors such as procurement, information governance etc.)	No or minimal impact or breach of guidance / statutory duty.	Breach of statutory legislation	Single breach in statutory duty	Major damage to property	Multiple breaches in statutory duty
		Reduced performance rating if unresolved	Challenging external recommendations / improvement notice	Enforcement action	Prosecution
				Multiple breaches in statutory duty	Complete system s change required
				Improvement notices	Zero performance rating
				Low performance rating	Severely critical report
				Critical report	

Descriptors for risk likelihood:

Level	Descriptor	Description / suggested frequency
1	Rare	The event may occur only in exceptional circumstances
2	Unlikely	The event could occur at some time
3	Possible	The event may occur at some time
4	Likely	The event will probably occur in most circumstances
5	Almost certain	The event is expected to occur

Overall risk matrix scoring (= impact x likelihood):

Impact	Likelihood				
	Rare 1	Unlikely 2	Possible 3	Likely 4	Almost certain 5
Insignificant 1	1	2	3	4	5
Minor 2	2	4	6	8	10
Moderate 3	3	6	9	12	15
Major 4	4	8	12	16	20
Catastrophic 5	5	10	15	20	25

West Yorkshire Integrated Care Board - Board Assurance Framework - Summary						Version: 8	Date: February 2025
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	16	Ian Holmes / Jonathan Webb	Finance, Investment and Performance Committee
	1.3	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
(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.	Open	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	6	8	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	9	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 / Shaukat Ali Khan	Finance, Investment and Performance Committee.Transformation Committee for Digital
(3) Use our collective resources wisely	3.1	There is a risk that we do not invest resources in a way which prioritises community, primary and prevention programmes and so doesn't maximise value for money.	Open	6	12	Jonathan Webb	Finance, Investment and Performance Committee
	3.2	There is a risk that we don't operate within our available system and organisational resources (revenue and capital) and so breach our statutory duties.	Cautious	9	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	9	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	8	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 / Shaukat Ali Khan	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 8									Dec - March 2025			
Mission		Strategic risk	WYICB and 5 Places	West Yorkshire		Bradford District and Craven		Calderdale		Kirklees		Leeds		Wakefield	
			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	16 ↑	9	12	9	9	6	12 ↓	12	16	9	16 ↑
	1.3	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.	Open	8	12	6	12	8	12	8	12 ↑	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	6 ↑	8 ↓	4	6	4	6	4	8	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	9	2	4	2	6	2	8	2	6 ↓	2	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	16 ↑	9	16	9	16 ↑	9	12	9	12
	2.5	There is a risk of an inability to deliver routine health and care services due to the emergence of a future pandemic leading to substantial loss of life and failure to deliver key functions and responsibilities.	Averse	16	16	Not required	Not required	Not required	Not required	Not required	Not required	Not required	Not required	Not required	Not required
Use our collective resources wisely	3.1	There is a risk that we do not invest resources in a way which prioritises community, primary and prevention programmes and so doesn't maximise value for money.	Open	6 ↑	12 ↑	4	12 ↑	4	12	8	12	4	9	4	9
	3.2	There is a risk that we don't operate within our available system and organisational resources (revenue and capital) and so breach our statutory duties.	Cautious	9 ↑	20	6	20	6	20	6	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	9 ↑	12	4	12	4	16	4	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	8 ↓	8	8 ↓	8	12	8	12	8	12	8	8 ↓
	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

WYICB - Board Assurance Framework - ICB and places							Version: 8	Date: October 2024
Mission 1	Failure to manage strategic risk could result in a failure to **REDUCE INEQUALITIES**						**Lead director(s) / board lead**	Ian Holmes
Strategic risk 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.						**Lead committee / board**	ICB Board (linked to place committees)
ICB risk appetite	**ICB risk scores**						**Rationale for current ICB score**	
	Target (ICB)			**Current (ICB)**			Inequalities have widened in recent years due to broader social and economic factors. Our health and care partnership will make a positive contribution on these issues, there are a range of factors outside of our control that are likely to make narrowing inequalities more challenging.	
BOLD	**Likelihood**	**4**	**16**	**Likelihood**	**5**	**20**		
	Impact	**4**		**Impact**	**4**			

Key controls *(What helps us mitigate the risk?)*		**Mitigating actions** *(What more are we/should we be doing at ICB level?)*
1	ICS Five Year Strategy, including the 10 Big Ambitions, focusing on health inequalities and wider economic, social and political factors.	(1) Development of granularity of data to have full insight across different inequalities and impact across different populations. This is aimed for completion by the end of 2025/26.
2	Health Inequalities Steering Group oversees spend of funding on specific initiatives to address inequalities.	
3	An MOU with WYCA setting out shared priorities, working and governance arrangements.	
4	Team working across health inequalities, with an in-house ICB team together with shared posts with WYCA.	
Sources of assurance *(Where is the evidence that the controls work?)*		**Links to ICB risk register** *(Reference numbers/brief description)*
1	Integrated Care Partnership Board - agenda items, discussions, evidenced by minutes	**2391** - people seeking asylum; **2120** - reduction/loss of VCSE services; **2402** - access to GP services; **2267** - maternity services access based on clinical need rather than social complexity; **2106** - cancer health inequalities; **2437** - GP collective action
2	ICB Board - four deep dives into health inequalities during 2024/25 - agenda and minutes	
3	ICB Board - six monthly performance dashboard metrics against 10 Big Ambitions - agenda and minutes	
4	System Oversight and Assurance Group - rolling programme of metrics reported - agenda and minutes	
5	WYCA / ICB Quarterly Leadership Team meeting to oversee MOU	
6	Internal Audit review of Health Inequalities Partnering Arrangements - Significant Assurance (June 2024)	**Positive Assurance** - see separate log

Bradford District and Craven (BD&C)	**Place lead:**	**Therese Patten**	**Nominated lead for this risk:**	**Sohail Abbas (28.01.25)**

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (BD&C)			**Current (BD&C)**			We agree with WYICB assessment and score the same for the BDC HCP with the following rationale: Inequalities occur due to health and wider determinants. We are working closely with health and social partners within BDC HCP. There are a range of factors where we have more limited control with regards to narrowing inequalities, e.g. around poverty, housing, skills. With the financial deficit in the ICB there is a risk of losing funding streams aimed at reducing health inequalities for example Core20Plus5.
BOLD	**Likelihood**	**4**	**16**	**Likelihood**	**4**	**20**	
	Impact	**4**		**Impact**	**5**		

Key controls *(What helps us mitigate the risk?)*		**Mitigating actions** *(What more are we/should we be doing at place by when?)*
1	BDC HCP (place) Population Health Management structure implemented and Business Intelligence team aligned to transformation priorities, enablers, Community Partnerships / Primary Care Networks	1. Health and Wellbeing Board Strategy - work is ongoing to finalise the district plan for 2025/2035 with a clear focus on improving economic activity and reducing wider inequalities. 2. EDI work and anti-racism strategy development in Bradford District and Craven (2025 ongoing). 3. The economic accelerator programme is starting from April 2025 with preparation ongoing (2025/26) 4. Core20Plus5 evaluation is undergoing (2025/26)
2	Wellbeing Board (Bradford District) and Health and Wellbeing Board (North Yorkshire)	
3	Health and Wellbeing Board Strategy	
4	Reducing Inequalities in Communities (RIC) work plan for the Reducing Inequalities Alliance sets out work on local priorities to address wider determinants; local Core20PLUS5 implementation group; Reducing Inequalities Alliance (cross partnership membership).	
5	The alliance has a work plan to deliver the Core20PLUS5 programme locally (with hyper local commissioning at community partnership level, and for CYP interventions to reduce inequalities).	
6	We are ensuring that our work to reduce inequalities runs as a golden thread through all that we do in the Act as One partnership and have published our Call to Action to reduce inequalities locally (and launched the Inequalities campaign and events with our workforce)	
7	The Core20Plus5 and health inequalities premium dashboards are established	
8	We are supporting West Yorkshire Health Equity fellowship scheme and mentoring local fellows across a range of work areas. Our Reducing Inequalities in Communities programme has 20 different projects covering health, wider determinants of health and community settings and we have extended many of these initiatives and embedded into business as usual where appropriate.	
Sources of assurance *(Where is the evidence that the controls work?)*		
1	Reducing inequalities alliance - regular meetings - Papers and Mins	
2	Health and Wellbeing Board - Papers and Mins	
3	The Core20Plus5 and health inequalities premium dashboards	
		Links to Place Risk Register
		2317, 2386, 2477, 2418, 2221

Calderdale	**Place lead:**	**Robin Tuddenham**	**Nominated lead for this risk:**	**Neil Smurthwaite (20.12.2024)**

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (Calderdale)			**Current (Calderdale)**			As WYICB outlines above
BOLD	**Likelihood**	**4**	**16**	**Likelihood**	**5**	**20**	
	Impact	**4**		**Impact**	**4**		

Key controls *(What helps us mitigate the risk?)*		**Mitigating actions** *(What more are we/should we be doing at place?)*
1	We have a shared set of priorities set by Calderdale Health and Wellbeing Board - local plan feeds into ICB / ICP 5-year strategy forward plan	1. Calderdale council run a cost of living programme (2022 - ongoing)
2	Reducing inequalities is a key ambition of the partnership	
3	Council Director of Public Health is lead for health inequalities work across Calderdale	
Sources of assurance *(Where is the evidence that the controls work?)*		
1	Progress against the ICB metrics on inequalities is reviewed regular by HWBB and CCPB	
2	Local JSNA	**Links to Place Risk Register;**
3	Council Director of Public Health- attends Partnership Board	2224, 2476, 2149, 1998, 1493, 62, 2162, 1977, 2469, 2449, 2484,

Kirklees	**Place lead:**	**Carol McKenna**	**Nominated lead for this risk:**	**Steve Brennan (13.01.2025)**

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (Kirklees)			**Current (Kirklees)**			Recognise that addressing inequalities will take time and there are factors beyond our control, however the partners are committed to addressing this through the work that they do.
BOLD	**Likelihood**	**4**	**16**	**Likelihood**	**5**	**20**	
	Impact	**4**		**Impact**	**4**		

Key controls *(What helps us mitigate the risk?)*	**Mitigating actions**

1 Kirklees Health and Wellbeing strategy	1. Progressing on the work of the inclusive community strategy (one of top tier partnership strategy) (2025/26) 2. The Kirklees ICB committee committed to continue with their work in the November 2024 meeting and actions were agreed as part of this work (2025/26)
2 Health and Wellbeing Plan	
3 Kirklees Economic, Environment and Inclusive Communities Strategies.	
Sources of assurance *(Where is the evidence that the controls work?)*	
1 Regular reports to Health and Wellbeing Board	
2 Regular reports to Partnership Forum / ICB committee/ and other place governance	
3 Project reports	**Links to place risk register:** 2475, 2240, 2445

Leeds	Place lead:	Tim Ryley				Nominated lead for this risk:	Nick Earl (19.12.2024)
ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (Leeds)			**Current (Leeds)**			Inequalities continue to widen in Leeds due to wider social and economic factors. LHCP has a strong and continued focus to address these disparities through our operating framework.
BOLD	**Likelihood**	**4**	**16**	**Likelihood**	**5**	**20**	
	Impact	**4**		**Impact**	**4**		

Key controls *(What helps us mitigate the risk?)*	**Mitigating actions** *(What more are we/should we be doing at place?)*
1 The Population and Care Delivery Board focus on health inequalities as a specific part of their remit.	1. Prioritisation of focus areas for next year includes a specific selection criteria around inequalities (2025/26) 2. 2024/25 embedded Core20Plus5 into general practice incentive scheme (GPOP) - continue and review in 2025/26 3. Leeds is re-focusing its healthcare inequalities oversight group made up of executives from local providers to align and focus our efforts in this space (2025/26) 4. A health inequalities dashboard has been established and will undergo refinement in 2025/26 5. The ICB and other health partners will be supporting Leeds City Council ambition to be a Marmot city (2025 - onwards)
2 The Delivery and Inequalities Sub-Committee	
3 Healthy Leeds Plan priorities focussed on improving health in the most deprived parts of the city	
4 Leeds financial planning process include a specific principle to minimise impact on inequalities and includes work to Equality impact and population as well as scheme level.	
5 A health inequalities dashboard has been established	
6 2024/25 embedded Core20Plus5 into general practice incentive scheme (GPOP)	
7 The local strategy identifies its priorities by looking at the needs of the most deprived in the city (IMD1)	
Sources of assurance *(Where is the evidence that the controls work?)*	
1 Meeting notes from Tackling Health Inequalities Group (THIG). In future this will come from the healthcare inequalities oversight group	
2 Population and Care Delivery Board Bi-annual reports	**Links to place risk register:** 2415, 2354, 2301, 2018, 2016
3 Delivery and Inequalities Sub-Committee minutes	
4 Core20Plus5 dashboard	

Wakefield	Place lead:	Mel Brown				Nominated lead for this risk:	Ruth Unwin, Amrit Reyat (23.01.25)
ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (Wakefield)			**Current (Wakefield)**			Local position reflects the WYICB position. Current likelihood is high due to significant pressures in the system.
BOLD	**Likelihood**	**4**	**16**	**Likelihood**	**5**	**20**	
	Impact	**4**		**Impact**	**4**		

Key controls *(What helps us mitigate the risk?)*	**Mitigating actions** *(What more are we/should we be doing at place?)*
1 Healthy Standard of Living for All is one of the four priorities in the Health and Wellbeing Strategy	1. Community of Practice event being scheduled for May 2025 and the Wakefield together partnership has established a steering group which is taking forward the development of a district plan which has a focus on wider determinants of health. 2. The work to develop the place response to reducing economic inactivity is currently taking shape (2025/26) 3. Wakefield is working with funding from Health Determinants Research Collaborative (HDRC) to establish research capacity around health inequalities (2025/26)
2 Economic Strategy is in place led by the local authority. Elements that impact on health inequalities are reported to Health and Wellbeing Board	
3 Joint post working across health and the Local Authority addressing inequalities is in place	
4 Joint Steering Group established	
5 Community of Practice event being scheduled for May 2025	
6 We are now established as a enabler programme in our transformation and delivery collaborative	
Sources of assurance *(Where is the evidence that the controls work?)*	
1 Regular reports such as Bi-monthly public health profiles addressing inequalities are presented to the Health and Wellbeing Board and to the Wakefield District Health and Care Partnership	
2 Wakefield Joint Strategic Needs Assessment	**Link to Place Risk Register**
4 Report to WDHCP Committee in March 2024 on the evaluation and principles of allocation of 2024-25	2481

WYICB - Board Assurance Framework - ICB and places		Version: 8	Date: November 2024
Mission 1	Failure to manage strategic risk could result in a failure to **REDUCE INEQUALITIES**	**Lead director(s) / board lead**	Ian Holmes
Strategic risk 1.3 (previously 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.	**Lead committee / board**	ICB Board *(linked to place committees)*

ICB risk appetite	**ICB risk scores**						**Rationale for current ICB score**
	Target (ICB)			**Current (ICB)**			
OPEN	**Likelihood**	**2**	**8**	**Likelihood**	**3**	**12**	Integrated care in communities is fundamental to our strategy for improving outcomes and tackling inequalities and a priority for all places. We have made good progress in some areas, but progress has been variable and there is still significant work to be done.
	Impact	**4**		**Impact**	**4**		

	Key controls *(What helps us mitigate the risk?)*	**Mitigating actions** *(What more are we/should we be doing at ICB level?)*
1	ICS and HWB strategies, together with the Joint Forward Plan set out a clear and aligned vision and plans for integrating services in communities, in line with the Fuller recommendations and the medium term strategy.	1. Place Partnership Review (led by Anthony Kealy) will support further development of Place model including provider collaboratives and integration in Places. Anticipated conclusion by March 2025. 2. National focus on integrated neighbourhood health as part of the new Government's objectives will create greater focus. The ICB's response to this will create further impetus for change with further detail expected in Spring 2025. This will influence ICB planning for 2025/26.
2	ICB medium term financial plan supports a differential investment towards primary and community care.	
3	Working with stakeholders through the Power of Communities programme on 4 key priority areas for specific focus over the next 5 years to ensure reduction in inequalities and to add value and maximise impact including: Acute & Specialist Provision; Community & Neighbourhoods; Access, inclusion and working with diverse communities and workforce.	
4	Quality Committee and ICB Board receive Integrated Performance Dashboard which reflects progress made towards integrating services and neighbourhoods.	
5	Development of a Blueprint for delivering neighbourhood-based care, driven by integration, to deliver outcomes important to people and tackle inequalities. This is being overseen by the Transformation Committee.	

	Sources of assurance *(Where is the evidence that the controls work?)*	**Links to ICB risk register** (Reference numbers/brief description)
1	Published ICS health and wellbeing strategy and Joint Forward Plan	**2120** - risk of a widening of health inequalities and poorer health outcomes due to the reduction or loss of VCSE services and aggregated impact of disinvestment in the VCSE
2	Delivery of the Fuller Board work plan (minutes and actions)	
3	Metrics within the Integrated Performance Dashboard, discussion evidenced through minutes of Quality Committee and ICB Board	
4	Internal Audit review - Primary Medical Services Commissioning (significant assurance)	**See the separate Positive Assurance Log**

Bradford District and Craven (BD&C) **Place lead:** **Therese Patten** **Nominated lead for this risk:** **Sohail Abbas. Helen Farmer (30.01.25)**

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (BD&C)			**Current (BD&C)**			
OPEN	**Likelihood**	**2**	**8**	**Likelihood**	**3**	**12**	Key priority with significant work required across our PCNs, CPs and localities. Challenges are capacity to deliver and maturity of multi-sector provider collaboration. We are prioritising based on areas PHM data is highlighting.
	Impact	**4**		**Impact**	**4**		

	Key controls *(What helps us mitigate the risk?)*	**Mitigating actions** *(What more are we/should we be doing at place?)*
1	Development of our Primary Care Networks and Community Partnerships (CPs) that together support integrated neighbourhood health service models - and which can be flexible to the specific needs of local communities across BDC.	1. Continuing to expand use population health management data and analysis to drive our commissioning intentions and decisions on service transformation and provision - and empower service change at the neighbourhood level (2025/26) 2. Reducing Inequalities Alliance are working with our Community Partnerships (CPs) in relation to on-going roll out of Core20+5 initiatives. CPs are grouped by LA wards, have linked PCNs and also have strong input from the VCSE, to further facilitate opportunities for neighbourhood co-production on integrating care and tackling inequalities (2025/26) 3. BdC health and care strategy and national 10 Year Plan will inform continued evolution of local integrated neighbourhood health models (2025/26) 4. Long term conditions and multi-morbidity needs assessment and development of a holistic model of care, with focus on those at high/rising risk and high intensity users of health services (2025/26)
2	Reduce Inequalities Alliance (RIA) built around 4 themes: to set the strategic vision; support best practice; build leadership capacity; and facilitate and share learning. This is also enabling embedding of Core20Plus5 approaches at the neighbourhood level.	
3	Strategic commissioning intent and development of our health and care strategy is underway.	

