

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

1.15 pm to 4.30 pm, Wednesday 11 February 2026

(Private pre-meet for members 1.00 pm; meeting in public 1.15 pm)

HEART: Headingley Enterprise and Arts Centre, Bennett Road, Headingley, Leeds, LS6 3HN

AGENDA

No.	Item	Lead	Page	BAF Link(s)	Time
1	Welcome, Introductions	Rebecca Charlwood Independent Chair	-	N/A	1.15
2	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	-
3	Minutes of the Previous Meeting - To approve the minutes of the meeting held on 19 November 2025.	Rebecca Charlwood Independent Chair	004	N/A	-
4	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	-
5	Action Tracker - To note any outstanding actions.	Rebecca Charlwood Independent Chair	01700	N/A	-
6	People's Voice - To receive a lived experience of health care services in Leeds: Communication, Compassion, Co-ordination: Are Leeds Health and Care Services joined up? An update from the "How Does It Feel For Me?" Working Group.	Healthwatch Leeds Co-Chair	019	N/A	1.20

No.	Item	Lead	Page	BAF Link(s)	Time
7	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	1.35
8	Place Lead Update - To receive a verbal update from the Place Lead.	Tim Ryley Place Lead	-	N/A	1.45
ROUTINE REPORTS					
9	Quality and People's Experience Sub-Committee Update - To receive an assurance report from the Chair of the sub-committee.	Rebecca Charlwood Independent Chair and Chair of the Quality and People's Experience Sub-Committee	026	N/A	2.05
10	Finance, Value and Performance Sub-Committee Update - To receive an assurance report from the Chair of the sub-committee.	Cheryl Hobson Independent Member and Chair of the Finance, Value and Performance Sub-Committee	To follow	N/A	2.10
FINANCE					
11	Financial Position Update - To receive an update on the financial position.	Alex Crickmar Director of Operational Finance	029	3.2	2.15
BREAK 2.25 – 2.35					
ITEMS FOR DECISION / ASSURANCE / STRATEGIC UPDATES					
12	Financial and Operational Planning Update - To receive an update on the 2026/27 Financial and Operational Plan.	Alex Crickmar Director of Operational Finance Jo Howard Head of Strategy and Outcomes (Interim)	Presentation	3.2 3.3	2.35
13	Neighbourhood Planning Update To receive an update on Neighbourhood Planning.	Nicola Nicholson Associate Director for Strategy and Programmes	045	3.1	2.50
14	Health Inequalities Update - To receive an update (including a full update of the Year 3 Marmot City Plans) by way of a report also presented to Leeds City Council Adults, Health and Active Lifestyles Scrutiny Board on 10 February 2026.	Tim Fielding Deputy Director of Public Health Sarah Erskine Head of Public Health – Health Inequalities Ruth Burnett Executive Medical Director, Leeds Community Healthcare Trust	061	1.1 1.2	3.05
15	Work, Skills and Health Programme Update – Healthy Working Life - To consider the recommendation of the ICB matrix team regarding the schemes that might be continued, stood down, or modified for 2026/27.	David Edeson Associate Director of Medicines Optimisation and Clinical Lead	137	1.1	3.40

No.	Item	Lead	Page	BAF Link(s)	Time
16	Merger Application – Manston Surgery and Ashfield Medical Centre - To consider the application.	Kirsty Turner Associate Director of Primary Care	140	3.1	3.55
GOVERNANCE/RISK MANAGEMENT					
17	Risk Register (Cycle 4 2025/26) - To receive and consider the risk management information provided.	Tim Ryley Place Lead supported by Asma Sacha Risk Manager	242	All	4.10
18	Changes to NHS West Yorkshire ICB Governance Arrangements for 2026/27 (transitional year) and Committee Year End Arrangements for 2025/26 - To receive and consider the attached report.	Sue Baxter Head of Partnership Governance	292	N/A	4.20
FORWARD PLANNING					
19	Items for the Attention of the ICB Board - To identify items to which the ICB Board needs to be alerted, of which it needs to be assured, which it needs to action, and positive items to note.	Rebecca Charlwood Independent Chair	-	N/A	4.25
20	Any Other Business - To discuss any other business.	Rebecca Charlwood Independent Chair	-	N/A	4.30
21	Date and Time of Next Meeting To be confirmed.	Rebecca Charlwood Independent Chair	-	N/A	-

Draft Minutes

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

1.15 pm, Wednesday 19 November 2025

HEART: Headingley Enterprise and Arts Centre, Bennett Road, Headingley, Leeds, LS6 3HN

Members	Initials	Role
Rebecca Charlwood	RC	Independent Chair, Leeds Committee of the WY ICB
Jason Broch (deputising for SF)	JB	Medical Director, ICB in Leeds (deputy)
Ed Cornick (deputising for BB)	EC	Associated Director – Policy and Partnerships, Leeds Teaching Hospitals NHS Trust
Victoria Eaton	VE	Director of Public Health, Leeds City Council
Pip Goff	PG	Volition Director, Forum Central
Jo Harding	JH	Director of Nursing and Quality, ICB in Leeds
Jonathan Phillips	JP	Co-Chair, Healthwatch Leeds
Yasmin Khan	YK	Independent Member – Health Inequalities
Dr Sara Munro	SM	Chief Executive, Leeds and York Partnership Foundation Trust and Chief Executive Designate, Leeds Community Healthcare NHS Trust
Tim Ryley	TR	Place Lead, ICB in Leeds
Dr George Winder	GW	Chair, Leeds GP Confederation
In attendance		
Sue Baxter	SB	Head of Partnership Governance, WY ICB
Chris Ellison	CE	Deputy Director of Finance, Leeds Teaching Hospitals NHS Trust
Rob Hakin	RH	Director of Healthcare Planning, Leeds Teaching Hospitals NHS Trust
Karen Lambe	KL	Governance Officer, WY ICB
Nick Lamper	NL	Governance Manager, WY ICB
Helen Lewis	HL	Director of Pathway and System Integration, ICB in Leeds
Kirsty Turner	KT	Associate Director of Primary Care, ICB in Leeds
Apologies		
Caroline Baria	CB	Director of Adults and Health, Leeds City Council
Brendan Brown	BB	Chief Executive, Leeds Teaching Hospitals NHS Trust
Alex Crickmar	AC	Director of Operational Finance, ICB in Leeds
Dr Sarah Forbes	SF	Medical Director, ICB in Leeds

Cheryl Hobson	CH	Independent Member – Finance and Governance
Julie Longworth	JL	Director of Children and Families, Leeds City Council
Sabina Armstrong	SA	Director of Partnership and Operations, ICB in Leeds
Asma Sacha	AS	Risk Manager, WYICB

Members of public and/or staff observing – 2

42 WELCOME AND INTRODUCTIONS

The Chair opened the meeting and welcomed all members and attendees.

43 APOLOGIES AND DECLARATIONS OF INTEREST

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

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

In respect of the Place Lead Update (minute 49 below), it was acknowledged that ICB employees had a direct financial interest in the organisational change element but, as this was an update for information and no decision was being sought, it would not be necessary for anyone to withdraw from the meeting.

In respect of the item on Chapel Allerton Hospital New Elective Care Centre (minute 55 below), EC declared a direct financial interest as an employee of LTHT and would withdraw to the public gallery during the consideration of the item.

44 MINUTES OF THE PREVIOUS MEETING

The minutes of the meeting held on 3 September 2025 were approved as an accurate record.

The Leeds Committee of the WY ICB:

- **APPROVED** the minutes of the previous meeting held on 3 September 2025.

45 MATTERS ARISING

No matters were raised.

46 ACTION TRACKER

There were no current open actions.

47 PEOPLE'S VOICE

JP presented a report and briefing entitled [Keeping every door open: Ensuring access beyond digital in health and care](#), which built upon previous Healthwatch Leeds reports, including [Digitising Leeds: Risks and Opportunities for Reducing Health Inequalities in Leeds](#) (2020, Healthwatch Leeds and [People's Voices Partnership](#)) and the accompanying briefing focusing on people at risk of health inequalities, [Digitising Inclusion Leeds: How does it feel for me?](#) The briefing also touched on digital in the context of reports that Healthwatch Leeds had written about people's experience of [cost of living](#), [repeat prescriptions](#), and [digital appointments](#). Members of the committee had been requested to view the video [Diane and Gemma May 2025 update part 1](#) prior to the meeting.