	Sources of assurance *(Where is the evidence that the controls work?)*	**Links to Place Risk Register**
1	Place priorities for system transformation, including integrated neighbourhood health services development, report to Partnership Leadership Executive and to the BDC HCP Partnership Board	
2	Reducing Inequalities Alliance reporting to PLE and BDC HCP Partnership Board	
3	Development of our health and care strategy; co-production with Bradford LA on the district plan (delivery oversight by the Health and Wellbeing Board); ongoing work with NY LA via our localities	2221, 2486

Calderdale **Place lead:** **Robin Tuddenham** **Nominated lead for this risk:** **Neil Smurthwaite (20.12.2024)**

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (Calderdale)			**Current (Calderdale)**			
OPEN	**Likelihood**	**2**	**8**	**Likelihood**	**3**	**12**	Integrated care in communities is fundamental to our strategy for improving outcomes and tackling inequalities and a priority for Calderdale.
	Impact	**4**		**Impact**	**4**		

	Key controls *(What helps us mitigate the risk?)*	**Mitigating actions** *(What more are we/should we be doing at place?)*
1	Calderdale Cares Community Programme Board is in place for integrating services and community.	1. Looking to utilise data over coming year to ensure efficiency and effectiveness of services to ensure out of hospital care reduces inequalities, there is a programme of work ongoing (Quality group) 2025/26
2	Tranformation deliver plan has integrated neighbourhood team as key objective for the partnership board	
3	Calderdale Community Collaborative Programme board in placed led by PCN Directors.	
4	Senior leadership meeting in July 2024, discussion on integrated neighbourhood teams	
5	There are variety of governor forums and enabler groups that bring partners across the health and care partnership together to address issues relating to issues in a joined up way	

	Sources of assurance *(Where is the evidence that the controls work?)*	
1	A year end report will be presented to the partnership board on the tranformation delivery plan for which integrated neighbourhood is the key priority	
2	Joint Forward Plan being developed.	**Links to Place risk register:**
3	Calderdale Community Collaborative Programme board in place led by PCN Directors. Terms of Reference and mins.	2476, 2163, 1493, 62, 1977, 2469, 2449, 2484, 2092, 2156

Kirklees **Place lead:** **Carol McKenna** **Nominated lead for this risk:** **Catherine Wormstone (10.01.2025)**

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (Kirklees)			**Current (Kirklees)**			
OPEN	**Likelihood**	**2**	**8**	**Likelihood**	**3**	**12**	While a strategy is in place, there is a need to focus on the delivery of transformation and improvements on the ground across Kirklees and to better align the work that is already in train across the place.
	Impact	**4**		**Impact**	**4**		

	Key controls *(What helps us mitigate the risk?)*	**Mitigating actions** *(What more are we/should we be doing at place?)*
1	Core20+5 is being lead by the Public Health team on behalf of the Partnership	1. Focus on West Yorkshire blueprint and INTs at January (2025) delivery collaborative 2. Development session with PCNs in February 2025 3. Plan to re-visit next steps with ICB Committee in March 2025 with a view to take in a public paper in May 2025. 4. Building on agreement to use PCN footprints as a basis for further developing INTs (March 2026) 5. Planned refresh of the objective within the health and care plan (March 2025)
2	Addressing inequalities is and will continue to be written into the scope and terms of reference for all place based work areas, to ensure that the focus on inequalities is a common theme to all our work	
3	PCN data packs refreshed and re-issued to provide population based data at neighbourhood level	
4	A number of services including VCSE already aligned around communities	

	Sources of assurance *(Where is the evidence that the controls work?)*	
1	Published Health and Wellbeing Strategy	Positive assurance
2	The local Health and Care Plan follows directly on from the Health and Wellbeing Strategy	Data available at PCN level is already driving the delivery plans of PCNs working in partnership with statutory and VCSE partners in each footprint to support change and integration on the ground.
3	Extensive engagement (lead by Healthwatch) with local people to inform strategy and plans to ensure they meet the needs of the local population	

4 ICB Committee meetings - notes Delivery collaborative - notes PCN meetings - notes	**Links to place risk register** 2475

Leeds	**Place lead:**	**Tim Ryley**	**Nominated lead for this risk:**	**Helen Lewis (10.01.2025)**

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (Leeds)			**Current (Leeds)**			Strong work plans already between Leeds Community Healthcare (LCH) and the GP Confederation, within LCP areas and in key areas such as frailty, mental health and transfer of care. More to do, and the impacts of getting it wrong for individuals remain high but good progress.
OPEN	**Likelihood**	**2**	**8**	**Likelihood**	**3**	**12**	
	Impact	**4**		**Impact**	**4**		

Key controls *(What helps us mitigate the risk?)*	**Mitigating actions** *(What more are we/should we be doing at place?)*
1 Strong LCPs and PCNs.	1. Developing integrated neighbourhood clinics (2025/26) 2. LCH and GP confederation looking at neighbourhood integration opportunities (2025/26) 3. LCH and Leeds City Council developing their active recovery offer to improve integration (2025/26) 4. Community mental health programme engaging all relevant partners to improve service integration and focus on those people most at risk (new contract with VCSE 2025/26)
2 All relevant data displayed by IMD and other key variables linked to inequalities.	
3 Population and care delivery board structures in place, with increasing access to data that enables analysis of issues at very local levels	
Sources of assurance *(Where is the evidence that the controls work?)*	**Positive Assurance**
1 Access to Leeds data model/power BI platforms, and RAIDR to review data sets.	
2 Notes of LCP/PCN meetings.	Data available at PCN level is already driving the delivery plans of PCNs working in partnership with statutory and VCSE partners in each footprint to support change and integration on the ground.
3 All LHCP programmes pay due attention to joining up services, demonstrated via minutes.	**Link to place Risk Register**
	2415

Wakefield	**Place lead:**	**Mel Brown**	**Nominated lead for this risk:**	**Ruth Unwin, Amrit Reyat (23.01.25)**

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (Wakefield)			**Current (Wakefield)**			There is limited opportunity for place to influence the impact of inequalities but reducing inequalities is a priority for the Health and Wellbeing Board and the Wakefield District Health and Care Partnership.
OPEN	**Likelihood**	**2**	**8**	**Likelihood**	**3**	**12**	
	Impact	**4**		**Impact**	**4**		

Key controls *(What helps us mitigate the risk?)*	**Mitigating actions** *(What more are we/should we be doing at place?)*
1 Wakefield Transformation and Delivery Collaborative established supported by a network of Provider Alliances with responsibility for joining up services and addressing inequalities	1. The development of a neighbourhood model enables a targeted and more planned approach to care (2025/26) 2. The reducing healthcare inequalities steering group is connected into the VCSE collaborative which is taking forward the development of the VCSE strategy for the district (2025/26) 3. The work to develop the place response to reducing economic inactivity is currently taking shape (2025/26)
2 Core Senior Leadership team established across Wakefield place with distributed leadership responsibilities	
3 Action plan to address the gaps following the publication of the Fuller report	
Sources of assurance *(Where is the evidence that the controls work?)*	**Positive Assurance**
1 Transformation and Delivery Collaborative Chair's report to Wakefield District Health and Care Partnership highlights key discussions - bi monthly	An update report was provided to the health and wellbeing board on the 30 January 2025 regarding the development of the VCSE strategy.
2 Provider Alliance deep dive regarding progress against priorities reported to Transformation and Delivery Collaborative - monthly	**Links to Place Risk Register**
3 Medical Director for Integrated Community Services attends Fuller Board	2397, 2429

WYICB - Board Assurance Framework - ICB and places							Version: 8	Date: October 2024
Mission 2	Failure to manage the strategic risk could result in a failure to **MANAGE UNWARRANTED VARIATION IN CARE**						**Lead director(s) / board lead**	Kate Sims
Strategic risk 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.						**Lead committee / board**	Transformation Committee
ICB risk appetite	**ICB risk scores**						**Rationale for current ICB score**	
	Target (ICB)			**Current (ICB)**			Workforce recruitment and retention remains a challenge across the system. There is an ambitious long term workforce plan and adult social care workforce strategy in place. National and regional messaging around being ready for workforce expansion versus reality of being asked to reduce overall workforce costs.	
OPEN	**Likelihood**	**4**	**8**	**Likelihood**	**4**	**12**		
	Impact	**2**		**Impact**	**3**			

	Key controls *(What helps us mitigate the risk?)*	**Mitigating actions** *(What more are we/should we be doing at ICB level?)*
1	WY People Board (multi-sector) oversight of priority programmes - a system wide overview of the responses to the workforce challenges under the West Yorkshire People Plan	(1) WY People Strategy is being refreshed during 2025. (2) ICBs are required to respond on workforce controls to regional offices during December 2024, with the intention of providing a clear overall picture. (3) Workforce Strategy and Planning Team - primary agenda is aligned with Strategic Workforce Transformation Forum, and as this develops they will provide a level of workforce transformation capacity. (4) One of the agreed terms of reference for the Strategic Workforce Transformation Forum centres on influencing regionally and nationally. The Forum is newly developed, and this aspect needs to develop further.
2	WY Mental Health and Well Being Hub - a system wide offer to all staff across the WY partnership to ensure that access to Mental Health Wellbeing is available to all - with regular reporting into People Board	
3	WY Strategic Workforce Transformation Forum established (system wide) to have strategic overview to ensure readiness against long term workforce plan and adult social care workforce strategy	
4	Workforce Place Leads and place-based plans (for further details, see Place BAF below)	
5	Creating Global partnerships for the supply of International recruits into challenged areas - to ensure ethical and sustainable international recruitment, education pathway and to offer system support. Dedicated global team working directly with NHS England.	
6	Active leadership on workforce part of annual operating plan cycle, with ongoing assurance through Finance Investment and Performance Committee, Transformation Committee and ICB Board.	
	Sources of assurance *(Where is the evidence that the controls work?)*	**Links to ICB risk register** *(Reference numbers/brief description)*
1	Transformation Committee; Strategic Workforce Forum; People Board - agenda, papers and minutes	**2296** - YAS workforce; **2108** - cancer workforce; **2324** - ICB workforce; **2294** - ICB workforce; **2406** - pharmacy workforce; **2197** - maternity workforce; **2175** - discharge from hospital delays due to social care capacity; **2436** - maternity workforce; **2402** - general practice workforce
2	Place workforce leads meet with WY People Team to ensure progress is monitored and shared across WY. WY People Team actively attend Place workforce committees. Director of People is a member of Yorkshire and Humber Workforce Steering Group for adult social care.	
3	NHS sickness absence and turnover is reported to ICB Board via Integrated Performance Report.	
2	Active data flow across wider People agenda, which is presented to the People Board and Strategic Workforce Transformation Forum.	
3	(NHS specific) Staff Survey annual results	**See the separate Positive Assurance Log**

Bradford District and Craven (BD&C)	**Place lead:**	**Therese Patten**	**Nominated lead for this risk:**	**Lesley Tillotson, Andrew Milner 14.01.2025**

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (BD&C)			**Current (BD&C)**			The workforce challenges remain across both health and social care within the public and independent sector. Additionally, there are similar challenges within the voluntary, community and social enterprise sector where issues around living wage and competition from larger employers is cited as a particular challenge. Within health, retention remains a signficant challenge.
CAUTIOUS	**Likelihood**	**2**	**6**	**Likelihood**	**4**	**12**	
	Impact	**3**		**Impact**	**3**		

	Key controls *(What helps us mitigate the risk?)*	**Mitigating actions** *(What more are we/should we be doing at place?)*
1	BDC HCP System Finance and Performance Committee (System FPC) – led by an independent NED chair who champions the agenda at the BDC Partnership Board. Broad based senior participation including care sector and primary care. Quarterly review of the detailed workforce dashboard with a view to identifying workforce risks and issues.	1. Delivery of the workforce priority programme at place with emphasis on building recruitment pipelines for health and social care staff specifically through the development of a consolidated entry level recruitment programme run via Skills House within Bradford Metropolitan District Council (Ongoing 2025/26) 2. Working across the system within partners including Higher Education Institutions to develop a pipeline for registered health and care roles (Ongoing 2025/26) 3. Embedding inclusive recruitment practices across the partnership (Ongoing 2025/26)
2	BDC HCP People Plan has been refined to ensure alignment with the priorities of partner organisations and the partnership more broadly. As a part of this, particular focus has been placed upon capacity and ability to deliver.	
3	'People' is one of five strategic priorities for BDC HCP which means that additional focus and resource applied to delivery of the People Plan. Reported on at Partnership Leadership Executive and Partnership Board. With CEO lead Foluke Ajayi in place.	
	Sources of assurance *(Where is the evidence that the controls work?)*	**Links to Place Risk Register**
1	Triple A report from SFPC to Partnership Board	2386, 2227, 2477, 2434, 2422, 2420, 2418, 2417, 2215, 2421,
2	Highlight reports from the People Programme through a newly established Programme Board	
3		

Calderdale	**Place lead:**	**Robin Tuddenham**	**Nominated lead for this risk:**	**Neil Smurthwaite (20.12.2024)**

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (Calderdale)			**Current (Calderdale)**			The workforce challenges remain across social care both within the public and independent sector, together with the voluntary, community and social enterprise sector, with challenges of living wage and competition from larger employers cited as a particular challenge. Within health, retention of staff is seen as a priority alongside recruitment.
CAUTIOUS	**Likelihood**	**4**	**8**	**Likelihood**	**4**	**12**	
	Impact	**2**		**Impact**	**3**		

	Key controls *(What helps us mitigate the risk?)*	**Mitigating actions** *(What more are we/should we be doing at place?)*
1	West Yorkshire plans reflected at place.	
2	Operating model is in place	
3		
	Sources of assurance *(Where is the evidence that the controls work?)*	
1	Update to the partnership board	**Links to Place Risk Register;**
2		2224, 1338, 2149, 1493, 62, 2162, 1977, 2092, 2156
3		

Kirklees	**Place lead:**	**Carol McKenna**	**Nominated lead for this risk:**	**Steve Brennan (13.01.2025)**

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (Kirklees)			**Current (Kirklees)**			Whilst workforce data shows that generally the workforce is increasing at a modest rate, it is not in line with growth targets and therefore workforce challenges still remain across all sectors of Health and Social Care. Some of the challenges are structural [such as rates of pay within social care] and therefore are difficult to address in the short term. Others, such as the expansion of training capacity take time to have an impact. Therefore addressing the challenges will require a concerted effort over a number of years. The workforce challenges with Kirklees are in line with those across West Yorkshire as a whole, and therefore our risk scores are in line with those for the wider West Yorkshire ICB. Risk score changed to mirror WY ICB, impact changed from 2 to 3, changing the overall risk score from 8 to 12.
CAUTIOUS	**Likelihood**	**4**	**8**	**Likelihood**	**4**	**12**	
	Impact	**2**		**Impact**	**3**		

	Key controls *(What helps us mitigate the risk?)*	**Mitigating actions** *(What more are we/should we be doing at place?)*
1	Kirklees actively engaged in West Yorkshire arrangements.	1 We have made progress in supporting the social care workforce with initiatives to help recruit staff. We are building on this by working with the newly established Kirklees Care Association, for example, to support staff wellbeing within care homes.

2	Workforce arrangements well established within Kirklees for working with health and care providers and sectors including the VCSE and social care. We have an agreed integrated workforce approach with Calderdale which focuses on 3 pillars (1. Looking after our people, 2. Recruiting and retaining our people, and 3. Developing our people together). We have a system Senior Responsible Officer in place and a joint Workforce Steering Group which is supported by a Working Group for each of the 3 pillars.	However, this is an area where we want to do more going forward with an emphasis in 2025/26 on supporting staff health and wellbeing. 2 We want to develop approaches to building training capacity in non-acute settings, but this will take time. Working as part of the WY placement expansion work with a focus around pharmacy placements and placements in care home settings (2025/26) 3 We also want to build more on the opportunities created by working with the University of Huddersfield, particularly around the new Health Innovation Campus, Health and Wellbeing Academy, and Leadership Development. Recently established a partnership board to oversee this work (2025/26)
Sources of assurance *(Where is the evidence that the controls work?)*		
1	Evidence on the impact of projects and initiatives is monitored within the appropriate Working Group for each of the pillars.	
2	Each of the 3 Working Groups reports into our Joint Workforce Steering Group to present evidence of impact of their projects and initiatives.	**Link to place risk register:** 2078
3	Regular updates on the Joint Workforce Programme are reported into the Kirklees Partnership Forum, which is part of our overall place governance arrangements. Updates are also presented to other governance forums when required such as the Kirklees Transformation sub-committee.	