The report, which contained five recommendations, was on the agenda for the February meeting of the Health and Wellbeing Board. JP raised the question as to whether the topic of digital exclusion should feature on the corporate risk register or Board Assurance Framework.

YK commented that this was not all new information, and asked how it may be possible to move forward around capturing and measuring the impact of transformation from analogue to digital, and maintaining accountability.

PG described the initiative as important and timely, providing a huge opportunity to transform and free up resources, but the report was about the effect on patients and their experiences. She welcomed the suggestion of raising this as a risk.

The Chair observed that the Quality and People's Experience Sub-Committee had highlighted the positive effect of the third sector and the Welfare Rights Service; she noted that financial constraints were pushing the initiative further and faster. She suggested that the concerns be captured in the Advise section of the committee's AAA Report.

JP was not sure whether people were aware of the overall picture of what was happening across Leeds, and VE supported the need for the impact to be looked at proactively and for measures to be built in to mitigate against health inequalities.

TR saw three parts to the issue – how to enable and equip a bigger proportion of the population to be digitally enabled; how the issue impacted upon commissioning intentions; and how providers could enact that in a way that did not exclude people. He asked GW about the Primary Care landscape. GW responded that, from 31 October 2025, there had been a requirement for equity of access to digital, telephone and front door services. The opportunity was great, but there was risk associated with the quick implementation. Monthly digital inclusion clinics were being run and were used well; digital could also be inclusive from a language perspective (by offering automatic translation) and could help meet the needs of the deaf community.

TR noted that there was a limit to what any one partner could do. The equity of access requirement for Primary Care was intended as a contractual measure to stop services being only online.

The Chair commented that the system could create friction and be a barrier to access, but it clearly provided opportunities and benefits as well as risks.

JP indicated that Healthwatch intended to go to each partner in Leeds to ask how they were responding to the report's recommendations.

SM suggested that, even if every service had a different system, the digital "front door" to the NHS should be consistent; YK believed there was an opportunity to make that change via the NHS app.

The Chair asked whether there should be a progress report or annual update, and YK suggested this could be incorporated into the twice-yearly health inequalities update.

The Leeds Committee of the WY ICB:

- **RECEIVED** and **NOTED** the content of the People Story and **COMMITTED** to work with Healthwatch to help it move forward with the key recommendations of the briefing [Keeping every door open: Ensuring access beyond digital in health and care](#).

(JB joined the meeting.)

48 QUESTIONS FROM MEMBERS OF THE PUBLIC

The following question had been submitted in advance of the meeting:-

"NHS England considers that around 10 million adults in the UK lack digital skills. Based on this figure, there are likely to be around 150,000 digitally excluded adults in Leeds. The Health Foundation estimates that digitising the NHS and adult social care in the UK will require investment of £21bn over five years, although there is a striking lack of clarity with regard to resourcing in the Ten Year Plan for Health. I welcome the report by Healthwatch Leeds and its recommendations, including that non digital options for accessing care will always remain available. This report is an example of the importance of an independent voice for patients and I wonder what plans the Leeds Committee of the West Yorkshire ICB has to ensure an independent voice will be maintained for the people of Leeds following the demise of Healthwatch in several years' time?"

TR responded to the question, saying that discussions were underway with the local authority to determine how there could be some sort of independent representation. West Yorkshire had well-established Healthwatch branches and there was opposition to the organisation's abolition, including from the Greater Manchester Mayor Andy Burnham. More of a challenge was being put into the ICB Board and work was being undertaken with the West Yorkshire Mayor to make a case for the retention of Healthwatch. A lot of MPs and Peers were concerned about this issue, and the government could give ground on it fairly easily. The issue would be included in the committee's AAA Report to the ICB Board.

JP added that there was "twin-track" activity taking place, with senior managers and politicians wanting some kind of independent voice in Leeds. This could strengthen representation beyond Healthwatch's current activity, and there was a growing head of steam in this direction nationwide.

The Leeds Committee of the WY ICB:

- **NOTED** the question submitted and the response provided.

49 PLACE LEAD UPDATE

(It was acknowledged that ICB employees had a direct financial interest in the organisational change element of this item but, as this was an update for information and no decision was being sought, it would not be necessary for anyone to withdraw from the meeting.)

TR presented a verbal update covering the topics of the national NHS picture and planning; provider partnerships and neighbourhoods; and ICB organisational changes and timelines.

The national context was a challenging one, with winter approaching and an early rise in the prevalence of flu, giving rise to a need for operational attention from very stretched people. There was significant industrial unrest and wider workforce unrest. The tone of the planning guidance provided a very tight financial settlement for the NHS and an even tighter one for local authorities. The pace and scale of plans was quite significant, with a sharpening divide between commissioners and providers. The first draft of plans needed to be submitted before Christmas and strategic commissioners would set commissioning intentions to which providers would respond, with a shift towards a key set of performance measures.

In relation to the move towards neighbourhood healthcare and prevention, NHS England was now picking up a stronger performance role. All trusts had been required to carry out a self-assessment on leadership and organisational ability. Provider partnerships were part of the strategic direction, and the Value Circle's strategic review of partnerships had just been published, along with the response thereto.

TR invited SM to provide an update in respect of LCH and LYPHT, and she advised that the organisations' boards had agreed upon a portfolio of services which they should look at bringing together. The boards had agreed the merger the previous week and this had now been communicated to the public. The Strategic Outline Case considered patient benefits as well as those for staff. This was considered the best direction of travel and was fully supported by partners.

TR outlined the leadership changes at LTHT, which had a new leadership team with Brendan Brown having taken on the role of Chief Executive. The work resulting from the inquiry into Maternity Services at the trust was at the stage of issues being investigated, understood, and put right.

The latest position in respect of the organisational changes at the ICB was that His Majesty's Treasury would now make available money to meet approximately two-thirds of the cost of the circa 50% reduction in headcount. A reduction of 18,000 was required nationally. A voluntary redundancy offer would go out to staff the following week, when indicative staffing structures would also be shared. A formal consultation on the proposed changes would be launched in mid-January, with reductions starting around the middle of March. Work was being undertaken to establish what the transitional nine months would look like, and there would be impacts around this committee. The accelerated timeline had come as a surprise to leaders across the country.

JP asked whether some money was being brought forward from future service budgets, and TR advised that it could be oversimplistic to separate out administrative costs from other NHS budgets. Over the three-year period there was an expectation to spend more money on services rather than less (although it may be less in the first year).

The Chair noted that there was a significant piece of work to be undertaken between LCH and LYPFT; Leeds was a big employer in the wider NHS space as well as the ICB itself.

The Chair thanked TR for the update.

The Leeds Committee of the WY ICB:

- **RECEIVED** and **NOTED** the content of the Place Lead Update and its implications for the committee and the Leeds Health and Care Partnership.

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

The committee received the AAA report on behalf of the Chair of the above sub-committee.

JH commented on the Care Quality Commission's (CQC) rating of Leeds City Council's (LCC) adult social care provision as 'Good', following a site visit in May 2025.

(The Chair declared a direct financial interest in the CQC's work as an employee of the organisation.)

JP noted the reference in the report to Risk 2568 – 'There is a significant risk of an inability to deliver the statutory functions of the ICB with regard to All Age Continuing Care (AACC) in Leeds due to challenging workforce pressures and being unable to source high-quality cost-effective care which could result in reputational damage, financial inefficiency, complaints, challenges and appeals, and staff burnout', while the Finance Value and Performance Sub-Committee Assurance Report stated that one risk score had been reduced: Risk 2508 – 'There is a risk of overspend against the All Age Continuing Care (AACC) budget due to increasing service demand and rising care costs which could result in Leeds place financial targets not being met.' The risk score had reduced from 20 to 12 due to AACC meeting their rates of spend and review of care packages.