Leeds	**Place lead:**	**Tim Ryley**		**Nominated lead for this risk:**	**Kate O'Connell (07/01/2025)**
ICB risk appetite	**Place risk scores**				**Rationale for current place score**
	Target (Leeds)			**Current (Leeds)**	The current risk score reflects the scale of unfilled vacancies across the vast majority of employers in the context of a tight labour market. Although targeted activity has reduced some vacancies, the financial pressures have created recruitment controls and so notable risk remains. There has been a shift in focus from recruitment to retention. There are also insufficient numbers of trainees in the system, with a potential long term negative impact on workforce supply. Current pressures on services and the cost of living increase creates significant risk of retention, partricularly for the lowest paid staff, many of whom are in the third sector. Existing mitigations are unlikely to resolve the scale and nature of these challenges in the short term.
CAUTIOUS	**Likelihood** 3	**9**	**Likelihood** 4	**12**	
	Impact 3		**Impact** 3		

Key controls *(What helps us mitigate the risk?)*		**Mitigating actions** *(What more are we/should we be doing at place?)*
1	The Leeds One Workforce Strategy has been refreshed, continuing to providing a cohesive, prioritised approach for the city's health and care partners and a clearly defined programme of work.	1. Continue to identify and secure diverse funding which supports collaborative recruitment and retention. The Leeds Health and Care Academy leads this on behalf of the city and income is assessed annually. Next annual review April 2025. 2. Continue to increase and diversify student placement opportunities and experience, and support transition from education to employment. This is a priorty strategic project in the Leeds One Workforce Programme due for review in November 2025. **Link to place risk register:** None.
2	Leeds City Resourcing Group (LCRG) guide and monitor the collective impact of workforce recruitment and retention activity across Leeds Health and Care Partnership.	
3	Leeds H&W Community of Practice (CoP) collaborates on city-wide funding and services for H&SC staff including sound relaxation, wellbeing retreats, WRAP courses and welfare officer support. The funding for these will end in March 2025 but the Academy is exploring alternative delivery models and available funding.	
Sources of assurance *(Where is the evidence that the controls work?)*		
1	Minutes from Leeds One Workforce Strategic Board (LOWSB), LCRG and Leeds H&W CoP	
2	Academy Steering Group quarterly reports	
3	Leeds One Workforce City Risk profile	

Wakefield	**Place lead:**	**Mel Brown**		**Nominated lead for this risk:**	**Dominic Blaydon 30.01.25**
ICB risk appetite	**Place risk scores**				**Rationale for current place score**
	Target (Wakefield)			**Current (Wakefield)**	The current likelihood and impact scores recognise the work underway as part of the implementation and delivery of The Wakefield People Plan. The Plan consists of 6 Pillars, all aligned to supporting staff health and wellbeing, retention and recruitment included in Pillar 1 'Looking after our People' and Pillar 5 'Growing and Developing Our Workforce. These programmes will support partnership and collaborative initiatives. It also includes commitment to the Memorandum of Understanding (MoU) and Operational Template to support the deployment of staff between organisations. This MoU will mitigate any future impact of operational and process challenges with recruitment and retention of staff at an organisational level.
CAUTIOUS	**Likelihood** 4	**8**	**Likelihood** 4	**12**	
	Impact 2		**Impact** 3		

Key controls *(What helps us mitigate the risk?)*		**Mitigating actions** *(What more are we/should we be doing at place?)*
1	Wakefield People Alliance oversight of priority programmes - a system wide overview of the responses to the workforce challenges under the Wakefield People Plan	The Wakefield People Alliance's Pillar 5 Programme adopts a comprehensive approach to tackling workforce risks through strategic recruitment initiatives. These initaitives mitigate workforce risks associated with recruitment and retention of staff across the health and care system. Initiatives include: (timescale - 2025/26) 1. Hyperlocal Recruitment Programme, which focuses on attracting talent from within the local community. By partnering with local organisations and offering tailored recruitment opportunities, this programme supports the development of a diverse workforce that is connected to local communities. 2. School Engagement Programme, which fosters early career awareness by engaging students and raising the profile of the full range of careers available in our sector. This initiative not only encourages the pursuit of healthcare careers but also strengthens the pipeline of future professionals. 3. The Student Placement Framework further enhances workforce sustainability by providing students with hands-on experience within the Wakefield health and care sectors, helping to bridge the gap between academic learning and real-world application. The Wakefield People Alliance addresses retention through its Pillars 1-3 Programmes. Initiatives include: (timescale - 2025/26) 1. The Wakefield Health and Care Learning Portal supports continuous development by offering accessible training and development resources for current staff, promoting career growth within the sector. 2. The Compassionate Leadership Programme cultivates empathetic leadership to create supportive working environments, while The Leading Wakefield Together training builds collaborative leadership skills across the workforce. 3. Coaching and Mentoring Hubs provide personalised support to staff, helping them navigate career challenges and fostering long-term engagement.
2	Mental Health and Well Being Hub - a system wide offer to all staff across the West Yorkshire partnership to ensure that access to Mental Health Wellbeing is available to all.	
3	The Wakefield People Plan has 6 Pillars within it, each with two Pillar Leads, supported by a Programme Manager to plan, lead the delivery of each Programme	
4	Wakefield Workforce Project Management Office established across the Wakefield system	
Sources of assurance *(Where is the evidence that the controls work?)*		
1	Access and analysis of workforce sector data to inform the development of a Workforce Plan dashboard to be reported through to Integrated Assurance Committee.	
2	Wakefield has been supported via system-wide funding/workstreams including staff training and support, coaching and mentoring, money buddies, physical health checks.	
	Positive Assurance The current Programme within the Wakefield People Plan focuses on the following priorities: - Community Career Events co-designed by the Community delivered by all health and social care providers across Place and hosted in Community Anchors. Hyper local recruitment in place with job interviews on the day and roles offered to community members. This is an evolving programme which will be delivered across all localities. - International recruitment of Nurses and GPs via MYTT - System approach to the pooling of the apprenticeship levy and developing resources specifically for young people and co-designed by young people to increase the number of apprenticeships in the system and grow our own from the future generation - Strategy to support older staff to return or remain in the workforce via pension options and volunteering opportunities - Working with the social care independent sector to support their key challenges identified and co-design solutions, which include system offers on training, well-being and local recruitment. - Strong place-based governance arrangements are in place to support the delivery of the programmes, including a well-developed People Alliance, dedicated System Workforce Programme Management Office and Wakefield Health and District Partnership People Hub.	
		Links to Place Risk Register
		2129

WYICB - Board Assurance Framework - ICB and places							Version: 8	Date: October 2024
Mission 2	Failure to manage the strategic risk could result in a failure to **MANAGE UNWARRANTED VARIATION IN CARE**						**Lead director(s) / board lead**	James Thomas
Strategic risk 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.						**Lead committee / board**	Quality Committee
ICB risk appetite	**ICB risk scores**						**Rationale for current ICB score**	
	Target (ICB)			**Current (ICB)**			More formal assurance is needed through Transformation Committee and Partnership Board. Significant work has taken place over the last 12 months. Digital is a risk in terms of separation with the new leadership arrangements however this is being focused on.	
OPEN	**Likelihood**	**2**	**6**	**Likelihood**	**2**	**8**		
	Impact	**3**		**Impact**	**4**			

Key controls *(What helps us mitigate the risk?)*		**Mitigating actions** *(What more are we/should we be doing at ICB level?)*
1	Clear governance around Quality with NHSE, providers and places working collaboratively to share learning and report via System Quality Group and ICB Quality Committee	1. Develop assurance mechanisms to Transformation Committee and Partnership Board. 2. Annual review to bring additional rigour with lens on innovation.
2	Research via Applied Research Collaborative (ARC)	
3	West Yorkshire Innovation Leadership Collaborative – joint chaired by Medical Director with Health Innovation Network Clinical lead	
4	West Yorkshire Health and Care Partnership Research Leadership Working Group (RLWG), chaired by Medical Director	
5	HIVE network brings together research and innovation networks	
6	Collaboration with Digital	
Sources of assurance *(Where is the evidence that the controls work?)*		**Links to ICB risk register** *(Reference numbers/brief description)*
1	Agenda and minutes of meetings listed as controls	WY Corporate Risk Register - reference - 2108
2	SOAG oversight of innovation and research networks	
3	Clinical and Care Professional Forum	**See the separate Positive Assurance Log**

Bradford District and Craven (BD&C)	**Place lead:**	**Therese Patten**	**Nominated lead for this risk:**	**Phillipa Hubbard, Grainne Eloi, John Hartley (10.01.2025)**

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (BD&C)			**Current (BD&C)**			Target as per the WYICB scores. Recommend the BDC HCP current score is less at 2x3. Would agree with the rationale noted but recognise that we don't have the issue of 5x places and the logistical challenges associated with this. Recognise the requirement to implement the BDC HCP strategy and 'inverting the power to act' at locality level - this is ongoing through Healthy Communities and Living Well Programmes
OPEN	**Likelihood**	**2**	**4**	**Likelihood**	**2**	**6**	
	Impact	**2**		**Impact**	**3**		

Key controls *(What helps us mitigate the risk?)*		**Mitigating actions** *(What more are we/should we be doing at place?)*
1	Committee structure in place including BDC HCP System Quality Committee which oversees the process of mutual assurance of quality of care delivered by local providers, which identifies issues, and supports improvement. In addition we have Priority and Enabler Programme Boards that provide ownership to transforming services across all place based partners. The system quality insight and assurance group meets monthly to triangulate themes, intelligence and learning which then reports into the System and Quality Committee. The SQC reports quarterly into place partnership board and WY Quality Committee and Quality Group.	1.The Quality Team input into BDC priorities and transformation programmes and patient safety/ quality is taken into account when responding to financial pressures (Work ongoing 2024/25-2026) 2. Development of the dashboard to include patient outcomes to be used as a source of assurance operational is ongoing (2024/25 - 2026) 3. Work is progressing on the BDC clinical strategy to support and streamlining of clinical pathways which supports the work of the place based clinical forum (2024/25)
2	The Innovation Hub working alongside the development of improves as one portal and accompanying process identifies proven best practice and supports local teams to adopt and adapt across the BDC HCP	
3	Model of Distributive leadership in place in Bd&C with HCP for Chief Nurse which provides opportunities to provide assurance and oversight, share best practice, learning and improvement opportunities between partner organisations	
4	Prioritisation framework and WY ICB wide QEIA process has been implemented alongside strategic principles that have been produced by the BDC System Strategy working group to try and narrow the gap	**Links to Bradford place risk register:** 2419
5	Quality requirements are represented with all providers and monitored through the contract management process	
Sources of assurance *(Where is the evidence that the controls work?)*		
1	Assurance through Internal Audit of our transformation programmes and via ongoing reporting and challenge through individual Programme Boards, Partnership Board, Clinical Forum PLE and PLT at place and SQC/SQG and ICB governance structures - through AAA updates from assurance and governance committees (F&PC and SQC) and priority and enabler programmes.	
2	Redeveloped model/way of working for the Place (Bd&C) System Quality Committee (SQC) including the provision of governance and assurance and sharing of best practice through the work of sub-groups and the reporting structure. Terms of Reference and Mins.	
3	The Innovation Hub networked to all other parts of our BDC governance structure, including whole system enabling strategy groups for population health management, workforce, digital, estates, and communication & engagement. Supported by shared system committees for Finance and Performance, Quality and Safety, and our Clinical Forum. The Hub maintains strong links with Bradford Institute of Health Research (BIHR), Yorkshire & Humber AHSN, Yorkshire and Humber Improvement Academy (IA) and the University of Bradford (UoB). Terms of Reference and Meeting Minutes.	
4	Recommendations on investment / dis-investment take into account EQIAs/QEIAs, output from the prioritisation tool and demonstrate strategic fit. EQIA/QEIA roll out commenced in 2023.	

Calderdale	**Place lead:**	**Robin Tuddenham**	**Nominated lead for this risk:**	**Neil Smurthwaite (20.12.2024)**

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (Calderdale)			**Current (Calderdale)**			Governance arrangements are continually reviewed locally. Development time dedicated at PB to discuss key issues as a system,
OPEN	**Likelihood**	**2**	**4**	**Likelihood**	**2**	**6**	
	Impact	**2**		**Impact**	**3**		

Key controls *(What helps us mitigate the risk?)*		**Mitigating actions** *(What more are we/should we be doing at place?)*
1	Place-based Quality Group established to ensure we continue to share lessons and good practice.	
2	Clinical and Professional Forum currently being reviewed with a aim to link the output of the forum to our transformation priorities and financial position	
3	Primary Care Strategy Group meets quarterly and reports to the partnership board.	
4	Urgent care model has been developed that will help UECB and Community programmes joined up impactful initiatives.	
Sources of assurance *(Where is the evidence that the controls work?)*		**Links to Place risk register;**
1	Regular reporting to Calderdale Care Partnership Board.	1338, 2476, 2163, 2149, 1493, 62, 1977, 2092, 2156
2		
3		

Kirklees	**Place lead:**	**Carol McKenna**	**Nominated lead for this risk:**	**Carol McKenna (09.01.2025)**

ICB risk appetite	**Place risk scores**	**Rationale for current place score**

ICB risk appetite		Target (Kirklees)			Current (Kirklees)			Kirklees place reflects the current WYICB wide score.
OPEN	Likelihood	2	4	Likelihood	2	8		
	Impact	2		Impact	4			

	Key controls *(What helps us mitigate the risk?)*	Mitigating actions *(What more are we/should we be doing at place?)*
1	Kirklees ICB Transformation Sub-Committee, supported by the Kirklees Delivery Collaborative as mechanism to enable shared learning across providers	1. Increase visibility and understanding of the West Yorkshire Innovation Leadership Collaborative and the interface between this network and place (Review 2025/26)
2	Working across places and with WY programmes to share learning and experience, identify variation, and opportunities for improvement	2. Establish clearer connections between the WY ICB and the West Yorkshire Innovation Leadership Collaborative (Review 2025/26)
3	Clear governance around Quality oversight in place with providers, working collaboratively to share learning and report via System Quality Group and ICB Quality Sub-Committee	
4	Active participation in WY networks and programmes with evidence of having shared learning from Kirklees, and adopted it from elsewhere.	**Link to place risk register:** 2445
	Sources of assurance *(Where is the evidence that the controls work?)*	
1	Evidence of early adoption and innovation in place e.g. UCR, Lung Health Checks, approach to neighbourhood working.	
2	Reports to Kirklees Sub-Committees demonstrating provider collaboration, examples of innovation and shared learning. Papers and Mins.	
3	System Quality Group and ICB Quality Sub-Committee. Papers and Mins.	

Leeds — **Place lead:** Tim Ryley — **Nominated lead for this risk:** Jason Broch (20.12.2024)

ICB risk appetite		Target (Leeds)			Current (Leeds)			Rationale for current place score
OPEN	Likelihood	2	4	Likelihood	3	12		Although the Leeds governance arrangements have been established with a wide range of stakeholders, these are relatively new and are currently establishing a rhythm and recognition of function. Throughout the last Quarter of 2024/25 and into 2025/26 there is a continual improvement approach to the Leeds governance and priortisation.
	Impact	2		Impact	4			

	Key controls *(What helps us mitigate the risk?)*	Mitigating actions *(What more are we/should we be doing at place?)*
1	Clear governance arrangements in place to provide assurance to the Leeds Committee of the ICB. Place partners working collaboratively through the Assurance Sub-Committees (Quality & People's Experience, Delivery and Finance & Best Value).	1. There are currently a series of joint workshops between members of CPEG and Cheif Operating Officers to develop a collective understanding of risk and modify our decision making framework around mutual support for when the system is experiencing high pressure (2024 - 2025/26)
2	Regular contribution and representation at the ICB Quality Committee and System Quality Group	2. Leeds partnership has appointed a Lead Chief digital information officer (CDIO) from one of the partners to oversee partnership development work and facilitate integration. New governance around this is being developed to be in place by 2025/26.
3	Regular contribution and representation at the WY ICB Safeguarding Oversight and Assurance Partnership	3. All Leeds partnership across Leeds health and social care are working collaboratively with the University of Leeds to develop a research project (SEISMIC) to bring academic rigour to system improvements and integration for people with long term conditions and mental illness, facilitating the use of innovative technology (bid will go in at the end of January 2025, 55 month programme)
4	Leeds Academic Health Partnership membership with representation at Board and implementation levels.	
5	As a partner with Leeds Academic health partnership identifying opportunities from health professionals,	**Link to place risk register:** 2480, 2487
6	The Clinical Professional Executive Group (CPEG) meet monthly and has been reviewing a system approach to risk and learnings from escalated cases to make sure there is a Leeds based approach to those learnings and that partners can better manage system risk collectively	
	Sources of assurance *(Where is the evidence that the controls work?)*	
1	Regular arrangements to evaluate the effectiveness of the Sub-Committees.	
2	Emerging system-wide networking between Quality Improvement leaders across the partnership.	
3	WY ICB Safeguarding Oversight and Assurance Partnership. Papers and Mins	
4	ICB Quality Committee and System Quality Group. Papers and Mins	
5	West Yorkshire clinical and professional forum (monthly) - representation from Leeds	
6	The Clinical Professional Executive Group (CPEG) meet monthly	

Wakefield — **Place lead:** Mel Brown — **Nominated lead for this risk:** Penny McSorley (28.01.25)

ICB risk appetite		Target (Wakefield)			Current (Wakefield)			Rationale for current place score
OPEN	Likelihood	2	4	Likelihood	3	12		WDHCP governance arrangements are now well established and relationships strengthened. Examples of sharing and learning across key forums in the ICB and wider partners. Governance is in place with connection to West Yorkshire System Quality Group and WY Quality Committee.
	Impact	2		Impact	4			

	Key controls *(What helps us mitigate the risk?)*	Mitigating actions *(What more are we/should we be doing at place?)*
1	Clear governance around quality, safety and patient experience with regular reports through to Integrated Assurance Committee, Wakefield District Health and Care Partnership and People Panel	Timescale 2025/26: 1. District plan in development
2	Experience of Care Network - sharing good practice following feedback from service users	2. Further work on patient safety priorities, development of place quality priorities, and alignment with West Yorkshire quality priority areas
3	Transformation and delivery committee established to which shares good practice and focus on improving services	4. Shared quality frameworks in place
4		5. Professional Collaboration Forum strengthened and is feeding into the transformation prioritisation process
	Sources of assurance *(Where is the evidence that the controls work?)*	6. Clinical and professional engagement takes place and is collated and monitored.
1	Reports provided of quality across the WDHCP of areas of transformation and improvement	
2	Minutes of meetings from multiple governance forums	
3	Recommendations and action plans from Care Quality Commission inspections and quality visits	**Links to Place Risk Register**
4	Local perfomance dashbords and improvement plans	None.

WYICB - Board Assurance Framework - ICB and places		Version: 8	Date: January 2025
Mission 2	Failure to manage the strategic risk could result in a failure to **MANAGE UNWARRANTED VARIATION IN CARE**	**Lead director(s) / board lead**	Jonathan Webb / Shaukat Ali Khan
Strategic risk 2.4	There is a risk that our infrastructure (estates, facilities, digital) hinders our ability to deliver consistently high quality care.	**Lead committee / board**	Finance, Investment and Performance. Transformation Committee - for Digital.

ICB risk appetite	ICB risk scores						Rationale for current ICB score
	Target (ICB)			Current (ICB)			This risk relates to two specific areas; - the backlog of maintenance is circa c£750m with operational capital significantly lower at £158m in the current financial year - the risk that ICB / organisational IT have insufficient capacity to implement ICB and regional solutions due to increasing demands for solutions and the prioritisation of local vs regional projects, resulting in delays to progression of regional solutions, impacting delivery of benefits or reduced opportunities to implement ICB / regional solutions at scale.
OPEN	Likelihood	3	9	Likelihood	4	16	
	Impact	3		Impact	4		

Key controls *(What helps us mitigate the risk?)*		Mitigating actions *(What more are we/should we be doing at ICB level?)*
1	Estates strategy and wider ICS capital infrastructure board	1.Consider approaches to 'carve out' an element of operational capital to support schemes more strategic in nature. 2. Digital investments to be increased within ICB and place budgets to strategise and to enable increased capacity and expectations, with the dedicated time allocated to regional and national programmes (2025/26 - 2026/27) 3. (Digital) - evaluating the current operating model to leverage the maximum benefit on resources and technical skils (2025/26)
2	Capital working group discussions on operational capital and maximising spend	
3	Digital Strategy Board - oversight of digital strategies and risks	

Sources of assurance *(Where is the evidence that the controls work?)*		Links to ICB risk register *(Reference numbers/brief description)*
1	Minutes from - ICS Capital Infrastructure Board; Finance Forum; Digital Strategy Board	**2118** - Not able to spend all capital **2165** - There is a risk that place IT teams have insufficient capacity to implement regional solutions due to increasing demands for digital solutions and the prioritisation of local vs regional projects **2121** - There is a risk of the VCSE sector being left behind digitally due to lack of capacity, resource and understanding at statutory level as to what is needed by VCSE
2	ICB / Regional digital projects are well planned with resources allocated. No milestone delays due to resource constraints.	
		See the separate Positive Assurance Log

Bradford District and Craven (BD&C)	Place lead:	Therese Patten	Nominated lead for this risk:	Robert Maden (29.01.2025)

ICB risk appetite	Place risk scores						Rationale for current place score
	Target (BD&C)			Current (BD&C)			For digital, investment in AFT, BDCT will move us to a higher level of digital maturity over the next 18 months 2025/26. However, we have investment challenges in Primary Care persisting due to limited primary care capital. For estates, even allowing for investment in the Airedale Hospital development and Lynfield Mount, significant backlog maintenance remains an issue, both for the acute estate and the primary and community estate. Significant affordability issues remain in relation to primary care developments. Risk score increased from 3 likelihood to 4 likelihood, from 12 to 16.
OPEN	Likelihood	3	9	Likelihood	4	16	
	Impact	3		Impact	4		

Key controls *(What helps us mitigate the risk?)*		Mitigating actions *(What more are we/should we be doing at place?)*
1	Programme Boards established to take forward the business cases for the new hospital at AFT and for the redevelopment of Lynfield Mount.	1. The existing WY digital strategy is undergoing review across the ICS. Each organisation will review and update its own digital strategy and plan alongside (2025/26) 2. Place clinical strategy being developed which will shape the development of the new hospital at Airedale to support the shift of services into the community and deliver an affordable solution 2025/26. 3. Initial Place Based Capital Infrastructure Strategy completed and will continue to be developed to ensure that our estate planning across health and care reflects changing service delivery models and supports safe and innovate service provision that is targeted at the areas of highest population need. Implementation will be overseen by the Strategic Estates Group on an ongoing basis. Ongoing. More emphasis on the better use of our existing estate as opposed to looking at new build solutions, unless there is no alternative option (2025/26)
2	Estates is an enabler in BDC HCP (place) operating model and is key to supporting the shift of services into the community.	
3	BDC HCP continues to be supported by the BDC Digital Programme Board, chaired by Dr Paul Rice and meets bi-monthly. It reports into BDC executive. Digital programme of work in place with formal workstreams identified, inclusive of partnership representation (Cyber Security, Work as One, Shared Care Records, workforce, Digital Inclusion). Additional subgroups focus on infrastructure and services, research and business intelligence linked to priority programmes.	

Sources of assurance *(Where is the evidence that the controls work?)*		Links to Place Risk Register
1	Programme Board minutes for the Airedale and Lynfield Mount developments and regular updates to PLE.	**2314, 2312, 2482, 2215**
2	Place Based Estates strategy being developed in support of the clinical strategy and regular updates to PLE.	
3	Minutes of the BDC Digital Programme Board.	

Calderdale	Place lead:	Robin Tuddenham	Nominated lead for this risk:	Neil Smurthwaite (20.12.2024)

ICB risk appetite	Place risk scores						Rationale for current place score
	Target (Calderdale)			Current (Calderdale)			Our main mitigation is CHFT reconfiguration. Detailed work undertaken in primary care but biggest risk is capacity to bring partner plans together as a system
OPEN	Likelihood	3	9	Likelihood	4	16	
	Impact	3		Impact	4		

Key controls *(What helps us mitigate the risk?)*		Mitigating actions *(What more are we/should we be doing at place?)*
1	Regular round-table on financing of CHFT reconfiguration.	1. Need to be able to identify capacity and capability to support further estates and digital transformation - Operating Model clearly identified risks around estates and digital capacity gaps due to affordabililty. This hasnt been addressed fully. Local support purchased to enable invovlement in WY Infrastructure Strategy for primary care (2025/26) 2. Work still ongoing to identify local capacity for estates going forward (2025/26) 3. Digital need to be addressed by new Digital Director (2025/26) 4. Recruitment for CKW estates post hampered due to cost control (2025/26) **Link to place risk register** 2396
2	Calderdale is a member of: ICS Capital Infrastructure Board; Finance Forum;	
3	General practice PCN estate strategies in plan	

Sources of assurance *(Where is the evidence that the controls work?)*	
1	Reports to Committee
2	
3	

Kirklees	Place lead:	Carol McKenna	Nominated lead for this risk:	Alison Needham (07.01.2025)

ICB risk appetite	Place risk scores						Rationale for current place score
	Target (Kirklees)			Current (Kirklees)			Place is refreshing Estates and IT strategies to understand the infrastructure needs of the wider system. Currently, constraints in both funding and resources have resulted in lower investment into the Kirklees Estates, which will create unwarranted variation of services for the Kirklees place. Risk score has increased from 9 to 16 in line with challenges at place and across the ICB.
OPEN	Likelihood	3	9	Likelihood	4	16	
	Impact	3		Impact	4		

Key controls *(What helps us mitigate the risk?)*		Mitigating actions *(What more are we/should we be doing at place?)*
1	Estates Strategy	1. Create an Estates lead to focus on key developments in estates within the place and wider ICB (2025/26) 2. Support Primary Care to understand the need to develop and support services from an IT and an Estates perspective. Explore creative solutions with other public sector partners, particularly to
2	IT Strategy	
3	Estates and IT leads	

4	
5	
Sources of assurance *(Where is the evidence that the controls work?)*	
1	Estates Forums
2	IT and Digital Groups
3	Reports to Committee

an Estates perspective. Explore creative solutions with other public sector partners, particularly to develop primary care estate 2025/26.
3. Ensure funding available flows into the Kirklees place.
4. Work with partners and stakeholders to access capital resources to support development in primary care (2025/26)

Link to place risk register:
None.

Leeds	**Place lead:**	**Tim Ryley**	**Nominated lead for this risk:**	**Tim Ryley (06.01.2025)**

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (Leeds)			**Current (Leeds)**			The new hospitals scheme for Leeds General Infirmary rebuild is critical to the transformations in the Leeds Health and Care system. Currently we have only limited assurance that, despite all the processes completed to secure NHSE approval to proceed, the scheme will be allowed to finally proceed. Primary Care expansion of roles and the ambition for a neighbourhood health model is placing greater strain on estates in Primary Care with little access to capital.
OPEN	**Likelihood**	**3**	**9**	**Likelihood**	**3**	**12**	
	Impact	**3**		**Impact**	**4**		

Key controls *(What helps us mitigate the risk?)*	
1	Leeds City Strategic Estates Board and its Specific Programme Boards meet
2	City Wide Digital Resources are combined across Health and Social Care jointly
3	Providers have strong infrastructure to manage capital planning and building.
Sources of assurance *(Where is the evidence that the controls work?)*	
1	Providers have strong infrastructure to manage capital planning and building.
2	Minutes of Strategic Estates and Programme Boards.

Mitigating actions *(What more are we/should we be doing at place?)*
Continue to work with NHSE to progress the new hospital scheme, expecting to receive outcome of current national review during 2025/26
Exploring innovative joint ventures/schemes and strenghten a one city estates strategy across NHS and Local Authority and cutting-edge digital solutions with detailed plans in place by March 2026
City Wide Digital and Estates Strategies linked to our wider H&WB plans (2025/26)

Link to place risk register:
None

Wakefield	**Place lead:**	**Mel Brown**	**Nominated lead for this risk:**	**Colin Speers (28.01.25)**

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
				Current (Wakefield)			There is currently no process or forum for bringing together a total estates strategy across Wakefield Place. There is no identified capital resources for any estates across the sectors. The Digital Strategy is in delivery phase for place.
OPEN	**Likelihood**	**3**	**9**	**Likelihood**	**3**	**12**	
	Impact	**3**		**Impact**	**4**		

Key controls *(What helps us mitigate the risk?)*	
1	Wakefield Place Digital Strategy in place and now being aligned across partners
2	Wakefield Place Finance Working Group linking into the West Yorkshire
3	Leads at Place that are fully involved in the Integrated Care Board strategy meetings
Sources of assurance *(Where is the evidence that the controls work?)*	
1	Minutes from Digital Programme Board
2	Place nominated lead on West Yorkshire groups

Mitigating actions *(What more are we/should we be doing at place?)*
1. Place digital forum brings together all sector and it delivers on the place digital strategy (2025/26)

Link to place risk register:
2481, 2440

WYICB - Board Assurance Framework - ICB (no requirement for places to complete)							Version: 8	Date: September 2024
Mission 2	Failure to manage the strategic risk could result in a failure to **MANAGE UNWARRANTED VARIATION IN CARE**						**Lead director(s) / board lead**	Anthony Kealy
Strategic risk 2.5	There is a risk of an inability to deliver routine health and care services due to the emergence of a future pandemic leading to substantial loss of life and failure to deliver key functions and responsibilities.						**Lead committee / board**	ICB Board
ICB risk appetite	**ICB risk scores**						**Rationale for current ICB score**	
	Target (ICB)			**Current (ICB)**			The likelihood of a future pandemic is certain; the scale, severity and impact is unknown. This risk is based on the potential impact of a serious pandemic, based on learning from Covid. The scoring mirrors the regional NHS England score.	
AVERSE	**Likelihood**	**4**	**16**	**Likelihood**	**4**	**16**		
	Impact	**4**		**Impact**	**4**			

Key controls *(What helps us mitigate the risk?)*		**Mitigating actions** *(What more are we/should we be doing at ICB level?)*
1	Surveillance systems	(1) Yorkshire and Humber Pandemic Influenze Plan is currently being reviewed and is due to completion by March 2025. (2) EPRR Core Standards are due to be reported to the ICB Board in December 2024. (3) Awaiting findings of the national Covid inquiry to incorporate learning into plans. Specific recommendations around the NHS are due by June 2025.
2	Pandemic Plan	
3	Exercises	
4	Business Continuity Plans	
5		

Sources of assurance *(Where is the evidence that the controls work?)*		**Links to ICB risk register** *(Reference numbers/brief description)*
1	EPRR Core Standards and assurance process provide evidence that plans are in place and tested - this is reported to the ICB Board annually	2448 - Bradford place, risk of a future pandemic and infectious diseases
2	Local Health Resilience Partnership meets quarterly to review learning from incidents and exercises.	
3	Local Resilience Forum (multi agency) meets quarterly	**Positive Assurance** (1) ICB Board agenda and minutes - 21 November 2023 (2) Agenda and minutes of LHRP (last met September 2024) (3) Agenda and minutes of LRF (last met September 2024)

WYICB - Board Assurance Framework - ICB and places							Version: 8	Date: October 2024
Mission 3	Failure to manage the strategic risk could result in a failure to **USE OUR COLLECTIVE RESOURCES WISELY**						**Lead director(s) / board lead**	Jonathan Webb
Strategic risk 3.1	There is a risk that we do not invest resources in a way which prioritises community, primary & prevention programmes and so doesn't maximise value for money.						**Lead committee / board**	Finance, Investment and Performance Committee
ICB risk appetite	**ICB risk scores**						**Rationale for current ICB score**	
	Target (ICB)			**Current (ICB)**			There has been a disproportionate increase of resource in recent years into acute hospital services in West Yorkshire and no clear plan to remedy this.	
OPEN	**Likelihood**	**2**	**6**	**Likelihood**	**4**	**12**		
	Impact	**3**		**Impact**	**3**			

	Key controls *(What helps us mitigate the risk?)*	**Mitigating actions** *(What more are we/should we be doing at ICB level?)*
1	Board approved Finance Strategy which sets out intentions.	(1) ICB Board could issue clear intent to all Places that there should be increased positive investment in community and primary care services, as part of planning during December 2024 / January 2025 after publication of planning guidance. (2) Place Committees to develop plans in line with this intent.
2	ICS Financial Plan	
3	ICB Medium Term Financial Plan and Annual Plan	
4	Local plans implemented through Health and Wellbeing Strategy, Health and Wellbeing Boards and Place Committees	
	Sources of assurance *(Where is the evidence that the controls work?)*	**Links to ICB risk register** *(Reference numbers/brief description)*
1	Internal Audit Plan, Head of Internal Audit Opinion and individual internal audit reviews	None
2	External Audit VFM opinion	
3	Performance Report alongside Finance Report into Finance Investment and Performance Committee and ICB Board	
4	Mental Health Investment Standard independent review	**See the separate Positive Assurance Log**

Bradford District and Craven (BD&C)	**Place lead:**	**Therese Patten**	**Nominated lead for this risk:**	**Karen Parkin, Helen Farmer (13.01.2025)**

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (BD&C)			**Current (BD&C)**			Agree with the WYICB scores and these are relevant for place too. Financial position of Bradford Health and Care partners may mean we are unable to mitigate impact on community services. Likelihood increased from 3 to 4, risk score increased from 9 to 12.
OPEN	**Likelihood**	**2**	**4**	**Likelihood**	**4**	**12**	
	Impact	**2**		**Impact**	**3**		

	Key controls *(What helps us mitigate the risk?)*	**Mitigating actions** *(What more are we/should we be doing at place?)*
1	Section 75 and Better Care Fund arrangements in place reporting to planning and commissioning forum which is embedded within our governance arrangements between NHS and Local Authority for Bradford district	1. Review of Better Care Fund services for 2025/26. Presentation to WY ICB Board on 25 February 2025. Submission (review of BCF line by line, to include all integration currently underway and with ambition to go further). (End of March 2025) 2. Review and implementation of 2025/26 planning guidance to support community and mental health investment intentions. In particular in the development of neighbourhood teams (end of March 2025) 3. Review of VCSE sector with the commitment to funding in line with WY decision making e.g. uplift factors (end of March 2025) 4. Ongoing review of closing the gap intent and difficult decisions list alongside Local Authority budget review. (2025/26 (Q4))
2	Financial and operational plans (including closing the gap and difficult decisions) will include decision making on VCSE and wider community services with oversight at PLE and partnership board.	
	Sources of assurance *(Where is the evidence that the controls work?)*	
1	Better Care Fund submission 2025/26 and monitoring overseen by the Planning and Commissioning Forum	
2	Updates from the Planning and Commissioning Forum regarding integration between Health and Care provided to PLE and the Wellbeing Board.	**Link to Place risk register:** 2447, 2386, 2227, 2486, 2040
3	Work programme underway re "closing the financial gap". This includes a focus on difficult decisions list and reducing the deficit. Assurance from mitigating the impact on community services will come from existing governance structures.	