TR explained that, having now got to the gaps in the service, this meant there may be a loss of some of the ground that had been gained.

The Leeds Committee of the WY ICB:

- **RECEIVED** and **NOTED** the content of the AAA report.

51 FINANCE, VALUE AND PERFORMANCE SUB-COMMITTEE ASSURANCE REPORT

The committee received the AAA report on behalf of the Chair of the above sub-committee.

EC concurred with the sub-committee's provision of PARTIAL ASSURANCE in respect of the Risk Management Report, which reflected confidence in mitigating actions, but

uncertainty regarding delivering against financial and performance plans. LTHT was fully committed to meeting its plan but it was looking increasingly unlikely that the organisation would achieve this. YK acknowledged that people were working really hard to mitigate the risk.

PG noted that the CORE20PLUS5 funding in Leeds had not been ringfenced but used “in and amongst” to help health inequalities. Leeds had done well in terms of indices of multiple deprivation, but that had the impact of reduced funding.

TR responded that Leeds had been really up-front in the way it used CORE20PLUS5 funding; there was much talk about statutory providers and their (danger of) deficit, but not as much about Primary Care and services bought from the third sector.

The Chair commented that, if all resources were pointed to areas of greatest need, the CORE20PLUS5 funding would naturally go towards meeting that need. She also asked whether the threat to voluntary sector services was being addressed through the risk register or elsewhere. PG advised that there was a Resilience Dashboard, and Third Sector Leaders (TSL) was looking at third sector finance.

YK commented that, with the pace and scale of financial constraints in the public sector, the impact on the third sector was significant. She suggested an alert be included in the committee’s AAA Report to the ICB Board in relation to the potential immediate, medium-term and long-term risk to the sector.

The Leeds Committee of the WY ICB:

- **RECEIVED** and **NOTED** the content of the AAA report.

(HL joined the meeting.)

52 FINANCIAL POSITION UPDATE

In AC’s absence, TR presented a report providing an update on the month 6 financial position of the ICB in Leeds, the wider Leeds Place, and the West Yorkshire Integrated Care System (ICS).

At month 6 the ICB in Leeds was reporting a year-to-date (YTD) £1.2m surplus financial position. However, this was showing as circa £1.4m behind plan at month 6, due to the stretch targets of providers included in the ICB. The ICB in Leeds was still forecasting a balanced full year forecast position to deliver the stretched plan of a £2.5m surplus (showing as £2.7m adverse against plan due to provider full year stretch). The main overspending areas within the ICB continued to be within Mental Health, Community and Acute Services offset by underspends in Primary Care, CHC and running costs.

Overall, the Leeds Place was reporting a £23.8m deficit at month 6, which was circa £11.1m adverse to plan. This was driven by the position in LTHT (£10.5m adverse to plan). Overall, the Leeds Place was forecasting delivery of a £4.3m surplus position which was £0.9m behind plan due to the forecast non-delivery of the stretch target at LTHT. At month 6 LCH and LYPFT had shown improved forecast positions in line with the stretch target. The LTHT position was driven by: investment in Maternity and Neonatal Services and loss

of MIS rebate; increased referral demand driving elective activity above planned value at additional cost; bed capacity required to accommodate level of NRTR patients and maintain safety; capital constraints and requirement to maintain safety and continuity of services following NHP decision; and step-up in Waste Reduction Programme.

The month 6 YTD position for the ICS was a £43.6m deficit against a planned £29.5m deficit, a shortfall/adverse variance against plan of £14.1m. The month 6 adverse variance of £14.1m had deteriorated from the adverse variance at month 5 of £9.3m, a deterioration of £4.8m. The deterioration in month was mainly due to a one-off £2.7m clawback of the Maternity Incentive Scheme (MIS) for year 5 at LTHT, plus continued efficiency slippage in providers.

The Chair asked about the methodology for meeting the cost of redundancies, and TR advised that this would need to be accounted for, but the detail was as yet unclear. YK added that, although the headcount would decrease in 2026/27, the staffing bill would not reduce straight away. TR noted that 2.7% had already taken account of the reduction in headcount.

TR advised that, where pressures were being seen (eg around neurodiversity), there was a need to get agreement around thresholds for diagnosis. He added that Leeds was delivering to plan despite being below its fair share allocation.

VE commented that Leeds was an outlier on the formula for the funding for the Public Health Grant; there was no short-term resolution for the resulting £8m gap, but national conversations were ongoing.

The Leeds Committee of the WY ICB:

- **RECEIVED** and **REVIEWED** the ICB in Leeds month 6 position including key risks and mitigations, the Leeds Place month 6 position, and the West Yorkshire ICS Financial Position.

(KT joined the meeting.)

(The meeting was adjourned for a break at 2.50 pm and reconvened at 3.00 pm.)

53 NHS PLANNING FRAMEWORK

HL presented a report, on behalf of SA, advising of the publication of the NHS Planning Framework, and subsequent publication of supporting guidance, which introduced a rolling five-year planning horizon and a continuous, integrated planning process across systems and providers. It outlined the expectations for the Leeds Committee, WY ICB and its partners.

The framework was supported by mobilisation activities and system-wide governance arrangements designed to deliver compliant and robust plans through two phases, and four component plans, as outlined within the document.

The report provided an overview of the collaborative approach to meeting the requirements of the NHS England Planning Framework and supporting guidance, details of the local approach to implementation, and assurance on governance and sign-off arrangements.

EC commented that his organisation was sighted on all of the challenges between the present time and Christmas, and HL concurred that there was sufficient partner ownership.

JP believed that this seemed to be the only pragmatic approach under the circumstances, and suggested that the main headlines could be brought back to the next meeting of the committee. HL advised that it would also be necessary to bring an updated Neighbourhood Health Plan, so they could be included with that. TR concurred that the key points and challenges could be shared, and also committed to sending the submission to members for comments. HL advised that she would send it in parallel with submitting it to the West Yorkshire team for consolidation.

SM advised that her plan would go to the wire in terms of the timing of submission, but she would send something that was meaningful.

Referring to section 3.4(c) of the report (review and assimilation of existing strategies), VE advocated knitting together the delivery plan against the Healthy Ambition in the Leeds Strategic Framework.

The Leeds Committee of the WY ICB:

- (1) **NOTED** the publication of the NHS Planning Framework and supporting guidance;
- (2) **REVIEWED** and **SUPPORTED** the proposed approach for the current year, ensuring appropriate forums would be used to enable timely delivery within current circumstances; and
- (3) **ENDORSED** the proposal to work with the Leeds Accountable Officer and Leeds Committee Chair to provide final sign-off on behalf of the Leeds Committee, including the Board Assurance Statement (subject to published national guidance).

(RH and CE joined the meeting.)

54 PROPOSAL FOR MERGER/CLOSURE OF ASHTON VIEW MEDICAL CENTRE AND CONWAY MEDICAL CENTRE

KT presented a report setting out the background to and rationale for the above proposed merger.

A robust engagement exercise had taken place over a period of six-and-a-half weeks, and the report summarised the key outcomes from the feedback gathered, the practice responses to this, and the impact the merger of the two practices would have.

JP referred again to digital access and the risk of exclusion, along with the expectation of a really clear digital inclusion strategy. KT advised that this would be built upon the service development.

YK asked what other forms of engagement had been used, and KT explained that these had included local community forums, local councillors, and posters in waiting rooms.

PG asked whether the initiative had come from the practices and KT confirmed that it had.

The Chair asked about the availability of buildings, money and plans, and KT advised that plans had been made previously but the planning permission had lapsed; the initiative was therefore about developing existing premises, for which capital was available. The Chair believed it would be helpful to map out what would be wished to be seen from the Primary Care/General Practice offer (for example, undertaking a needs assessment for Community Pharmacy).

TR advised that there was an ongoing conversation at the Leeds Directors' Meeting regarding the future of Primary Care. The direction of travel around neighbourhood care would include consideration of estates to ensure the correct model for delivering neighbourhood care. Such an assessment would link into that piece of work. HL added that "market-shaping" work was being undertaken with partners. KT commented that it was possible to plan for some things but not others.