Calderdale	**Place lead:**	**Robin Tuddenham**	**Nominated lead for this risk:**	**Neil Smurthwaite (20.12.2024)**

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (Calderdale)			**Current (Calderdale)**			Significantly pressured financial environment with acute hospital in deficit. This means lack of resources to move funds to invest in other areas or services. Current allocations suggest we are utilising more financial resource than we should, therefore not able to invest new money in additional areas to integrate services.
OPEN	**Likelihood**	**2**	**4**	**Likelihood**	**4**	**12**	
	Impact	**2**		**Impact**	**3**		

	Key controls *(What helps us mitigate the risk?)*	**Mitigating actions** *(What more are we/should we be doing at place?)*
1	Partnership Board in place has membership from all place organisations.	1. Financial strategy in development (2025/26) 2. Need to understand the place-based allocation process to clearly identify where we are using more resource than currently indicated (2025/26)
2	Joint Forward Plan has been signed off - which includes health, social care and fourth sector priorities.	
3	Ongoing review around sustainability of fourth sector and voluntary sector.	
4	New strategic finance group has been set up with an aim to develop a Calderdale financial strategy (2025/26) and medium to long term financial strategy.	
	Sources of assurance *(Where is the evidence that the controls work?)*	
1	Finance and performance a key component of partnership board meetings. Papers and Minutes.	**Link to place risk register:** 2163, 2469, 2449, 2450
2		
3		

Kirklees	**Place lead:**	**Carol McKenna**	**Nominated lead for this risk:**	**Alison Needham (07.01.2025)**

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (Kirklees)			**Current (Kirklees)**			Kirklees place is at the start of working more collaboratively, which can cause challenges, due to organisational form. Current organisational structures and contractual forms do not allow funding to flow around the system to allow services to align. Continued financial challenges in the system generates barriers to move funds
OPEN	**Likelihood**	**2**	**8**	**Likelihood**	**3**	**12**	
	Impact	**4**		**Impact**	**4**		

	Key controls *(What helps us mitigate the risk?)*	**Mitigating actions** *(What more are we/should we be doing at place?)*
1	Place committees, which comprise of partner organisations to discuss utilisation of resources	1.Continue the development of the provider collaborative to allow the discussions to support more joined-up working - 2025/26 2. Priority setting across Kirklees partnership in relation to maximising the utilisation of resources (January 2025) 3. Using the financial strategy to break down the boundaries currently in place and allow the system to work to maximise resources of staff and funds.
2	Financial Strategy has been developed to support how resources are utilised within the place, which links to the overarching West Yorkshire Strategy	
3	Development of PMO function to enable investment are review in order to ensure value for money and consideration of specific service impact.	
	Sources of assurance *(Where is the evidence that the controls work?)*	
1	Kirklees Finance Sub-Committee and Transformation Sub-Committee to agree on utilisation of resources.	**Link to place risk register:** None.
2	All investments reviewed via a priority matrix	
3	PMO reports and financial review against Value for Money criteria	

Leeds	**Place lead:**	**Tim Ryley**	**Nominated lead for this risk:**	**Nick Earl (19.12.2024)**

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (Leeds)			**Current (Leeds)**			Despite progress for a more integrated approach to financial planning across LHCP there remain challenges based on organisational boundaries and ongoing financial pressures. Current financial pressures, deficits and system flow issues mean that there is no head room in resources (money and workforce) to move the patients along the pathway to a more optimal service provision model - resources and outcomes wise.
OPEN	**Likelihood**	**2**	**4**	**Likelihood**	**3**	**9**	
	Impact	**2**		**Impact**	**3**		

	Key controls *(What helps us mitigate the risk?)*	**Mitigating actions** *(What more are we/should we be doing at place?)*
1	Integrated finance reports through LHCP governance - Leeds Finance and Best Value Committee oversees Leeds System Financial and Commissioning positions.	1. A programme of work is underway to continue to develop our joint approach to financial planning and decision-making to allow us to make the most value-driven

2	Population and Care Delivery Board receive information on spend through lens of populations not services.	decisions on resource allocation across the LHCP. To be actioned within the medium term financial plans (2025/26)
3	Strategic Finance Executive Group and Joint Planning Process established	2. Front runner bid for Leeds, Newton Europe Programme to continue delivery of the redesign Intermediate Care Beds and social care resources to increase home care resources (2025/26)
4	Finance sub-committee oversees financial planning and decisions.	
5	Regular attendance of DOFs at LHCP Partnership Exec Group.	
Sources of assurance *(Where is the evidence that the controls work?)*		
1	Finance sub-committee receives financial planning and decisions. Papers and Minutes	
2	DOFs at LHCP Partnership Exec Group. Papers and Minutes	
		Links to Place Risk Register
		2414

Wakefield		**Place lead:**	**Mel Brown**		**Nominated lead for this risk: Jenny Davies (17.01.25)**
ICB risk appetite	**Place risk scores**				**Rationale for current place score**
	Target (Wakefield)		**Current (Wakefield)**		
OPEN	**Likelihood**	**2**	**4**	**Likelihood**	**3**	**9**	Continued development of the Wakefield Place working together, investment in services, greater understanding required of service join-up within Place in order to invest more wisely. Greater involvement of system partners in decision making, for example - voluntary sector. A requirement for more robust return on investment modelling within place.
	Impact	**2**		**Impact**	**3**		

Key controls *(What helps us mitigate the risk?)*		**Mitigating actions** *(What more are we/should we be doing at place?)*
1	Partnership Committee comprises of partner organisations and Integrated Assurance Committee looks in more detail at financial decision making	1. Within Wakefield place, there is Transforming Development collaborative (TDC) whereby they engage with all parties to ensure there is investment in the right areas and in 2025/26 planning there will be a commitment to increase investment within primary care and a paper went to EMT in December 2024 and January 2025 to confirm this (2025/26)
2	The Wakefield Place Finance Leaders meeting is now established, forming a wider financial strategy, including the voluntary sector and local authority.	2. Investment panel will be held in February 2025 to prioritise investment decisions (2025/26)
3	Each place finance lead closely connected with director of finance for Integrated Care Board therefore strategies aligned.	
4	Shared posts across partner organisations - link services together to make more informed decisions around	
5	A framework for investment decisions agreed and implemented	
6	Financial Plan in place	
Sources of assurance *(Where is the evidence that the controls work?)*		
1	Minutes from meetings (TDS and Wakefield management meetings)	
2	Honorary contracts in place	
3	Regular reporting mechanisms for quality, performance and finance in place	**Links to Place Risk Register**
		None.

WYICB - Board Assurance Framework - ICB and places							Version: 8	Date: October 2024
Mission 3	Failure to manage the strategic risk could result in a failure to **USE OUR COLLECTIVE RESOURCES WISELY**						**Lead director(s) / board lead**	Jonathan Webb
Strategic risk 3.2	There is a risk that we don't operate within our available system and organisational resources (revenue and capital) and so breach our statutory duties.						**Lead committee / board**	Finance, Investment and Performance Committee
ICB risk appetite	**ICB risk scores**						**Rationale for current ICB score**	
	Target (ICB)			**Current (ICB)**			Despite five years of strong performance as an ICS, there is a challenging plan to deliver this year and risks are materialising.	
CAUTIOUS	**Likelihood**	3	9	**Likelihood**	4	20		
	Impact	3		**Impact**	5			

Key controls *(What helps us mitigate the risk?)*	**Mitigating actions** *(What more are we/should we be doing at ICB level?)*
1 Financial Framework document agreed by FIPC	(1) Further ICB Board sponsored work on transformation opportunities. (2) Implementation of recommendations from the external review.
2 All Plans are signed off by the organisational Boards	
3 Escalation and joint approach with NHS England for Trusts in NOF3	
4 Finance Forum, SOAG, FIPC, EMT and Board all have oversight	
5 Place Committees and their finance sub-committees have oversight and provide assurance upwards	
Sources of assurance *(Where is the evidence that the controls work?)*	**Links to ICB risk register** *(Reference numbers/brief description)*
1 Quarterly review meetings with NHS England and outcome letters	**2431** - managing within capital limits; **2430** - financial breakeven
2 Agendas, reports and minutes of all meetings above	
3 Internal Audit and External Audit	
4 External review commissioned into Finance by WYAAT and across the ICS	**Positive Assurance Log -** see separate

Bradford District and Craven (BD&C)	**Place lead:**	**Therese Patten**	**Nominated lead for this risk:**	**Mike Woodhead, Karen Parkin (17.01.25)**

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (BD&C)			**Current (BD&C)**			Due to the current financial pressures there is a significant risk that Bradford Place will fail to operate within current resource envelopes.
CAUTIOUS	**Likelihood**	2	6	**Likelihood**	4	20	
	Impact	3		**Impact**	5		

Key controls *(What helps us mitigate the risk?)*	**Mitigating actions** *(What more are we/should we be doing at place?)*
1 System Finance & Performance Committee oversight of Place financial position	1. Implementation of closing the gap programme - Peer reviews and check and challenge sessions - The ongoing service strategy review - The implemention of population health approach - Joint working with the council 2. Difficult decisions list established and being prioritised 3. Balance sheet reviews have been completed and actions being implemented 4. Grip and control and PWC work being acted upon 5. Recovery plans agreed with those relevant organisations and regular scrutiny **Alignment to place risk register:** 2433, 2337, 2314, 2039, 2047
2 The Bradford place follows the West Yorkhire established principles and process.	
3 Significant work undertaken to identify non-recurrent mitigations in 24/25, including an ICS wide balance sheet review.	
3 Regular detailed review of in-year financial performance by Place DoFs with full transparency of cost pressures and sources of mitigation.	
4 Ongoing closing the gap programme reports to Place Leadership Executive (PLE) and Partnership Board	
5 Partnership Board oversight and PLE oversight (monthly)	
6 Closing the gap and programme board oversight (monthly)	
7 Business case appraisal panel - monthly (if required)	
8 Organisations under regulatory scrutiny meet monthly by ICB/ NHSE	
Sources of assurance *(Where is the evidence that the controls work?)*	
1 SF&PC minutes. Place financial performance reported to System F&P on a regular basis and key messages reported to PLE and BDC Health and Care Partnership Board.	
2 Strategic Partnering Agreement - approved by Partnership Board on 3 February 2023. Updates on plan development for PLE and the BD&C Health and Care Partnership Board. Recommendation on Place financial plan from System F&P to PLE and the BD&C Health and Care Partnership Board. EQIAs on efficiency plans	
3 PLE, partnership board, closing the gap programme board minutes	
4 PWC final report and action plans received in November 2024	
5 Resource shifts and any new additional expenditure commitment approved by the Partnership Leadership Executive.	

Calderdale	**Place lead:**	**Robin Tuddenham**	**Nominated lead for this risk:**	**Neil Smurthwaite (20.12.2024)**

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (Calderdale)			**Current (Calderdale)**			As a place we are in deficit due to acute pressures.
CAUTIOUS	**Likelihood**	2	6	**Likelihood**	4	20	
	Impact	3		**Impact**	5		

Key controls *(What helps us mitigate the risk?)*	**Mitigating actions** *(What more are we/should we be doing at place?)*
1 Strategic finance group established with a aim to develop a Calderdale financial strategy.	1. As WYICB above. However we are also undertaking work in strategic finance group to understand where our acute and commissioning budgets are overspending compared to best practice and allocation tool to be clear where we need to target to bring down costs (meet monthly, then quarterly) 2025/26 **Link to place risk register:** 2163, 2469, 2449, 2450
2 Financial Framework document agreed by FIPC, monitored by partnership board.	
3 Robust budget setting in open book approach so all places understand allocations and basis	
Sources of assurance *(Where is the evidence that the controls work?)*	
1 Financial Framework as agreed by FIPC.	
2 Bi-monthly monitoring at CCPB, evidenced in minutes. Detailed board reports.	
3	

Kirklees	**Place lead:**	**Carol McKenna**	**Nominated lead for this risk:**	**Alison Needham (07.01.2025)**

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (Kirklees)			**Current (Kirklees)**			Due to the current financial pressures there is a real risk that Kirklees Place will fail to operate within current resource envelopes.
CAUTIOUS	**Likelihood**	2	6	**Likelihood**	4	20	
	Impact	3		**Impact**	5		

Key controls *(What helps us mitigate the risk?)*	**Mitigating actions** *(What more are we/should we be doing at place?)*
1 Financial Strategy	1. Engage in WY-wide work to drive transformation and efficiency, including leading efficiency programmes undertaken on a WY footprint (2025/26) 2. Develop priority setting of resources within Kirklees place (January 2025) 3. Undertake actions outlined in PwC report (Jan - Apr 2025) 4. Develop long list of difficult decisions around contracts and services that could be paused/ stopped/ slowed down across the Kirklees place. Ensuring decisions made align with West Yorkshire principles, and consider the prioritisation and disinvestment / decommissioning framework across the place (Jan - Apr 2025) 5. Develop financial and operational plan that achieves control total by robust efficiency planning (Jan - Apr 2025) **Link to place risk register:** None
2 Review of Financial position and plans by Kirklees Finance Sub-Committee and ICB Committee, both locally and at a West Yorkshire level.	
3 Kirklees & Calderdale Recovery group	
4 Collaborative meetings to discuss how services can be undertaken differently to maximise resources	
5 Utilisation of the cross- partner Finance Forum to strengthen ownership of place based solutions.	
Sources of assurance *(Where is the evidence that the controls work?)*	
1 Financial plan will be signed off by the ICB Committee and risks identified	
2 PMO function to support financial recovery for the ICB and its wider system	
3 Aligned to West Yorkshire ICB approach to planning and final plan signed off by WY Committees	

Leeds	**Place lead:**	**Tim Ryley**	**Nominated lead for this risk:**	**Alex Crickmar (reviewed 16.12.24)**

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (Leeds)			**Current (Leeds)**			Due to the current financial pressures there is a significant risk that Leeds Place will fail to operate within current resource envelopes.
CAUTIOUS	**Likelihood**	2	6	**Likelihood**	4	20	
	Impact	3		**Impact**	5		

Key controls *(What helps us mitigate the risk?)*	**Mitigating actions** *(What more are we/should we be doing at place?)*
1 Leeds Finance, Investment and Best Value Committee oversees Leeds System Financial and Commissioning positions.	(1) Development of a number of key transformation business cases for change aimed at changing suboptimal care pathways with potential for significant savings longer term (timing: ongoing and part of planning for 25/26 - March 25) (2) Review of potential opportunities and mitigating financial actions within each organisation and across Place, including delaying/stopping spend, focus on efficiencies and productivity including outcomes of external PwC review (timing ongoing and part of each month end) (3) Review of difficult decisions/choices across organisations/place (timing: ongoing first draft Jan 2025) (4) Single planning process agreed upon across NHS partners (Jan 2025) (5) Integrated Commissioning Executive share plans between LCC and NHS and present jointly to Adults and Health Scrutiny. (Scrutiny Dec 24 to review plans)
2 Strategic Finance Executive Group	
3 Financial Framework and controls within each organisation at Place	
4 Robust Budget setting and financial planning	
5 Leeds Health and Care Partnership Committee oversight of City wide statutory duties on behalf of the WY ICB.	
Sources of assurance *(Where is the evidence that the controls work?)*	
1 Agendas, reports and minutes of all meetings above	
2 External Review of system finances (PwC report)	
3 Internal and External Audit	
4 Fortnightly meetings between DoFs to review position	
5 Budgets/Financial plans set	
6 PMO functions within each org	**Links to Place Risk Register**
	2413

Wakefield	**Place lead:**	**Mel Brown**	**Nominated lead for this risk:**	**Jenny Davies (17/01.25)**

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (Wakefield)			**Current (Wakefield)**			Due to the current financial pressures there is a real risk that Wakefield Place will fail to operate within current resource envelopes.
CAUTIOUS	**Likelihood**	2	6	**Likelihood**	4	20	
	Impact	3		**Impact**	5		

Key controls *(What helps us mitigate the risk?)*	**Mitigating actions** *(What more are we/should we be doing at place?)*
1 Monthly monitoring of Integrated Care Board delegated financial position to assurance committee including efficiency savings	1. Review of difficult decisions/choices across organisations/place (timing: ongoing first draft February 2025) 2. Set financial plans in line with planning guidance (2025/26) 3. Agree Quality, Improvement and Performance Productivity (QIPP) to identify savings and reduce pressures whilst improving patient quality (2025/26) 4. Work with all system partners to increase efficiency and effectiveness (2025/26)
2 Monthly monitoring of Wakefield partners financial position to assurance and partnership committees	
3 Robust budget setting with place programmes	
4 Regular sharing of information and agreements via the Integrated Care System Finance Forum	
5 Consistency Checks within Wakefield against other places.	
Sources of assurance *(Where is the evidence that the controls work?)*	
1 Minutes from Wakefield District Health and Care Partnership and Integrated Assurance Committee meetings	
2 Financial plans or any amendments to financial plans presented and discussed at partnership committee.	**Links to Place Risk Register**
3 Principles already established at Wakefield District Health and Care Partnership Committee	2329

WYICB - Board Assurance Framework - ICB and places							Version: 8	Date: November 2024
Mission 3	Failure to manage the strategic risk could result in a failure to **USE OUR COLLECTIVE RESOURCES WISELY**						**Lead director(s) / board lead**	Rob Webster
Strategic risk 3.3	There is a risk that ICB capacity and infrastructure is not sufficient nor targeted effectively towards key priorities.						**Lead committee / board**	ICB Board
ICB risk appetite	**ICB risk scores**						**Rationale for current ICB score**	
	Target (ICB)			**Current (ICB)**			We have developed the new operating model which clarifies roles and responsibilities and ensures capacity in the right areas. Ongoing demands following new Government ambitions coupled with reductions in staffing means difficult choices continue to need to be made.	
OPEN	**Likelihood**	**3**	**9**	**Likelihood**	**3**	**12**		
	Impact	**3**		**Impact**	**4**			

	Key controls *(What helps us mitigate the risk?)*	**Mitigating actions** *(What more are we/should we be doing at ICB level?)*
1	An agreed operating model, approved through the Board and set out in the constitution and handbook	1. Place Partnership Review (led by Anthony Kealy) will support further development of Place model and infrastructure. Conclusion anticipated March 2025. 2. Ongoing organisational development work across Executives to support level of agility required in current context.
2	Agreed objectives for all directors, including places, cascaded throughout the ICB	
3	Business planning processes that align capacity to our plans	

	Sources of assurance *(Where is the evidence that the controls work?)*	**Links to ICB risk register** *(Reference numbers/brief description)*
1	Annual business plan approved by the Executive and ICB Board	**2165** - insufficient IT team capacity to deliver digitial priorities
2	CEO and director appraisals, with outcome reported to Remuneration and Nominations Committee	
3	Annual review of governance and statement of internal control, reported through Audit to Board	**See the separate Positive Assurance Log**

Bradford District and Craven (BD&C)	**Place lead:**	**Therese Patten**				**Nominated lead for this risk:**	**Matt Sandford (21.01.2025)**
ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (BD&C)			**Current (BD&C)**			The move to a new Operating Model in April 2024, where BDC significantly reduced its capacity is still embedding, along with current vacancy controls due to the financial challenges, means that, similar to other Places, Bradford place is carrying a number of vacancies. This is having an impact, but Bradford is utilising partnership relationships to help boost that capacity by building on current joint roles, to identify opportunities for further targeted shared and aligned resources across our Place so they can continue to deliver against both local and national standards and priorities.
OPEN	**Likelihood**	**1**	**4**	**Likelihood**	**3**	**12**	
	Impact	**4**		**Impact**	**4**		

	Key controls *(What helps us mitigate the risk?)*	**Mitigating actions** *(What more are we/should we be doing at place?)*
1	The Partnership Leadership Executive oversee the deployment of resources (including ICB capacity) in pursuit of the BDC HCP strategy agreed by the Partnership Board	1. Utilise strength of our Health and Care Partnership, building on current joint roles, to identify opportunities for further targeted shared and aligned resources across Place (February – September 2025) 2. Annual business planning process to align resources to required activity/ priorities (April/ May 2025) 3. Priority Programme and Programme Board oversight of key system transformation plans (including workforce) and related activity, to review resource requirements against transformation delivery plans (February – September 2025) 4. Place level 'difficult decisions' programme to target resources at activity that delivers strategic and financial priorities (February – May 2025) 5. Adoption of WY Vacancy Control measures into Place level governance to ensure grip and control, alongside overarching understanding of Place resource requirements (already in place - ongoing)
2	System transformation priorities and enablers established through our operating model using a distributed leadership approach	
3	Place based lead influence deployment of ICB resource for BDC HCP	
4	Closing the Gap programme – already established – with widened scope to incorporate Investment/ Business Case review	
5	Difficult Decisions programme	
6	Place Clinical Strategy; and Place Financial Recovery Plan – providing greater oversight of resource	
		Link to place risk register 2447

	Sources of assurance *(Where is the evidence that the controls work?)*
1	An agreed BDC HCP operating model approved by the PLE and the PB within the BDC HCP governance handbook
2	Priority Programmes in place including: access; healthy communities; healthy minds; workforce and children and young people improvement. Enablers in place including: reducing inequalities alliance; digital, data, intelligence and insight; living well; and Estates. All priorities and enablers report into PLE
3	ICB SORD sets out place role within both the WY ICB SORD (WY Governance Handbook) and BDC HCP Strategic Partnering Agreement and Governance Handbook set our the way we work, including our operating model, SORD and Terms of Reference.
4	Closing the Gap programme – Partnership led and supported – Reviewed via System Finance and Performance Committee, PLE and Partnership Board.

Calderdale	**Place lead:**	**Robin Tuddenham**				**Nominated lead for this risk:**	**Neil Smurthwaite (20.12.2024)**
ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (Calderdale)			**Current (Calderdale)**			Capacity and capability within Calderdale Place team is severely limited for both finance and transformation resource. This impacts on our ability to address all ICB and place priorities. Whilst Operating Model work enabled no real impact on Calderdale financial the place team is still small and not resilient. Consolidated teams will impaction local resource and will work with colleagues to manage impact.
OPEN	**Likelihood**	**1**	**4**	**Likelihood**	**4**	**16**	
	Impact	**4**		**Impact**	**4**		

	Key controls *(What helps us mitigate the risk?)*	**Mitigating actions** *(What more are we/should we be doing at place?)*
1	Work undergoing with neighbouring places to ensure resilient finance function.	1. Transformation delivery plans list seven key priorities and discussions are ongoing at operational and senior leadership meetings (2025/26)
2	Partnership board regularly conducts deep dives for tranformational priorities.	
3	Prioritisation takes place on a weekly basis to assess place workload and ability to respond to asks.	
	Sources of assurance *(Where is the evidence that the controls work?)*	**Link to place risk register:** 1998, 2484
1	Tranformation delivery plan approved by Calderdale Care Partnership Board.	
2	Prioritisation process as part of annual planning round.	
3		

Kirklees	**Place lead:**	**Carol McKenna**				**Nominated lead for this risk:**	**Carol McKenna (09.01.2025)**
ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (Kirklees)			**Current (Kirklees)**			There are specific challenges in Kirklees place related to leadership changes in several parts of the health and care partnership and the transition period could lead to uncertainty. Time will have to dedicated to establish new working relationships when leadership changes take effect. The impact of the operating model changes are still being felt and challenges remain in some functions.
OPEN	**Likelihood**	**1**	**4**	**Likelihood**	**3**	**12**	
	Impact	**4**		**Impact**	**4**		

	Key controls *(What helps us mitigate the risk?)*	**Mitigating actions** *(What more are we/should we be doing at place?)*
1	Weekly SLT meetings to discuss current priorities and ensure capacity is dedicated to the right areas	1. Place Partnership Review (led by Anthony Kealy) will support further development of Place model and infrastructure. Conclusion anticipated March 2025. 2. Ongoing organisational development work within and across Teams in Kirklees (2025/26) 3. Specific organisational development work focused on hybrid teams (2025/26)
2	Health & Care Executive to support cross sector prioritisation within the Health & Care Partnership	
3	Business planning processes to support confirmation of priorities	
	Sources of assurance *(Where is the evidence that the controls work?)*	**Link to place risk register:** 2425
1	Clear examples of where capacity is being used to best effect by sharing teams with other places, in particular Calderdale (where there is a history of shared teams) and increasingly with Wakefield. Examples of capacity from across the partnership (not just the ICB) supporting our work e.g. Place Director of Finance role. Other examples of programme leadership from beyond the ICB team in place.	
2	Staff survey results relating to the ability of individuals to undertake their role within their designated hours, clarity of objective setting and additional hours worked.The action plan agreed to respond to findings of staff survey.	
3	Agreement from the Kirklees ICB Committee as to our shared priorities, supported by teams within partner organisations dedicating capacity to these priorities (e.g. Discharge, community services transformation)	

Leeds	Place lead:	Tim Ryley	Nominated lead for this risk:	Sabrina Armstrong (09.01.2025)

ICB risk appetite	Place risk scores						Rationale for current place score
	Target (Leeds)			Current (Leeds)			
OPEN	Likelihood	1	4	Likelihood	4	16	The current risk score- likelihood is likely. The move to a new Operating Model in April 2024, where Leeds reduced its capacity by 20% is still bedding in and Leeds is carrying a number of vacancies and is, therefore, operating with a lower capacity than required. Some of the vacancies are as a result of an evolving structure but the vacancy controls currently in place due to the financial challenges are also having an impact on vacancies that need to be filled. Failure to control this risk will lead to major impact on a number of financial, quality, operational and people fronts. We would see a failure to meet national standards, broadening of inequalities, financial distress and regulatory breaches in line with the definitions.
	Impact	4		Impact	4		

Key controls *(What helps us mitigate the risk?)*	Mitigating actions *(What more are we/should we be doing at place?)*
1 Agreed Operating Model with WY ICB and Leeds Health & Care Partnership	1. The ICB in Leeds has agreed a number of city priorities with partners in the Leeds Health and Care Partnership (LHCP). The ICB in Leeds needs to ensure that the majority of its capacity is working on these priority areas. Timescale: April - September 2025.
2 Capacity aligned to Healthy Leeds Plan and LHCP objectives	2. Refreshed OD priorities in place to support staff within the ICB in Leeds to deliver the capabilities needed to deliver the above priorities. Timescale: OD Plan in place by April 2025.
3 Director accountabilities finalised and objectives set by end of April	3. ICB in Leeds Business Plan for 25/26 in place, outlining the BU actions to deliver the priority objectives: Timescale: Business Plan in place April/May 2025
Sources of assurance *(Where is the evidence that the controls work?)*	4. Action plan on staff survey results most pertinent to Leeds. Timescale: March 2025
1 Healthy Leeds Plan and Business Plan reviewed monthly	5. Ensure a review of the current vacancy control process is undertaken. Action for WY EMT. Timescale April 2025
2 Ongoing appraisal throughout year with all directors in place	**Link to place risk register:**
3 Staff Survey results	None

Wakefield	Place lead:	Mel Brown	Nominated lead for this risk:	Mel Brown (21.01.25)

ICB risk appetite	Place risk scores						Rationale for current place score
	Target (Wakefield)			Current (Wakefield)			
OPEN	Likelihood	1	4	Likelihood	3	12	The current likelihood is possible, given the movement to a new operating model for the NHS and the Integrated Care Board. Failure to control this risk will lead to major impact on a number of financial, quality, operational and people fronts. We would see a failure to meet national standards, broadening of inequalities, financial distress and regulatory breaches in line with the definitions. Following some significant changes to senior leadership across Wakefield ICB in the Summer of 2024 the controls and mitigating actions that will be mobilised will ensure we continue to sustain the capacity we need to deliver our priorities across WY ICB.
	Impact	4		Impact	4		

Key controls *(What helps us mitigate the risk?)*	Mitigating actions *(What more are we/should we be doing at place?)*
1 Agreed operating model in place aligned to Integrated Care Board structures and went live in April 2024, some reviews have been underway due to leadership changes	1. Review of gaps in strategic capacity due to recent leadership changes and reallocated objectives across the current leadership team (for example the strategic leads on the walking centre review and Castleford health project have been reallocated) (February 2025)
2 Agreed objectives for all directors	2. Working with partner organisations in partner districts to maximise capacity to deliver place functions such as merging BI capacity across Mid Yorks and the ICB to deliver population health management (End of January 2025)
3 Investment Framework established (annual review)	3. Reviewing everyones PDR objectives to ensure any areas that need capacity are appropriately addressed such as EDI leadership (End of February 2025)
4 Business planning processes that aligns both to the WY ICB 10 ambitions and the Wakefield district plan (annual review)	
5 Developed a new business planning process that aligns with our Integrated Care System strategy and place delivery plan in line with national guidance	
6 Some Directors have previously undertaken leadership roles with partner organisations, these directors are now working full time for the ICB, such as Director of Nursing and Director of Strategy.	
Sources of assurance *(Where is the evidence that the controls work?)*	
1 Delivery plan approved including Outcomes Framework.	
2 The Mutual Accountability meetings chaired by Rob Webster, quarterly meetings, these provide assurance of the progress against the functions in Wakefield place.	
3 Director appraisals conducted and regular one to ones are mobilised across the Wakefield district, this ensures flexibility in responding to new work that emerges from WY ICB.	
4 Contribute to the annual governance review.	
.	**Links to Place Risk Register**
	None.

WYICB - Board Assurance Framework - ICB and places							Version: 8	Date: November 2024
Mission 4	Failure to manage the strategic risk could result in a failure to **SECURE BENEFITS OF INVESTING IN HEALTH AND CARE**						**Lead director(s) / board lead**	Ian Holmes
Strategic risk 4.1	There is a risk that partnership working on wider societal issues is deprioritised to meet current operational pressures.						**Lead committee / board**	ICB Board
ICB risk appetite	**ICB risk scores**						**Rationale for current ICB score**	
	Target (ICB)			**Current (ICB)**			Wider societal issues contribute significantly to health, wellbeing and inequalities. Working with partners to address these is a key part of our health and care strategy. We have dedicated capacity supporting this work which we will protect through the business planning process. The key is ensuring sufficient leadership focus.	
OPEN	**Likelihood**	**2**	**8**	**Likelihood**	**2**	**8**		
	Impact	**4**		**Impact**	**4**			
Key controls *(What helps us mitigate the risk?)*							**Mitigating actions** *(What more are we/should we be doing at ICB level?)*	
1	ICS strategy and 10 big ambitions will be used to create priority and focus on these issues. These will be tracked annually via an outcomes framework and associated integrated dashboard.						1. Economic Inactivity Accelerator work to be delivered throughout 2025/26 ensuring dedicated capacity and the establishment of a programme board with WY Combined Authority to oversee it.	
2	We have established dedicated capacity working on these issues at WY level, together with appropriate programme boards, working with the Combined Authority - focusing on issues such as poverty, climate change, violence reduction, housing and employment							
3	Business planning process describes how we use our capacity to support delivery of all ambitions.							
4	Memorandum of Understanding with WY Combined Authority which describes shared priorities, capacity and ways of working.							
5	Consultant in Population Health appointment ensures focus on wider societal issues.							
5	Director objectives, subsequently cascaded to teams, reflect partnership working.							
Sources of assurance *(Where is the evidence that the controls work?)*							**Links to ICB risk register** *(Reference numbers/brief description)*	
1	Progress against the strategy and 10 big ambitions is overseen by the Partnership Board, together with deep dives - evidenced in agenda and minutes						None identified	
2	ICB Board receives six monthly updates on 10 big ambitions - agenda / minutes							
3	SOAG - minutes evidence review of progress against 10 big ambitions						**See the separate Positive Assurance Log**	

Bradford District and Craven (BD&C)	**Place lead:**	**Therese Patten**	**Nominated lead for this risk:**	**Matt Sandford, Helen Farmer, Iain McBeath, Mike Woodhead (13.01.2025)**

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (BD&C)			**Current (BD&C)**			Challenging financial circumstances for all partner organisations may increase likelihood of retrenchment into siloed, short term approaches, emphasising direct operational delivery over longer term outcome focused system thinking, which evidence shows will have a bigger impact on the determinants of health and wellbeing outcomes. Reduced likelihood from 3 to 2, overall risk score reduced from 12 to 8.
OPEN	**Likelihood**	**2**	**8**	**Likelihood**	**2**	**8**	
	Impact	**4**		**Impact**	**4**		
Key controls *(What helps us mitigate the risk?)*							**Mitigating actions** *(What more are we/should we be doing at place?)*
1	Our BDC health and care strategy localises the WY strategy and clearly establishes the focus on the wider contribution of the health and care system to the determinants of health, and encourages stewardship for the future as well as short term delivery focus.						1. All district partners (including those outside health and care) will sign up to a new district strategy to improve the wellbeing, both health and economically in Bradford district (2025 - 2028) 2. Our reducing inequalities alliance continues to lead the way in identifying our wider determinants and mitigating the impact (continual). 3. Work underway with partners to develop our place based health and care service strategy, to jointly agree the safe and sustainable service models and pathways across all partners, driven by the health needs of our population. This will ensure a clear partnership led approach to prioritising health and care. (2025/26)
2	The Wellbeing Board (HWB for Bradford District) is comprised of the leaders of all local strategic partnerships and all local anchor organisations. Its focus is firmly on the 'wider determinants'. The BDC Partnership Board and its Committees have broad based participation across VCSE, Local Government and Care sectors. Our approach is to engage with communities through locality based **Listen In** visits and to take our Partnership Board meetings into communities, to understand the strengths and challenges of communities and what will help - which includes focus on the 'wider determinants' - e.g. development session on sustainability, Partnership Board papers on anti poverty actions etc.						
3	Our closing the gap business case appraisal process takes into account impact on wider health and care and public sector and population including health inequalities, social value etc (ongoing)						**Link to place risk register:** 2317, 2386, 2221
4	People priority include focus on inclusive community recruitment.						
5	Our partnership work is focused on five Strategic Priorities and four key Enablers. This includes a prevention focus through Living Well, Reducing Inequalities, an asset based approach to Healthy Communities, and a focus on net zero and local economic development through our partnership Estates work						
Sources of assurance *(Where is the evidence that the controls work?)*							
1	See strategy and closing the gap process on partnership website https://bdcpartnership.co.uk/						
2	Wellbeing Board (Bradford district) on the BMDC wellbeing web page https://bdp.bradford.gov.uk/about-us/health-and-wellbeing-board/ See partnership governance structure, TORs, meeting papers including Listen In reports - on website						
3	See priorities and enablers scoping documents on partnership website https://bdcpartnership.co.uk/our-strategic-priorities-re-set-programme/						

Calderdale	**Place lead:**	**Robin Tuddenham**	**Nominated lead for this risk:**	**Neil Smurthwaite (20.12.2024)**

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (Calderdale)			**Current (Calderdale)**			Wider societal issues contribute significantly to health, wellbeing and inequalities. Working with partners to address these is a key part of our health and care strategy.
OPEN	**Likelihood**	**2**	**8**	**Likelihood**	**3**	**12**	
	Impact	**4**		**Impact**	**4**		
Key controls *(What helps us mitigate the risk?)*							**Mitigating actions** *(What more are we/should we be doing at place?)*
1	Joint membership of HWBB and CCPB by each chair to ensure societal issues continue across.						1. The Transformation delivery plans list seven key priorities, these aim to address wider societal challenges in Calderdale, there is ongoing work at senior leadership level to ensure governance arrangements align with the transformational priorities (2025/26)
2	ICS strategy and 10 big ambitions will be used to create priority and focus on these issues. These will be tracked annually. We also have Health and Wellbeing Strategy, monitored via HWBB.						
3	Business planning process will describe how we use our capacity to support delivery of all ambitions.						**Link to place risk register:** None
4	The senior leadership group terms of reference refers to operational delivery as a "must do" so that our transformational plans are able to flourish						
Sources of assurance *(Where is the evidence that the controls work?)*							
1	Progress against health and wellbeing priorities is undertaken at every meeting. Evidenced by papers and minutes.						
2	We also have an inclusive economy strategy led by the local authority.						
3							

Kirklees	**Place lead:**	**Carol McKenna**	**Nominated lead for this risk:**	**Steve Brennan (13.01.2025)**

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (Kirklees)			**Current (Kirklees)**			As Kirklees place we have signed up to 4 top tier strategies that cover areas of joint working beyond just health and care, including the wider societal issues. These are: 1. Health and Wellbeing Strategy 2. Inclusive Communities Framework 3, Inclusive Economy Strategy 4. Environment Strategy. However, whilst we have agreed this strategic approach, there are still challenges of delivery to be navigated. Operational pressures are significant, alongside significant financial challenges across the partnership. This means that our ability to deliver on these in the short term is challenged. Due to capacity constraints realising the full benefits of the Economic Inactivity Accelerator and related programmes will be challenging.
OPEN	**Likelihood**	**2**	**8**	**Likelihood**	**3**	**12**	
	Impact	**4**		**Impact**	**4**		
Key controls *(What helps us mitigate the risk?)*							**Mitigating actions** *(What more are we/should we be doing at place?)*
1	4 top tier strategies for Kirklees that go beyond just health and care and cover wider societal issues.						1. Commitment to the 4 top tier strategies reiterated at the Kirklees partnership executive meeting in November 2024. There is a programme of work agreed for 2025/26 overseeing
2	Ownership of these 4 strategies assigned to partnership boards or forums.						