The Leeds Committee of the WY ICB:

- (1) **NOTED** the feedback from patients and local stakeholders around the impact of the merger and subsequent closure;
- (2) **NOTED** the recommendation from the Primary Care Operational Group to approve the merger; and
- (3) **APPROVED** the application from Conway Medical Centre and Ashton View Medical Centre to merge on 1 April 2026 and the subsequent closure of the Ashton View site.

55 CHAPEL ALLERTON HOSPITAL NEW ELECTIVE CARE CENTRE

RH and CE presented a report seeking support for the submission of Leeds Teaching Hospitals Trust's Full Business Case for the above centre to NHS England, and approval of a cover letter to be sent to Leeds Teaching Hospitals.

TR explained that, in supporting the proposal, the committee would be recommending the signing-off of the support to the ICB Chief Executive, Rob Webster. The Director Team of the ICB in Leeds was supportive of the proposal and mindful of the importance of estate and the implications on the rest of the system and its performance. HL added that the proposed regional spinal service would also give Leeds patients more access locally.

PG asked about the detail of the Equality Analysis and whether it had been viewed through a health inequalities lens. RH advised that in the full case there was an analysis, including taking account of people from deprived areas and the BME community; the same level of detail had not been done for the orthopaedic service as this was a repatriation from the independent sector.

GW asked about fluidity of clinical delivery and RH confirmed that theatres and wards were being built which could do almost everything.

JP asked whether there could be potential issues arising from the extensive uncertainties in the NHS, and RH responded that there was a very high level of confidence over the capital

funding; if some of the funding mechanisms changed, some of the outputs would change. HL added that there were some very old theatres and beds on the Leeds General Infirmary site and, in the worst case scenario, some of these could be swapped out – which would still result in getting more for less.

YK asked what would be the biggest challenge in building this, and RH responded that the site was very tight and the Chapel Allerton site would be affected for two years while building the centre.

The Leeds Committee of the WY ICB:

- **SUPPORTED** the submission of the Trust's Full Business Case to NHS England and **APPROVED** the sending of a cover letter to Leeds Teaching Hospitals.

56 RISK REGISTER (CYCLE 3 2025/26)

TR presented a report providing details of all risks on the Leeds Place Risk Register at the end of the current risk review cycle (Cycle 3, 2025/26). The total number of place risks for consideration, the numbers of risks which were marked for closure, new, increasing or decreasing in score were set out in the report, along with the numbers of Critical and Serious Risks.

The report included the Cycle 3 review of the Board Assurance Framework (BAF) for all five places; the BAF provided the ICB with a method for the effective and focussed management of the principal risks and assurances to meet its objectives. By using the BAF, the ICB could be confident that the systems, policies, and people in place were operating in a way that was effective in delivering objectives and minimising risks.

TR drew the committee's attention to the three financial high level risks on the Leeds register, relating respectively to capital, revenue and local authority finance – 2530 (the risk that the needs and demands for NHS infrastructure investment in West Yorkshire is greater than the resources being made available to the ICB/ICS), 2529 (the risk that the ICB in Leeds will not deliver the 2025/26 financial requirement of break-even), and 2414 (the risk that measures being taken to control expenditure in Leeds City Council will have an impact on other place partners). He then led the committee through the other high level risks, new risks, and those in respect of which the score had changed. SB noted the detail of the closed risks.

EC was pleased to see that the emerging risk of patient harm following the Laboratory Information Management System (LIMS) transition in December 2024 and the physical relocation of the laboratory from Leeds General Infirmary to St James University Hospital in June 2025, was being developed for inclusion on the register in the subsequent cycle.

(SM left the meeting.)

GW suggested that there was a strategic risk of not thinking as a system as to how partners committed to capital growth and infrastructure. JB believed that a whole host of infrastructure fitted into that risk, and there was a consequent need to take a more holistic view of how strategic investment was managed and mitigate that risk; work was ongoing in this respect. GW concurred that this was starting to be better acknowledged, but it was still

a big challenge. TR added that the provider partnership had a role in this, and the work was already underway.

VE noted the description of risk 2414 (relating to local authority finances) and, in relation to Children's Social Care and Adult Social Care, suggested there was a need for a control measure advocating the taking of a broader view, checking out the broader impact and consequences. Councils were statutory organisations with no NHS oversight, but the Public Health function did have some. There was a need to consider how to work with that in a new or evolving system; more could be done on mitigation of the Public Health element.

JP asked whether the risk register would be the appropriate place to capture the risk around digital inclusion which had been acknowledged in minute 47 above; TR agreed in principle with the capturing of this risk, but suggested a more appropriate approach would be for this to be fed into the Digital Strategy.

The Leeds Committee of the WY ICB:

- (1) **RECEIVED** and **NOTED** the High-Scoring Risk Report as a true reflection of the risk position in the ICB in Leeds;
- (2) Was **ASSURED** in respect of the effective management of the risks and the controls and assurances in place, subject to the additional points raised above; and
- (3) **RECEIVED** and **NOTED** the Board Assurance Framework for Cycle 3 2025/26.

57 ITEMS FOR THE ATTENTION OF THE ICB BOARD

SB summarised the content to be included in the committee's report to the West Yorkshire ICB on items to which it would alert the board, those upon which it would offer assurance, and those of which it wished to advise the board. These included : the month 6 financial position; Chapel Allerton Hospital new elective care centre; the potential risk of digital exclusion; the uncertain future of Healthwatch; the agreement for closer alignment and working arrangements between Leeds and Yorkshire Partnership NHS Foundation Trust and Leeds Community Healthcare NHS Trust; the leadership changes at LTHT; and the proposed merger of Ashton View and Conway Care Centre.

58 FORWARD WORK PLAN 2025/26

TR confirmed that the planning submission and neighbourhood planning work would be brought to the next meeting, and SB added that there would be a report on the governance arrangements for the ICB's transition year and provider partnership development. YK noted that future inequalities updates would include reference to digital exclusion.

The Leeds Committee of the WY ICB:

- **REVIEWED** the work plan and **NOTED** the changes outlined above.

59 ANY OTHER BUSINESS

No items were raised.

60 DATE AND TIME OF NEXT MEETING

The next meeting of the Leeds Committee of the WY ICB would be held at 1.15 pm on Wednesday 11 February 2026 at HEART: Headingley Enterprise and Arts Centre, Bennett Road, Headingley, Leeds, LS6 3HN.

The meeting concluded at 4.20 pm.

DRAFT

Action Tracker

Leeds Committee of the WY ICB

Action No.	Meeting Date	Item Title	Actions agreed	Lead(s)	Accountable body / board / committee	Status	Update
			No current open actions.				
Completed Actions							
78/24	26 February 2025	Risk Management Report	To feedback and reflect on the Place contributions to BAF 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.’	AS	LCICB		Update provided at meeting 21/05/25.
09/24	22 May 2024	Place Lead Update	To circulate the link to the recent Joint Targeted Area Inspection (JTAI) report.	HS	LCICB		Circulated 17/06/24.
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 21/08/24. Outputs are set out in the Risk Management Report (11/09/24).