3 Partnership Executive in place which includes business, education in addition to health, care and LA.	by the partnership executive.
Sources of assurance *(Where is the evidence that the controls work?)*	
1 Reporting to the relevant board/partnership forum on progress against each of the 4 strategies.	**Link to place risk register:**
Use of other partnership forums to support this e.g. Partnership Forum, ICB committee.	None
2	

Leeds	Place lead:	Tim Ryley	Nominated lead for this risk:	Tim Ryley (06.01.2025)

ICB risk appetite	Place risk scores						Rationale for current place score
	Target (Leeds)			Current (Leeds)			
OPEN	Likelihood	2	8	Likelihood	3	12	Wider societal issues contribute significantly to health, wellbeing and inequalities. Working with partners to address these is a key part of our health and care strategy. We have dedicated capacity supporting this work which we will protect through the business planning process. The key is ensuring sufficient leadership focus.
	Impact	4		Impact	4		

Key controls *(What helps us mitigate the risk?)*	Mitigating actions *(What more are we/should we be doing at place?)*
1 Health & Wellbeing Board Strategy	1: Creation of a joint neighbourhood model between NHS and Local Authority (2025/26)
2 Active participation and alignment to Marmot City agenda	2: Monitor and report on anchor institution work to test impact for the city (ongoing piece of work)
3 Shared goals across Leeds Health & Care Partnership reflecting 10 big ambitions and requiring addressing	3: Continue to drive digital and medical technology innovation through the Integrated digital service, Leeds Academic Health Partnership and the Leeds Health & Care Hub.
4 Continuing monitoring of metrics by ethnicity and deprivation as routine	5. Implement action plan arising from Marmot city programme led through public health (2025 - 2027)
Sources of assurance *(Where is the evidence that the controls work?)*	
1 Progress against 10 big ambitions in Leeds	
2 Reporting on key Healthy Leeds Plan metrics by deprivation	
3 Health & Wellbeing Board monitoring of HWB strategy	
4 Director of public health annual reports	**Link to Place Risk Register**
	None

Wakefield	Place lead:	Mel Brown	Nominated lead for this risk:	Ruth Unwin, Becky Barwick (10.01.25)

ICB risk appetite	Place risk scores						Rationale for current place score
	Target (Wakefield)			Current (Wakefield)			
OPEN	Likelihood	2	8	Likelihood	2	8	Impact score is high as there is strong evidence that failure to address social determinants leads to poor population health and increased demand on care services. The likelihood has reduced from 3 to 2, reducing the overall risk score from 12 to 8.
	Impact	4		Impact	4		

Key controls *(What helps us mitigate the risk?)*	Mitigating actions *(What more are we/should we be doing at place?)*
1 Wakefield District Health and Wellbeing strategy provides a framework for tackling wider determinants of health	1. A district plan is being developed under the joint leadership Wakefield Together (ststutory, voluntary and commercial sectors), which includes plans to improve population health by addressing wider determinants. Plan will be in place by summer 2026.
2 Wakefield Forward Plan includes work to deliver Health and Wellbeing Board priorities	
3 Core20plus5 funding directed to addressing social determinants, to be confirmed via the investment panel for 2025/26.	2. Bid to investment panel January 2025 to protect previous core 20 plus 5 funding for projects that address wider determinants.VCSE collaborative (ICB/council/VCSE) is working to develop a proposal for an investment standard to support national and local ambition to shift from treatment to prevention, hospital to community. Proposal to be developed for 2026/27 planning round.
Sources of assurance *(Where is the evidence that the controls work?)*	
1 Regular reports to Health and Wellbeing Board & Wakefield District Health and Care Partnership Committee on work to address priorities	
2 Outcomes framework has been developed for both the Health and Wellbeing Board and Wakefield District Health and Care Partnership Committee and being reported through both committees	**Link to Place Risk Register**
3 Impact of investment in Core20plus5 programmes was reported to Wakefield District Health and Care Partnership Committee November 2023	None.

WYICB - Board Assurance Framework - ICB and places							Version: 8	Date: October 2024
Mission 4	Failure to manage the strategic risk could result in a failure to **SECURE BENEFITS OF INVESTING IN HEALTH AND CARE**						**Lead director(s) / board lead**	Ian Holmes
Strategic risk 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.						**Lead committee / board**	Quality Committee
ICB risk appetite	**ICB risk scores**						**Rationale for current ICB score**	
	Target (ICB)			**Current (ICB)**			Our health and care partnership has done significant work on the race equality agenda, but we know that systemic problems still exist in all organisations in our system. We will continue to work with focus and energy on this agenda and broaden our focus to include other protected characteristics.	
BOLD	**Likelihood**	**2**	**8**	**Likelihood**	**3**	**12**		
	Impact	**4**		**Impact**	**4**			

Key controls *(What helps us mitigate the risk?)*		**Mitigating actions** *(What more are we/should we be doing at ICB level?)*
1	Five Year Integrated Care Strategy - Ambition 8	(1) EDI Strategy is being developed for approval at ICB Board in January 2025. This will be overseen by the Partnership Board including a number of objectives for delivery by the Partnership Board. (2) The Race Equality Review undertaken in 2020 will be reviewed by Donna Kinnair during 2025/26.
2	Race Equality Review Action Plan overseen by the Partnership Board	
3	EDI Oversight Group maintains oversight of statutory requirements and objectives	
4	ICB People Plan, with a strong focus on inclusivity	
5	EQIA process embedded to inform decision-making	
Sources of assurance *(Where is the evidence that the controls work?)*		**Links to ICB risk register** *(Reference numbers/brief description)*
1	Internal Audit Review 2023/24	None identified
2	People Plan had ICB Board sign off in September 2024	
3	Staff survey data	
4	WRES data	
5	EMT discussion and oversight of priorities and responses to audit actions	
6	Agenda and minutes of EDI Oversight Group	
7	Examples of reports and minutes showing consideration of EQIAs during decision-making	**See the separate Positive Assurance Log**

Bradford District and Craven (BD&C)	**Place lead:**	**Therese Patten**	**Nominated lead for this risk:**	**Kez Hayat (13.01.2025)**

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (BD&C)			**Current (BD&C)**			Concerted work on all aspects on EDI is required to meet the needs of our population and ensure our colleagues experience at work enables them all to flourish. Our data and qualitative information tells us that much remains to be done, building on the strong commitment shown already EDI leads have identified that 'If we are unable to improve outcomes for our population and workforce by advancing our collective approach to EDI then our population and workforce will continue to experience inequality of outcome, unfair treatment and discrimination'.
BOLD	**Likelihood**	**2**	**8**	**Likelihood**	**3**	**12**	
	Impact	**4**		**Impact**	**4**		

Key controls *(What helps us mitigate the risk?)*		**Mitigating actions** *(What more are we/should we be doing at place?)*
1	Place wide (broader than health and care - all sectors) EDI group, chaired by Prof Udi Archibong, work led by Zahra Niazi (whole system EDI lead, resourced by all partners). Good engagement from EDI leads Acting As One. ICB input through Act As One partnership EDI lead Kez Hayat. 6-8 weekly Systems Equalities Group meeting to ensure collective plan for EDI stays on track	Three priorities which align with the WY ICB strategic equality objectives for 2025/26; 1. Continue with our focus and efforts on reducing health inequalities across the district with particular focus on 'Access, Experience and Outcomes' for our diverse communities and wider communities of interest. This will foster collaborative processes that actively listen to patients and service users and act on their feedback to shape access, experiences, and outcomes. 2. To work with place level partners in influencing the development of an anti-racist approach/strategy for Bradford and Craven district with focus on targeted engagement and involvement with communities and wider workforce. REN currently taking the lead with system partners onboard with focus on co-producing an anti-racist approach for Bradford and Craven 3. Improve and advance our role and position in ensuring we have diverse senior leaders at band (8b) and above across our place with particular focus on positive action approaches for diverse staff across place. This links with the WY Race review that Professor Dame Donna Kinnair chaired. **Link to place risk register:** None
2	EDI reporting is carried out by each large organisation in line with national requirements e.g. WRES, WDES, EDS2, PSED and use of EQIAs/QEIAs for NHS Trusts/FTs. Also Public Sector Equality Duty annual reporting by all statutory bodies, includes 'place partnership view' fed into WY ICB report.	
Sources of assurance *(Where is the evidence that the controls work?)*		
1	Minutes of the systems EDI group	
2	BDC People Board	
3	Assurance provided via Partnership Leadership Executive (PLE), minutes.	
4	BDC Extended Leadership Team meeting, minutes.	
5	NHSE website for WRES and WDES data. WYICB PSED report on website	

Calderdale	**Place lead:**	**Robin Tuddenham**	**Nominated lead for this risk:**	**Neil Smurthwaite (20.12.2024)**

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (Calderdale)			**Current (Calderdale)**			Our health and care partnership has done significant work on the race equality agenda, but we know that systemic problems still exist in all organisations in our system. We will continue to work with focus and energy on this agenda and broaden our focus to include other protected characteristics.
BOLD	**Likelihood**	**2**	**8**	**Likelihood**	**3**	**12**	
	Impact	**4**		**Impact**	**4**		

Key controls *(What helps us mitigate the risk?)*		**Mitigating actions** *(What more are we/should we be doing at place?)*
1	Race equality standard compliance is monitored at place level.	1. Suporting the EDI strategy in West Yorkshire (2025/26) **Link to place risk register:** None
2		
3		
Sources of assurance *(Where is the evidence that the controls work?)*		
1	Outcomes of staff survey is discussed at Calderdale senior leadership team meetings	
2		
3		

Kirklees	**Place lead:**	**Carol McKenna**	**Nominated lead for this risk:**	**Steve Brennan (13.01.2025)**

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (Kirklees)			**Current (Kirklees)**			Place have history of tackling issues realted to inclusion, but recognise the need to go further given the diversity of our population, experiences of care and access to services and how our colleagues improve practice
BOLD	**Likelihood**	**2**	**8**	**Likelihood**	**3**	**12**	
	Impact	**4**		**Impact**	**4**		

Key controls *(What helps us mitigate the risk?)*		**Mitigating actions** *(What more are we/should we be doing at place?)*
1	Inclusive Communities Framework adopted by Place Committee	1. EDI Strategy is being developed for approval at ICB Board in January 2025. This will be overseen by the Partnership Board including a number of objectives for delivery by the Partnership Board. The Kirklees objectives of the EDI strategy has been developed and work is progressing (2025/26) **Link to place risk register:** None
2	EQIAs embedded as part of PMO functions	
3	Community champions / Community voices	
Sources of assurance *(Where is the evidence that the controls work?)*		
1	ICB (Kirklees) self-assessment against the ICF during 2025/26 (last completed 2023)	
2	Examples of EQIAs and subsquent action / mitgation	
3	Examples of voice and influence from diverse poputaltions in planning and transformation	

Leeds	**Place lead:**	**Tim Ryley**	**Nominated lead for this risk:**	**Nick Earl (19.12.2024)**

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (Leeds)			**Current (Leeds)**			ICB in Leeds works proactively in relation to EDI in respect of our workforce, organisational development and commissioning responsibilities. The controls currently in place should limit any impact to a potential single rather than multiple breaches in statutory duty and the likelihood is considered to be possible.
BOLD	**Likelihood**	**2**	**4**	**Likelihood**	**3**	**9**	
	Impact	**2**		**Impact**	**3**		

Key controls *(What helps us mitigate the risk?)*		**Mitigating actions** *(What more are we/should we be doing at place?)*
1	Compliance with the requirements of the Equality Act 2010 Public Sector Duties in relation to our workforce and commissioning responsibilities.	1. Suporting the EDI strategy in West Yorkshire (2025/26) 2. Increased focus on personal wellbeing within objective setting which may include

2	NHS Equality Delivery System 2 (EDS) and transition to EDS 2022; Workforce Race Equality Standard (WRES); Workforce Disability Equality Standard (WDES); Gender Pay Gap (GPG) report and subsequent action plans.	EDI components (2025/26)
3	ICB in Leeds Race Equality Network (REN); recruitment and selection and our REN procedure/guidelines.	**Link to place risk register:**
4	Ongoing interaction/partnership working in relation to our insights, communication and involvement team and equality, diversity, and inclusion.	None.
Sources of assurance *(Where is the evidence that the controls work?)*		
1	Development of ICB in Leeds equality, diversity, and inclusion (EDI) priorities; annual contribution to WYICB Public Sector Equality Duty Report; equality impact assessments completed for commissioning programmes/projects.	
2	Ongoing partnership working across Leeds Health and Care partnership and the wider WYICB partnership in relation to the EDS transition and development of key priorities. WYICB WRES; WDES; GPG actions plans.	
3	Continuation of ICB in Leeds REN; continued implementation of the REN recruitment and selection procedure/ guidelines.	
4	EDI involvement in the public/patient insight reports and involvement in our Population Board's public engagement workshops.	

Wakefield	**Place lead:**	**Mel Brown**			**Nominated lead for this risk:**	**Ruth Unwin, Dasa Farmer (17.01.25)**
ICB risk appetite	**Place risk scores**					**Rationale for current place score**
	Target (Wakefield)			**Current (Wakefield)**		
BOLD	**Likelihood**	**2**	**8**	**Likelihood**	**3**	**12**	Impact assessed as high due to evidence that people with different protected characteristics have poorer health outcomes. Likelihood assessed as high due to Wakefield District Health and Care Partnership having limited ability to change deeply ingrained attitudes
	Impact	**4**		**Impact**	**4**	

Key controls *(What helps us mitigate the risk?)*		**Mitigating actions** *(What more are we/should we be doing at place?)*
1	Equality, Diversity and Inclusion network established for place	1. A proactive approach to monitoring population health and uptake of services by groups with protected characteristics. Linked data model implementation for children and young people by April 2025.
2	Local equality objectives in development	
3	Work programme to ensure compliance with Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), Public Sector Equality Duty (PSED)	
4	Local, multi-agency health inequalities alliance developed.	
5	The workforce alliance has a specific workstream for belonging to ensure equality of opportunity in recruitment and career progression	**Link to place risk register:**
6	Communication, Involvement and EDI at place	None.
Sources of assurance *(Where is the evidence that the controls work?)*		
1	People panel (partnership committee) receives and scrutinises delivery of equality agenda	
2	Formal reports (WRES,DES, PSED, Equality Delivery System 2) to People Panel	
3		

WYICB - Board Assurance Framework - ICB (no requirement for places to complete)							Version: 8	Date: January 2025
Mission 4	Failure to manage the strategic risk could result in a failure to **SECURE BENEFITS OF INVESTING IN HEALTH AND CARE**						**Lead director(s) / board lead**	Anthony Kealy / Shaukat Ali Khan
Strategic risk 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.						**Lead committee / board**	ICB Board/Transformation Committee
ICB risk appetite	**ICB risk scores**						**Rationale for current ICB score**	
	Target (ICB)			**Current (ICB)**			This risk relates to the ability of the ICB to work with partners to mitigate the impact of a significant incident on the delivery of healthcare services. Our current score has been assessed against the operation of the controls during recent EPRR events and incidents . We have evidenced significant system ability to respond to an emergency, however there are limited controls the ICB can put in place for the largest scale event such as a future pandemic.	
AVERSE	**Likelihood**	**3**	**9**	**Likelihood**	**3**	**12**		
	Impact	**3**		**Impact**	**4**			

	Key controls *(What helps us mitigate the risk?)*	**Mitigating actions** *(What more are we/should we be doing at ICB level?)*
1	Engagement with all partners and direct alignment to WY Resilience Forum	1. Directorates and Places to complete Business Impact Assessments by March 2025 to support further development of business continuity plans. 2. EPRR Team to complete testing and exercising of business continuity plans by March 2025
2	Training at senior level - Principles of Health Command Training - Strategic Health Commander	
3	WY CIO Forum inc Place CIOs	
4	System Winter Plan with mitigating actions for surge and escalation inc Strategic Coordination Centre	
5	EPRR Compliance and Action Plans for each NHS organisation	
6	WY ICB has established arrangements for 1st and 2nd on-call.	
7	Business continuity plans are in place in the event of a prolonged IT system issue.	
8	WY ICB attends or facilitates a range of WY EPRR exercises during the course of each financial year.	

	Sources of assurance *(Where is the evidence that the controls work?)*	**Links to ICB risk register** *(Reference numbers/brief description)*
1	Reporting of EPRR Compliance to Board	**2194** - industrial action **2314 -** Airedale Hospital structural RAAC **2166** - Risk of a successful cyber attack, hack and data breach on ICB. **2234** - Risk of cyber attack on commissioned services **2295** - Business continuity arrangements
2	Minutes of Audit Committee and Internal Audit Meetings	
3	WY EPRR exercises - outputs, from papers and Mins.	
4	Significant learning from incidents	
5	Regular reporting on progress with DSPT annual self-assessment to WY ICB Audit Committee and internal audit assurance of DSPT submission	
6	There is a newly established directorate called Digital, Data and Technology (DDaT) - output from papers.	**Positive Assurance -** see separate log

WYICB - Board Assurance Framework - ICB (no requirement for places to complete)						Version: 8	Date: November 2024
Mission 4	Failure to manage the strategic risk could result in a failure to **SECURE BENEFITS OF INVESTING IN HEALTH AND CARE**					**Lead director(s) / board lead**	Ian Holmes
Strategic risk 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.					**Lead committee / board**	Transformation Committee
ICB risk appetite	**ICB risk scores**					**Rationale for current ICB score**	
	Target (ICB)			**Current (ICB)**		Climate change is already affecting us in West Yorkshire. International, national, regional and local strategies and actions are insufficient at present to avert the worst effects. In West Yorkshire, we are most likely to be directly affected by flooding, heatwaves, wind and wildfire, but specialist (medical) and general (food, office supplies) supply chains will be disrupted. There is a real risk of disruption to power, internet and gas grids at a regional level. We need to reduce our environmental impact (mitigation) and change what we do to make us ready for the new normal (adaptation).	
OPEN	**Likelihood**	**4**	**12**	**Likelihood**	**4**	**16**	
	Impact	**3**		**Impact**	**4**		

Key controls *(What helps us mitigate the risk?)*		**Mitigating actions** *(What more are we/should we be doing at ICB level?)*
1	Climate Change strategy approved by Partnership Board December 2023	No specific actions at this point, however consideration is being given to developing actions focused on adaptation.
2	Regular meetings and data submission to national Greener NHS team	
3	Transformation Committee will take oversight of ICB organisational response.	
4	Board Level Net Zero Leads network and the Operational Leads Network.	
5	Regional Greener NHS steering group.	