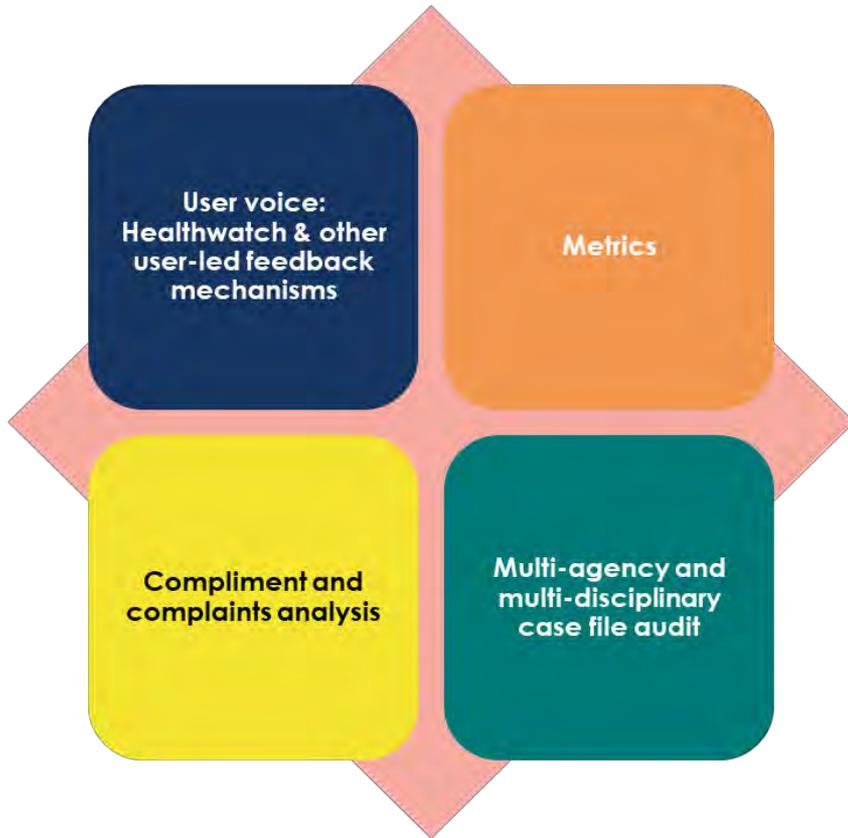
Action No.	Meeting Date	Item Title	Actions agreed	Lead(s)	Accountable body / board / committee	Status	Update
30/24	11 September 2024	Fairer Healthier Leeds – a Marmot City	To add 'Fairer Healthier Leeds – a Marmot City' update to the work programme for September 2025.	HS	LCICB		Added to the workplan.
35/24	11 September 2024	Assurance and update on our plan for financial sustainability in 24/25	To add a further efficiency scheme assessment process update to the work programme for February 2025.	HS	LCICB		Added to the workplan.
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 05/12/24.
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 (26/02/25).



Are Leeds Health and Care Services joined up?

An update from the How Does It Feel For Me working group

The balanced scorecard for joined up care



2025

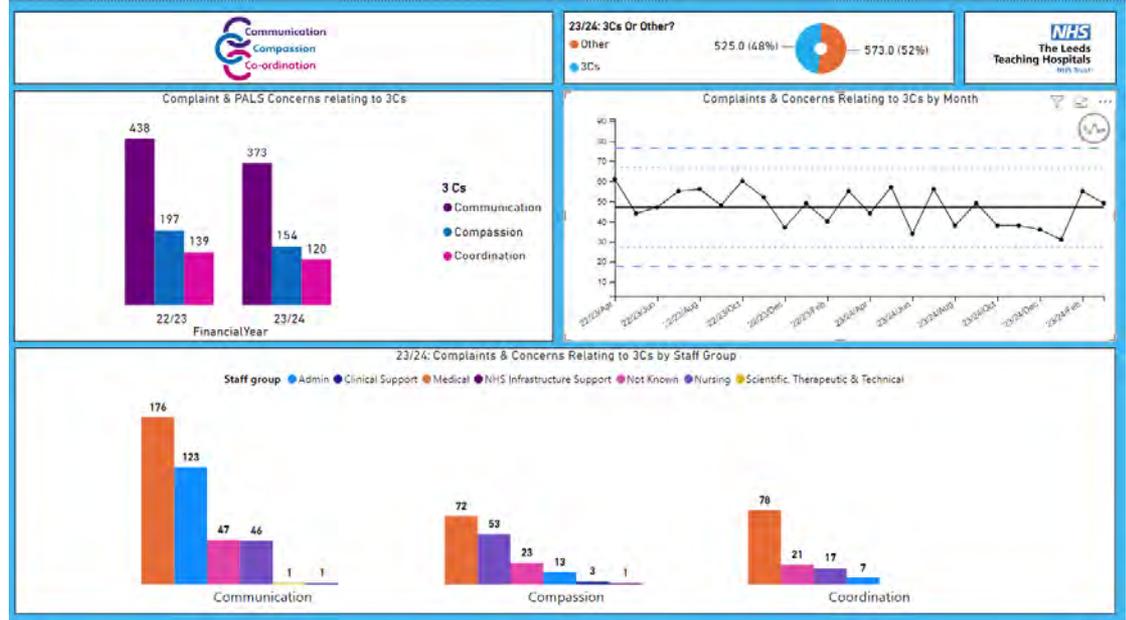


Mercy

Abdul

Diane & Gemma

Ayad



Impact

- 3Cs identify eight areas for change to improve people's experiences of care. This led to Accessible Information Standard pilot in Leeds as part of change to national standards. Eight areas reflected in the challenges for transformation identified with senior leadership group (PLT).
- Videos used in Trust Board development and population health boards to focus on people's journey of care.
- Specific pathway improvements in services adopted by providers.
- 3Cs heart of Healthy Leeds Plan and focus for transformation programmes.
- New metrics approach in e.g. HomeFirst Phase 2 based on 3Cs framework and consideration of evidence for different metric types.



2026

How can we build on accelerate



Intra-organisational quality improvement programmes



More 3Cs learning materials



Ideas from the group?

For more information

Healthwatch Leeds
Community Interest Company 09542077
Ground Floor, The Old Fire Station,
Gipton Approach,
Leeds,
LS9 6NL

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Committee Escalation and Assurance Report – Alert, Advise, Assure

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

Date of meeting: 21 January 2026

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

Date of meeting reported to: 11 February 2026

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

Key escalation and discussion points from the meeting

Alert:

WY ICB 2025 GP Patients Survey Results (Leeds Place)

The Quality and People's Experience (QPEC) Sub-Committee received the results of the 2025 GP Patients Survey and noted the survey response rate was 24%, with wide variation across the city. In Leeds, 79% of people agreed that they had had a good overall experience of their GP practice, above the national result of 75%.

The sub-committee noted challenges around the online survey including the high number of survey questions, language barriers and the need to request a paper copy if required. Members expressed concern regarding the variation in people's experiences around digital access to primary care and questioned the impact of variation on health inequalities, particularly in areas of deprivation and among specific communities. The sub-committee discussed the need for targeted engagement and alternative data collection methods to triangulate with the survey results.

Changes to NHS WY ICB Governance Arrangements for 2026/27

The sub-committee received a report detailing the changes to the WY ICB governance arrangements from 1 April 2026. The report detailed the cessation of the Leeds Place sub-committees and the role of the new provider partnerships. Members expressed concern regarding the risks to quality, safeguarding and user engagement during the transition period. The sub-committee wished to alert the Leeds Committee of the need to ensure no gaps emerged in oversight or assurance particularly with regard to support for safeguarding and quality assurance work in care homes and primary care.

Quality Highlight Report

The sub-committee discussed the impact of reduced Care Quality Commission (CQC) inspections and ICB organisational changes on care home quality assurance. Members wished to alert the Leeds Committee of the need to include quality assurance requirements into conversations around integrated neighbourhood health workstreams and provider partnerships.

Advise:

Maternity and Neonatal Services Update

The sub-committee received an update on the quality improvement work in Maternity and Neonatal maternity services at Leeds Teaching Hospitals NHS Trust (LTHT).

Following an announcement by the Secretary of State of an independent inquiry into maternity and neonatal services in Leeds, the Trust would no longer be included in the national maternity services review. The terms of reference and the inquiry lead for the Leeds independent inquiry were awaiting confirmation.

Assure:

Quality Highlight Report - Maternity and Neonatal Services Update

Quality improvement work was progressing at pace following a number of changes in the LTHT leadership team. Representatives from NHS England (NHSE), the Local Maternity System (LMS) and the ICB continued to meet monthly with maternity and neonatal services. Engagement work was ongoing with affected families and maternity staff. A Perinatal Improvement Committee chaired by a non-executive director would be established to provide assurance to the Trust Board.

Quality Highlight Report

Leeds Community Equipment Service continued to face a number of challenges, particularly regarding the provision of specialist children's equipment. Significant financial pressure and shortfall with the cost of supplying equipment had resulted in very long waits for children. A comprehensive improvement plan was in place and a WY Joint procurement framework was being developed to strengthen the commissioning frameworks for children's specialist equipment.

Enhanced monitoring had been reduced at Wheatfields Hospice from fortnightly to monthly following improved assurance. Twelve inpatient beds had been reopened by November 2025, with remaining beds planned to reopen following fire safety works from February 2026. An unannounced CQC inspection was anticipated within six months.

Safeguarding Annual Reports

The sub-committee received the 2024-25 Annual Reports of the Leeds Safeguarding Adults Board (LSAB), Leeds Safeguarding Children Board (LSCP) and WY ICB Combined Safeguarding Annual Report 2024-25 for assurance.

Key highlights in the LSAB 2024-25 Annual Report included: working with faith communities across the system to look at safeguarding support and practises within religious establishments; developing citizen-led approaches and hearing people's experiences of adult safeguarding processes to better understand their impact; and learning from Safeguarding Adults Reviews (SARs) and understanding the best methodology for learning to be disseminated and prevent recurrence

Key highlights in the LSCP 2024-25 Annual Report included: understanding how to support children as victims of domestic violence; focus on interventions for young people involved in serious youth violence and exploitation; and equality, diversity and disproportionality as cross-cutting themes.

Key highlights in the WY ICB Combined Safeguarding Annual Report 2024-25 included: delivery of an advanced Mental Capacity Act (MCA) training programme to MCA leads and supervisors in WY ICB and NHS Provider Trusts; and the dissemination of GP safeguarding self-assessment standards to all practices and returns collated at Place to allow for development of Place action plans.

Risk Management Report (Leeds Place risks 2494, 2480, 2354 and 2354)

The Sub-Committee received the Leeds Place risk report for risk cycle 4 of 2025/26. Ten risks were aligned to the QPEC and two risks were shared with the Finance, Value and Performance Sub-Committee. Three risks had reduced risk scores: 2494, 2480 and 2354.

One new risk had been added to the Leeds Place risk register: risk 2582 - 'There is a risk of patient harm to the population of Leeds due to ongoing operational challenges related to the Laboratory Information Management System (LIMS) system changeover, laboratory relocation, equipment validation, and supply chain disruptions have resulted in delayed test turnaround times, specimen rejections, and poor communication with clinical teams.' While the risk had a risk score of 9, feedback from managers in Leeds indicated that the issues were being well managed, the risk was lessening and was likely to be closed earlier than expected.

One risk had closed since the previous risk report: risk 2569 - 'There is a risk that there will be insufficient inpatient hospice capacity in Leeds for a period, due to quality improvement in Wheatfields following a CQC inspection and changes in staffing and leadership, and some planned remedial fire door work at St Gemma's.' The risk had been marked for closure due to the reinstatement of hospice capacity following the completion of building work.

Meeting name:	Leeds Committee of the West Yorkshire Integrated Care Board
Agenda item no.	11
Meeting date:	11th February 2026
Report title:	Financial Position Update 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 <input checked="" type="checkbox"/>	Decision <input type="checkbox"/> (approve/recommend/ support/ratify)	Action <input type="checkbox"/> (review/consider/comment/ discuss/escalate)	Information <input type="checkbox"/>
Previous considerations:			
Finance and Performance Sub Committee Directors Team Meeting			
Executive summary and points for discussion:			
<p>The purpose of this report is to provide an update to the Committee on the Month 9 financial position of the ICB in Leeds, the wider Leeds Place and West Yorkshire Integrated Care System (ICS) Position. The key points to note being:</p> <ul style="list-style-type: none"> The ICB in Leeds is forecasting delivery of a £5.2m surplus by year end which is in line with plan. The main overspending areas within the ICB continue to be within Mental Health, Community and Acute Services offset by underspends in primary care, CHC and running costs. Overall, the Leeds Place is reporting a £23.1m deficit at Month 9, which is c£10.5m adverse to plan. This is driven by the position in LTHT (£14.3m adverse to plan) offset by positive variances in the ICB, LCH and LYPFT. <p>Overall, the Leeds Place is forecasting delivery of a £7m surplus position which is ahead of plan by £1.8m.</p> <p>The LTHT position is driven by; investment in Maternity and Neonatal services and loss of MIS rebate, increased referral demand driving elective activity above planned value at additional cost, bed capacity required to accommodate level of NRTR patients and maintain safety, capital constraints and requirement to maintain safety and continuity of services following NHP decision, step up in Waste Reduction Programme required to achieve plan.</p> <ul style="list-style-type: none"> The month 9 YTD position for the ICS was an £69.5m deficit against a planned £25.8m deficit; a shortfall/adverse variance against plan of £43.7.1m. The key drivers of the YTD adverse variance continue to be industrial action, pay overspends and slippage on delivery of waste reduction/efficiencies, part offset by underspends in other areas. Above position includes recognition of Deficit Support funding (DSF) of £36.9m (9/12ths of total 			

annual value of £49.2m). NHSE have confirmed the ICS won't receive DSF funding for Qtr.4.

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:

- Review and comment on the ICB in Leeds month 9 position including key risks and mitigations
- Review and comment on the Leeds Place month 9 position
- Review and comment on the West Yorkshire ICS Financial Position
- Consider any specific areas that they wish to escalate to other Committees or forums for follow up

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

The report provides an update in terms of financial sustainability and deliver of in year financial plans.

Appendices

N/A

Acronyms and Abbreviations explained

N/A

What are the implications for?

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

Future Decisions and Policy Making	
Citizen and Stakeholder Engagement	

NHS West Yorkshire ICB

Leeds Place Financial Position

Month 9 2025/26

Contents

1. ICB in Leeds Integrated Care Board (ICB) Month 9 Financial Position
2. Leeds Place Month 9 Financial Position
3. West Yorkshire Integrated Care System (WYICS) Month 9 Financial Position

ICB in Leeds Integrated Care Board (ICB) Month 9 Financial Position



ICB in Leeds Month 9

	YTD Plan	YTD Spend	YTD variance	Annual Plan	Forecast Spend	Annual Variance
	£000	£000	£000	£000	£000	£000
RESOURCE						
Allocation - Programme	1,338,494	1,338,494	0	1,786,475	1,786,475	0
Allocation - Primary Care Co-Commissioning	142,794	142,794	0	190,356	190,356	0
Allocation - Running Costs	4,606	4,606	0	6,141	6,141	0
Allocation - Specialist Commissioning	0	0	0	0	0	0
TOTAL RESOURCE	1,485,893	1,485,893	0	1,982,972	1,982,972	0
SPEND						
Acute	725,986	726,865	(880)	968,342	970,442	(2,100)
Mental Health	234,990	238,616	(3,627)	313,324	318,273	(4,949)
Community	157,691	158,156	(465)	212,473	213,098	(625)
Continuing Care Services	69,031	67,773	1,257	92,041	90,385	1,656
Prescribing and Primary Care	140,705	136,456	4,249	187,605	181,984	5,621
Primary Care Co-Commissioning	146,498	143,513	2,985	195,295	191,314	3,981
Other	5,090	4,695	395	6,786	5,699	1,087
Specialised Commissioning	0	0	0	0	0	0
Programme Reserves	(2,602)	30	(2,632)	(4,234)	1,813	(6,047)
Subtotal Programme spend	1,477,387	1,476,105	1,283	1,971,632	1,973,008	(1,376)
Running Costs	4,606	3,448	1,158	6,141	4,765	1,376
TOTAL SPEND	1,481,993	1,479,553	2,441	1,977,772	1,977,772	0
Surplus / (Deficit)	3,900	6,341	2,441	5,200	5,200	0

ICB in Leeds Month 9 – Key headlines

At month 9 the ICB in Leeds is forecasting delivery of a £5.2m surplus by year end which is in line with plan.

The main overspending areas are within the ICB continue to be within **Mental Health, Community and Acute Services** offset by underspends in **prescribing/primary care, CHC and running costs**.