Sources of assurance *(Where is the evidence that the controls work?)*		**Links to ICB risk register** *(Reference numbers/brief description)*
1	Minutes of Partnership Board focus on Big Ambition number 9 (climate change)	None identified.
2	Dashboard received by ICB Board on 10 big ambitions	
3	Quarterly data submission to the National Greener NHS team	
4	Minutes of the Transformation Committee	**Positive Assurance** - see separate log

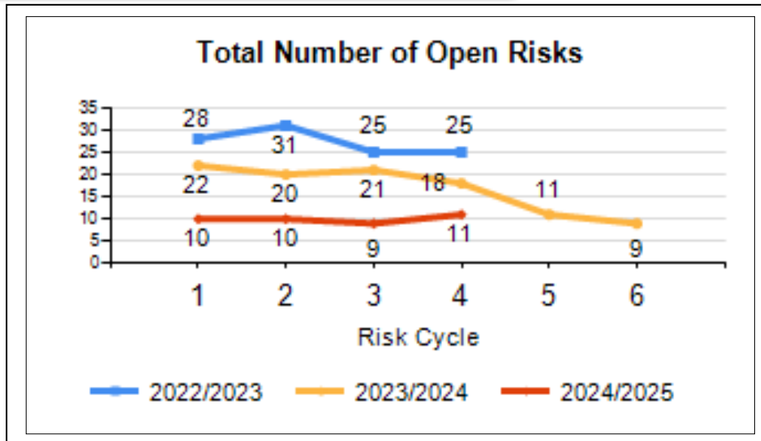
Appendix 3 - Leeds Place - Risk on a Page Report
Cycle 4 December 2024 – March 2025

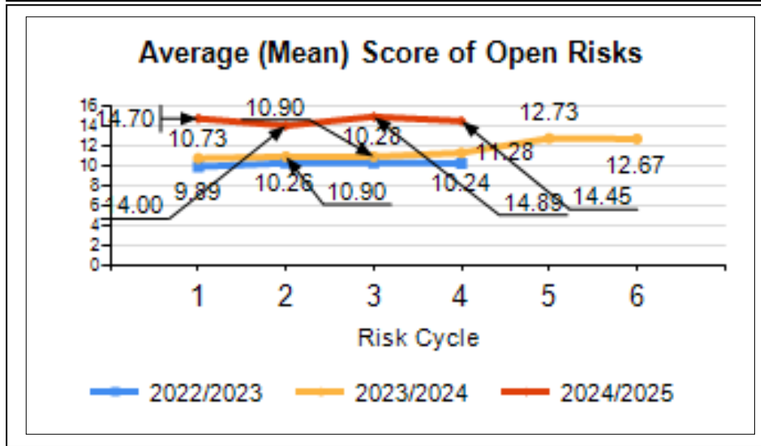
Leeds Health & Care Partnership

NHS West Yorkshire Integrated Care Board

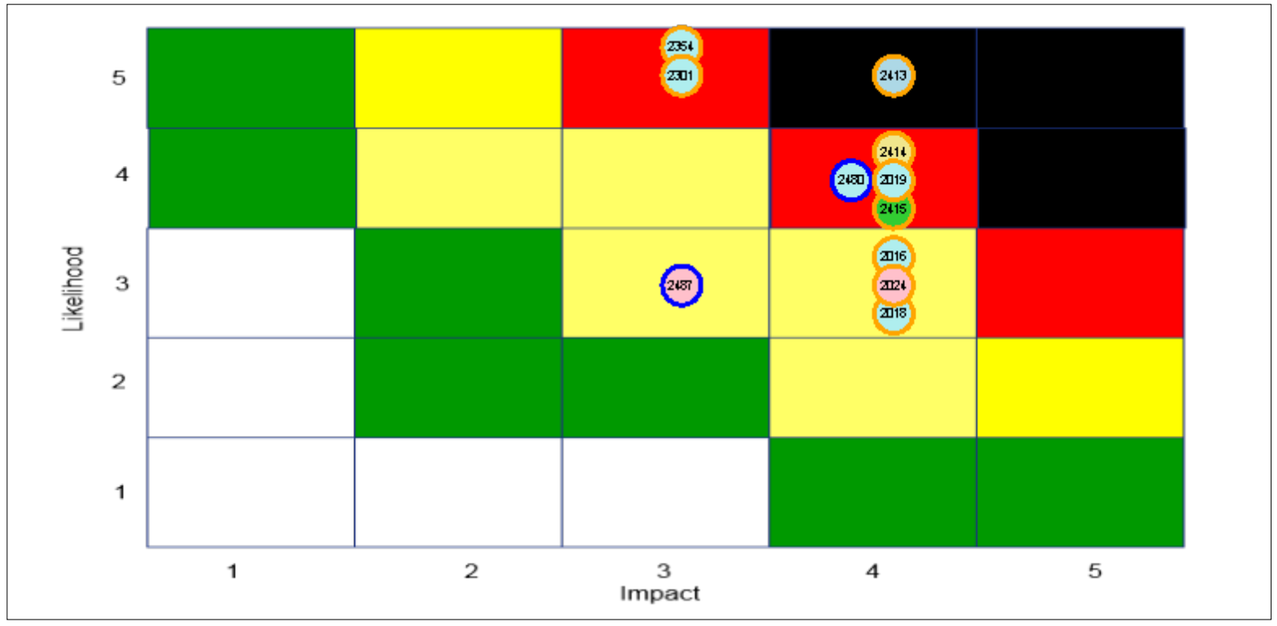
Total Place Risks	11
Delivery and Finance	1
Delivery and Quality	6
Delivery	1
Finance	1
Quality	2

Total Risks: 11		Risk Score Increasing	0
New	2	Risk Score Static	9
Marked for Closure	0	Risk Score Decreasing	0





Risk Overview (Leeds place)

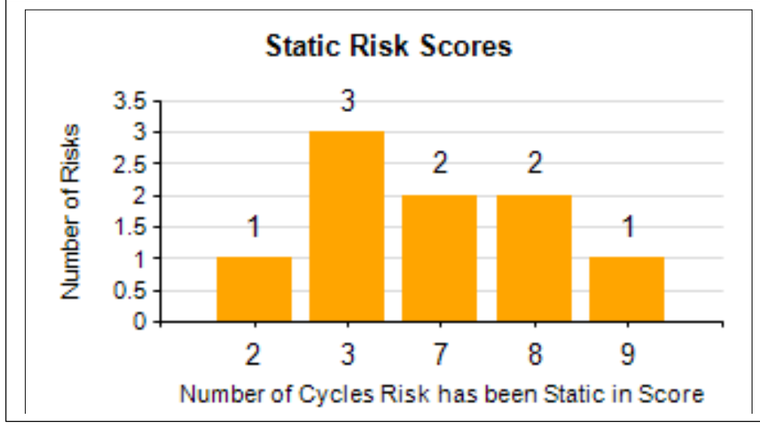


Score	Risk Level
1-3	Low risk
4-6	Moderate risk
8-12	High risk
15-16	Serious risk
20-25	Critical risk

Key

- Quality and People's Experience Committee
- Finance and Best Value Committee
- Delivery Committee
- 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



Leeds Health & Care Partnership

NHS West Yorkshire Integrated Care Board

Appendix 4

Leeds Health and Care Partners - Top Risks – February 2025						
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 2025/26** Risk of not being able to deliver a balanced revenue financial plan for 2025/26 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 2025/26, 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. Sources including market pressures relating to capacity and to increased cost of placements and packages of care

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

Meeting name:	Leeds Committee of the West Yorkshire Integrated Care Board
Agenda item no.	79/24
Meeting date:	26 February 2025
Report title:	Proposed Changes to the Leeds Place Sub-Committee Structure from 1st April 2025
Report presented by:	Tim Ryley, Place Lead
Report approved by:	Tim Ryley, Place Lead
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Purpose and Action			
Assurance ☐	Decision ☒ (approve/recommend/ support/ratify)	Action ☐ (review/consider/comment/ discuss/escalate	Information ☐

Previous considerations:

Finance and Best Value Sub-Committee – 22nd January 2025
Delivery Sub-Committee – 29th January 2025

Executive summary and points for discussion:

This report seeks approval of the proposed changes to the sub-committee structure from 1st April 2025. The proposal sets out the intention to move from three to two assurance sub-committees, effectively dissolving the Delivery Sub-Committee and reassigning its responsibilities to the Finance and Best Value Sub-Committee and the Leeds Committee.

The key principles of the proposal to move from three to two assurance sub-committees are as follows. Firstly, to bring together finance, performance and outcomes under the remit of one sub-committee to enable greater integration of all three aspects. Secondly, the proposed arrangement will align with that of the providers and committees at West Yorkshire. Finally, the proposal offers a pragmatic approach to addressing duplication of meetings across the system.

In summary, it is proposed that the Finance and Best Value Sub-Committee be renamed as the Finance, Value and Performance Sub-Committee and that the new sub-committee takes on performance management assurance responsibilities, and that the Leeds Committee would monitor health inequalities reporting moving forwards. If agreed, the Terms of Reference (ToR) will be submitted for approval at the next meeting taking place 21st May 2025.

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. Approve the proposal to dissolve the Delivery Sub-Committee from 1st April 2025 and realign responsibilities as set out in the report.
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) Realignment of Roles and Responsibilities within the Delivery Sub-Committee ToR
Acronyms and Abbreviations explained
1. Terms of Reference (ToR) 2. West Yorkshire Integrated Care Board (WYICB)

What are the implications for?

Residents and Communities	N/A
Quality and Safety	N/A
Equality, Diversity and Inclusion	The proposal set out in this report ensure that tackling health inequalities remains a central focus of future assurance reporting and decision making.
Finances and Use of Resources	The proposal for the new Finance, Value and Performance Sub-Committee acknowledges the importance of considering performance alongside financial planning.
Regulation and Legal Requirements	The proposal set out in this report supports the statutory functions of the WYICB.
Conflicts of Interest	N/A
Data Protection	N/A
Transformation and Innovation	N/A
Environmental and Climate Change	N/A
Future Decisions and Policy Making	The proposal set out in this report will ensure effective assurance on Leeds Place plans and performance.
Citizen and Stakeholder Engagement	N/A

1. Main Report

1.1 Following feedback received through the annual governance review for the sub-committees in April 2024 and in line with ongoing partnership development work to sharpen our governance arrangements, work began to consider the number, remit and scope of the three sub-committees at Leeds Place, which were first established in July 2022 when the WYICB became a statutory body. Discussions have taken place between the accountable officer, executive leads, governance colleagues and independent members to consider how to address challenges highlighted and ensure that the governance arrangements work efficiently and effectively, considering where there may be duplication with other key forums. As a result, it was suggested that moving to two assurance sub-committees could reduce demand on the Leeds system and better represent the distinction between quality of services and value of services, in line with the WYICB objectives and government priorities.

1.2 In September 2024, a session was held with members of the Delivery Sub-Committee where the proposal to dissolve the sub-committee was first presented, with its current assurance responsibilities as set out in the terms of reference to be realigned to the other sub-committees and the Leeds Committee. Members were supportive of the initial proposal, however reiterated the importance of clear governance for health inequalities and secondary prevention in the new arrangements. It was agreed that a report would be submitted to the Delivery Sub-Committee and the Finance and Best Value Sub-Committee in January 2025 setting out a more detailed proposal for comment in advance of formal consideration by the Leeds Committee.

1.3 Diagram 1 depicts the proposed restructure of the sub-committees at Leeds Place from 1st April 2025. Please note that the Quality and People's Experience Sub-Committee will be unaffected by the proposed changes set out and therefore this report focuses solely on realignment of the roles and responsibilities of the Delivery Sub-Committee to the Finance and Best Value Sub-Committee and the Leeds Committee.

Diagram 1:

1.4 It is proposed that the Finance and Best Value Sub-Committee be renamed the Finance, Value and Performance Sub-Committee, in line with the committee structure at West Yorkshire, to support reporting and ensure discussions around delivery of services and resources are joined up.

1.5 Discussions held at the sub-committee meetings in January 2025 highlighted the need for health inequalities to remain at the centre of discussions around performance and our financial plans, as well as balanced and appropriate representation from partners to ensure that the new sub-committee fulfils its new extended assurance function. Work is ongoing to determine the new membership, with the intention to limit the demand on partners by requiring attendance from one representative from each partner organisation. The membership will include balanced representation between Independent / Non-Executive Members, partner representatives, and Executive Officers of the Leeds Office of the WYICB, to support the sub-committee to seek comprehensive assurance of Leeds Place plans and performance, as well as key roles to ensure that health inequalities continue to be a prominent feature of discussions. If the proposal is agreed, we will speak with partners about the most suitable representatives from their organisation to join the new sub-committee and the draft ToR will be submitted for approval at the next meeting taking place 21st May 2025.

1.6 Proposed realignment of roles and responsibilities of the Delivery Sub-Committee as per the ToR are attached at Appendix 1. Further detail is provided in the sections below.

Health Inequalities

1.7 A key area of focus for the Delivery Sub-Committee has been to oversee work to address health inequalities within the Leeds Health and Care Partnership. It is proposed that a combined children and adults health inequalities report is taken directly to the Leeds Committee from April 2025. Sub-committee discussions highlighted the reiterated that despite the realignment of this assurance responsibility, health inequalities should remain integral to the wider work of the partnership and be embedded in the work of both remaining sub-committees.

Performance Monitoring

1.8 It is proposed that the performance monitoring responsibilities of the Delivery Sub-Committee are transferred to the new Finance and Performance Sub-Committee from April 2025, with a performance report submitted to each meeting.

Winter Planning

1.9 Assurance on winter planning arrangements is well established at several forums across the system, including Active System Leadership Executive Group and Adults Health and Active Lifestyles Scrutiny Board, and plans are subject to detailed oversight and peer review by WYICB colleagues. It is

proposed that, for completeness, regular updates are included in the Place Lead Update Reports to Leeds Committee.

Risk Management

1.10 The sub-committees have often discussed the impact of financial risk on service delivery and quality of services and how best to represent this on the risk register. The proposed restructure will therefore enable the Finance and Performance Sub-Committee to take a more rounded approach to reviewing the financial risks and mitigations in place. There is one risk currently aligned to the Delivery Sub-Committee - Risk no. 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'. This risk will be realigned to the Leeds Committee from 1st April 2025, if the proposed restructure is agreed.

2. Next Steps

2.1 If agreed, the changes will be implemented from 1st April 2025.

3. Recommendations

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

1) **Approve** the proposal to dissolve the Delivery Sub-Committee from 1st April 2025 and realign responsibilities as set out in the report.
2) **Consider** and **comment** on the proposed membership set on within the draft ToR for the new Finance, Value and Performance Sub-Committee.

4. Appendices

1) Realignment of Roles and Responsibilities within the Delivery Sub-Committee ToR

Appendix 1

Realignment of Roles and Responsibilities within the Delivery Sub-Committee ToR

Sub-Committee remit (ToR)	When considered	Where it will be considered from April 2025
Systems Resilience and Emergency Planning: • Assurance that Leeds has robust processes for dealing with emergencies including critical incidents, disease outbreaks and pandemics • Assurance that Leeds has a robust winter plan.	Preparation for Winter (13/09/2023)	Regular assurance through the Place Lead Update report to the Leeds Committee (already in place). Substantial scrutiny and consideration at several other forums across the Leeds system.
Operational Performance: • NHS constitutional standards and other national planning priorities • Local operational priorities set out in the LHCP operational plan.	NHS Operational Planning and Performance Update (17/04/2024) Operational Planning Round Update 23/24 (23/02/2023) Delivery Performance Report (standing item)	The Finance and Performance Sub-Committee (from April 2025)
Improving Outcomes: • Improvements in the health outcomes of the population as set out in Healthy Leeds: Our Plan for Health and Care in Leeds • Reducing health inequalities • Benchmarking against NHS Outcomes Framework • Progress on Service Transformation (Healthy Leeds Plan).	Population Health Board reports (standing item)	These reports are currently under review in line with the partnership development work. Future reports will continue to go to QPEC/Finance and Performance Sub-Committee.

	People's Voice (standing item)	Standing item at QPEC/F&BV Sub-Committees and Leeds Committee
	Children and Young People Core20PLUS5 Data Report (14/06/2023) and Core20PLUS5 Health Inequalities Data Reporting (23/02/2023 and 05/09/2022)	Inequalities report twice a year directly to the Leeds Committee (from April 2025)
	Healthy Leeds Plan Strategic Indicator Remeasurement 2022 (05/09/2022) and Refresh of Healthy Leeds Plan (14/06/2023)	HLP Refresh considered at the Leeds Committee, along with various other forums throughout the Leeds System.
West Yorkshire and NHSE: • Monitoring progress against the West Yorkshire 10 Priorities • Coordination of the LHCP input to the NHS England Quarterly Assurance processes.	Not considered to date.	
Climate Change: • Progress on delivery of net zero carbon targets across Leeds NHS Providers.	Not considered to date.	
Risk Management • Reviewing risks assigned to the sub-committee by the	Risk Management Report - every meeting	Will continue to go to QPEC, F&P and Leeds Committee.

Leeds Committee of the ICB and ensure that appropriate and effective mitigating actions are in place	Deep dive: Mental Health (Adults) risks (14/06/2023) Deep dive: Access to Primary Medical Services (17/11/2022)	