- Mental Health has a forecast overspend of £4.9m (£3.7m YTD), driven by demand pressures on ND (£6.4m) increasing LD pool package costs (mainly CHC), increasing s117 pressures and a high-cost package at Mitford of c£1m, which are partly offset by non-recurrent benefits/uncommitted budgets.
- Acute Services are showing a forecast overspend of £2.1m (c£1m YTD), due to increased independent sector spend on elective services above activity plans (£4.5m) offset by non-recurrent prior year and other benefits. This position is potentially at further risk (c£3m) if indicative activity plans for IS Providers is not adhered to.
- Community Services are forecasting an overspend of £0.6m, driven by spend on Neuro-rehab packages and TOPs.

These are being offset by underspends within:

- Primary Care/Prescribing is showing a forecast underspend of c.£9m. This includes an underspend on prescribing, identification of further efficiency savings within GPIT and several prior year non-recurrent benefits (prior year and in year such as AARS).
- CHC is currently showing a forecast underspend of £1.7m driven by lower than planned activity growth and on track delivery of the efficiency programme
- Running costs are showing a forecast underspend of £1.9m against budget with a share of WY underspends of £1.2m

ICB in Leeds Month 9 – Risks and mitigations/actions

Key risks

- IS Elective
- ND
- CHC, LD pool and other new high-cost packages in H2
- Prescribing volatility
- Children Services - Council
- Winter Pressures

Key actions

- Focus on delivery of overall efficiency plan. Key areas of focus include:
 - Delivery of IS Acute Indicative Activity Plans (IAPs)
 - Delivery of ND IAPs including front door hub, commissioning policy, accreditation
 - Prescribing and CHC efficiencies (need to review impact of Liaison)
 - Review all technical opportunities
 - Focus on supporting system transformation priorities to create long term financial sustainability

Leeds Place Month 9 Financial Position



Leeds Place - Month 9 Financial Position



Organisation	YEAR TO DATE - M9			FORECAST - M01 to M12		
	I&E reported Month 9 25/26			I&E forecast		
	Plan £m	Actual Surplus / (Deficit) £m	Reported Variance £m	FOT Plan £m	FOT Surplus / (Deficit) £m	FOT Variance £m
Leeds ICB	3.9	6.3	2.4	5.2	5.2	0.0
Leeds and York Partnership NHS Foundation Trust	0.0	0.5	0.5	0.0	0.9	0.9
Leeds Community Healthcare NHS Trust	0.0	0.8	0.8	0.0	0.9	0.9
Leeds Teaching Hospitals NHS Trust	(16.5)	(30.9)	(14.3)	0.0	0.0	0.0
Leeds Place Total	(12.6)	(23.1)	(10.5)	5.2	7.0	1.8

Overall, the Leeds Place is reporting a £23.1m deficit at Month 9, which is c£10.5m adverse to plan. This is driven by the position in LTHT (£14.3m adverse to plan) offset by positive variances in the ICB, LCH and LYPFT.

Overall, the Leeds Place is forecasting delivery of a £7m surplus position which is ahead of plan by £1.8m.

The LTHT position is driven by; investment in Maternity and Neonatal services and loss of MIS rebate, increased referral demand driving elective activity above planned value at additional cost, bed capacity required to accommodate level of NRTR patients and maintain safety, capital constraints and requirement to maintain safety and continuity of services following NHP decision, step up in WRP required to achieve best case.

Leeds Place Month 9 – Efficiencies



Organisation	YTD Plan	YTD Saving	YTD Variance	Annual Plan	Forecast Saving	FOT Variance
	£000's	£000's	£000's	£000's	£000's	£000's
Leeds ICB	26,842	26,433	(409)	35,872	35,872	0
Leeds and York Partnership NHS Foundation Trust	13,511	13,513	2	18,500	18,500	0
Leeds Community Healthcare NHS Trust	10,501	10,501	0	14,000	14,000	0
Leeds Teaching Hospitals NHS Trust	56,781	52,864	(3,917)	89,000	89,000	0
Total	107,635	103,311	(4,324)	157,372	157,372	0

Overall, the Leeds Place has delivered 103m savings at Month 9, which is £4.3m adverse to plan. The main adverse variances are in the ICB in Leeds and LTHT.

Overall, the Leeds Place is forecasting to deliver its planned savings of c.£157.4m, however delivery of this is still at risk.

West Yorkshire ICS Month 9 Financial Position



West Yorkshire ICS Financial position - Month 09

Organisation	YEAR TO DATE - M9			FORECAST - M01 to M12			Scenarios - Organisation assessment			
	I&E reported Month 8 25/26			I&E forecast			Best Case Variance £m	Likely Case Variance £m	Likely Case (Mitigated) £m	Worse Case Variance £m
	Plan £m	Actual Surplus / (Deficit) £m	Reported Variance £m	FOT Plan £m	FOT Surplus / (Deficit) £m	FOT Variance £m				
Bradford ICB	3.5	(2.2)	(5.7)	4.7	(1.6)	(6.3)	(3.0)	(6.3)	(6.3)	(16.9)
Calderdale ICB	3.3	4.9	1.6	4.4	5.9	1.5	2.7	1.5	1.5	(2.6)
Kirklees ICB	6.5	6.5	(0.0)	8.7	8.7	0.0	1.0	0.0	0.0	(4.3)
Leeds ICB	3.9	6.3	2.4	5.2	5.2	0.0	4.0	0.0	0.0	(7.5)
Wakefield ICB	2.0	2.3	0.3	2.6	4.6	2.0	5.3	2.0	2.0	(5.0)
WY ICB	(7.6)	4.7	12.3	(10.1)	(1.3)	8.8	6.1	8.8	8.8	5.1
West Yorkshire ICB Total	11.6	22.6	11.0	15.4	21.4	6.0	16.1	6.0	6.0	(31.2)
Airedale NHS Foundation Trust	(5.5)	(13.3)	(7.8)	(3.6)	(16.5)	(12.8)	0.0	(12.8)	(12.8)	(18.1)
Bradford District Care NHS Foundation Trust	0.5	0.6	0.1	2.0	2.0	0.0	0.0	0.0	(0.3)	(1.1)
Bradford Teaching Hospitals NHS Foundation Trust	(6.2)	(22.3)	(16.1)	(2.7)	(17.8)	(15.1)	(15.1)	(15.1)	(15.1)	(28.9)
Calderdale And Huddersfield NHS Foundation Trust	(3.2)	(2.8)	0.4	(3.0)	(10.2)	(7.2)	(7.2)	(7.2)	(7.2)	(9.1)
Leeds and York Partnership NHS Foundation Trust	0.0	0.5	0.5	0.0	0.9	0.9	0.9	0.9	0.9	0.0
Leeds Community Healthcare NHS Trust	0.0	0.8	0.8	0.0	0.9	0.9	1.1	0.9	0.9	0.0
Leeds Teaching Hospitals NHS Trust	(16.5)	(30.9)	(14.3)	0.0	0.0	0.0	0.0	0.0	(36.2)	(60.9)
Mid Yorkshire Teaching NHS Trust	(4.5)	(27.2)	(22.7)	(8.1)	(21.1)	(13.0)	(13.0)	(13.0)	(13.0)	(21.5)
South West Yorkshire Partnership NHS Foundation Trust	(1.6)	0.4	2.0	0.0	0.0	0.0	0.0	0.0	0.0	(2.5)
Yorkshire Ambulance Service NHS Trust	(0.3)	2.0	2.3	0.0	2.5	2.5	2.5	2.5	2.5	0.0
West Yorkshire Provider Total	(37.4)	(92.1)	(54.7)	(15.4)	(59.2)	(43.8)	(30.8)	(43.8)	(80.3)	(142.2)
West Yorkshire ICS Total	(25.8)	(69.5)	(43.7)	(0.0)	(37.8)	(37.8)	(14.7)	(37.8)	(74.3)	(173.4)

West Yorkshire ICS Month 09 – Key Headlines

West Yorkshire Integrated Care System (ICS)

- The month 9 **year-to-date** position for the ICS was an **actual £69.5m deficit** against a **planned £25.8m deficit**; a shortfall/adverse variance against plan of **£43.7m**.
- The month 9 **adverse variance of £43.7m** has deteriorated from the adverse variance at month 8 of **£32.2m**, a **deterioration of £11.6m**.
- The deterioration in month is mainly due to **industrial action costs** and **continued efficiency slippage** in providers and **non-pay overspends**.
- The key drivers of the YTD adverse variance continue to be **industrial action**, **pay overspends** and **slippage on delivery of waste reduction/efficiencies**, part offset by underspends in other areas.
- Above position includes **recognition of Deficit Support funding (DSF) of £36.9m** (9/12ths of total annual value of £49.2m). NHSE have confirmed the **ICS won't receive DSF funding for Qtr.4**.
- The ICS forecast is a **£37.8m deficit** based on receipt of £36.9m deficit support funding; **a change from a balanced forecast at Month 8**. This includes the loss of Q4 DSF.

Recommendations

The Committee is asked to:

- Review and comment on the ICB in Leeds month 9 position including key risks and mitigations
- Review and comment on the Leeds Place month 9 position
- Review and comment on the West Yorkshire ICS Financial Position
- Consider any specific areas that they wish to escalate to other Committees or forums for follow up

Meeting name:	Leeds Committee of the West Yorkshire Integrated Care Board
Agenda item no.	13
Meeting date:	Wednesday 11 th February 2026
Report title:	Neighbourhood Health in Leeds
Report presented by:	Nicola Nicholson
Report approved by:	Nicola Nicholson
Report prepared by:	Jo Howard

Purpose and Action			
Assurance <input type="checkbox"/>	Decision <input type="checkbox"/> (approve/recommend/ support/ratify)	Action <input type="checkbox"/> (review/consider/comment/ discuss/escalate)	Information <input checked="" type="checkbox"/>
Previous considerations:			
<p>The Board previously received an update on the Leeds Health and Care Partnership’s five transformation programmes, which collectively support delivery of the Leeds Ambitions and the Healthy Leeds Plan:</p> <ol style="list-style-type: none"> 1. Neighbourhood Health 2. HomeFirst Phase 2 3. Community Mental Health Transformation 4. Children and Young People with complex needs 5. Earlier identification of cardiovascular risk, with a focus on hypertension <p>This report provides a detailed update on Neighbourhood health, as work continues at pace to test, scale and embed new models across Leeds.</p>			
Executive summary and points for discussion:			
<p>This paper provides an update on the continued development of Neighbourhood Health in Leeds, reflecting national policy direction, local strategic priorities, progress through the National Neighbourhood Health Implementation Programme (NNHIP), and the next steps required to move from early testing to whole-system implementation.</p> <p>Neighbourhood health is a core pillar of national policy and a central mechanism for delivering the Leeds Ambitions. It shifts care from reactive and hospital-centric to integrated, preventative and neighbourhood-based, joining up health, care, VCSE and wider public services around people and communities.</p> <p>As a wave one site for the National Neighbourhood Health Implementation Programme (NNHIP), Leeds is benefitting from national coaching, peer learning and structured “test-learn-grow” methodologies. Early progress has been made in neighbourhood level multidisciplinary working, hub design, workforce development, population health management and reviewing financial and contracting mechanisms.</p>			

The Committee is asked to note progress, support continued system-wide development, and endorse the proposed next steps, including development of the first Leeds Neighbourhood Health Plan by April 2026 (subject to final national guidance).

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 progress on further developing and embedding neighbourhood health approach in Leeds
2. Continue to support system-wide development of Neighbourhood Health
3. Endorse the proposed next steps including the development of the Leeds Neighbourhood Health Plan by April 2026

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:

Implementing Neighbourhood Health model in Leeds aims to support:

- a **reduction in health inequalities** through targeted neighbourhood models focussed on prevention and community power
- a **reduction in urgent and emergency care** pressures via proactive care and reducing avoidable admission
- **workforce sustainability** by building multi-disciplinary, place based teams and redesigning roles across health, social care and the VCSE sectors.
- **Financial sustainability** through preventative approaches and potential pooled funding models

Appendices

- 1) Leeds Ambitions
- 2) Neighbourhood Health Highlight Report and illustrative road map
- 3) National Neighbourhood Health Implementation Programme Plan Leeds

Acronyms and Abbreviations explained

LCC: Leeds City Council

LCP: Local Care Partnership

NHS: National Health Service

NNHIP: Neighbourhood Health Implementation Programme

PCN: Primary Care Network

WY ICB: West Yorkshire Integrated Care Board

What are the implications for?

Residents and Communities	<p>Neighbourhood Health is designed to improve outcomes for residents by delivering accessible, preventative and person-centred care closer to home. It will strengthen community resilience by connecting people to local assets, increasing agency and supporting earlier intervention. The programme prioritises neighbourhoods with the greatest need, helping to reduce inequalities, improve quality of life and ensure that services better reflect the experiences, strengths and priorities of communities. Co-designing models and approach with residents, communities and community organisations will be a core part of development throughout 2026.</p>
Quality and Safety	<p>Neighbourhood Health is expected to enhance quality and safety through proactive care, improved continuity, earlier identification of risk and stronger integration between services.</p>
Equality, Diversity and Inclusion	<p>The programme directly targets inequalities through neighbourhood-based prevention, strengthened community partnership, and work in areas with the highest deprivation. An Equality Impact Assessment will be developed alongside the Leeds Neighbourhood Health Plan.</p>
Finances and Use of Resources	<p>No immediate financial or resource implications. Redesign within existing resources and any investment will be agreed by the partnership, targeted to pump prime benefits. In the future there is potential for pooled budgets, workforce development and estates optimisation.</p>
Regulation and Legal Requirements	<p>No immediate implications but future legislation is anticipated to formalise Neighbourhood Health plans. These plans will align with existing Leeds Health and Wellbeing Strategy.</p>
Conflicts of Interest	<p>None identified at this stage</p>
Data Protection	<p>Any development of digital tools, shared care records or data flows will comply with UK GDPR and information governance requirements. DPIAs will be completed as required.</p>
Transformation and Innovation	<p>Neighbourhood Health is a major transformation programme, supporting innovation in workforce, funding, digital and community led models</p>
Environmental and Climate Change	<p>Supporting care closer to home may reduce travel and carbon emissions. Opportunities exist to embed climate considerations in neighbourhood planning.</p>

Future Decisions and Policy Making	Neighbourhood Health Plans will inform future commissioning, resource allocation, and partnership development across the Leeds system.
Citizen and Stakeholder Engagement	Co-design with communities, elected members and staff is central to the approach. Engagement activity will continue throughout 2026

1. Purpose

1.1 The purpose of this paper is to provide the Leeds Committee of the West Yorkshire Integrated Care Board with an update on the continued development of Neighbourhood Health in Leeds. It summarises recent national policy developments, outlines local progress including early achievements through the National Neighbourhood Health Implementation Programme (NNHIP), and sets out the key next steps required to move from testing to wider system implementation. The paper also seeks to ensure Committee members are sighted on upcoming requirements, most notably the development of the Leeds Neighbourhood Health Plan, and to support collective understanding of how Neighbourhood Health will contribute to delivering the Leeds Ambitions, reducing inequalities and strengthening integrated, community-based care across the city.

2. National Context

2.1 The [Fit for the Future: The 10 Year Health Plan](#) for England, published July 2025, forms a key part of the government's health mission to build a system fit for the future. The plan sets out how the government intends to reinvent the NHS through three major shifts:

- Analogue to Digital
- Sickness to Prevention
- Hospital to Community

2.2 Deep-rooted economic and health inequalities are driving rising ill-health and placing unsustainable pressure on the NHS, Local Authorities and partners, particularly in our most disadvantaged communities. GP, community and acute services are stretched, and without significant shift toward proactive, preventative, community-based care, additional investment alone will not meet future need. Current planning, financial and delivery structures cannot respond effectively without a shared system vision and coordinated mechanisms for change, there is no viable “do nothing” option. Transforming how resources, workforce and infrastructure are used is complex but essential and past experience shows progress requires deliberate leadership, strengthened relationships, new commissioning approaches and ongoing organisational development.

2.3 Neighbourhood Health is a central pillar of this vision for a modern NHS. Both the 10 Year Health Plan and the NHS England Medium Term Planning Framework highlight Neighbourhood Health as a fundamental shift away from hospital-centric care towards local, integrated and proactive services (figure 1).

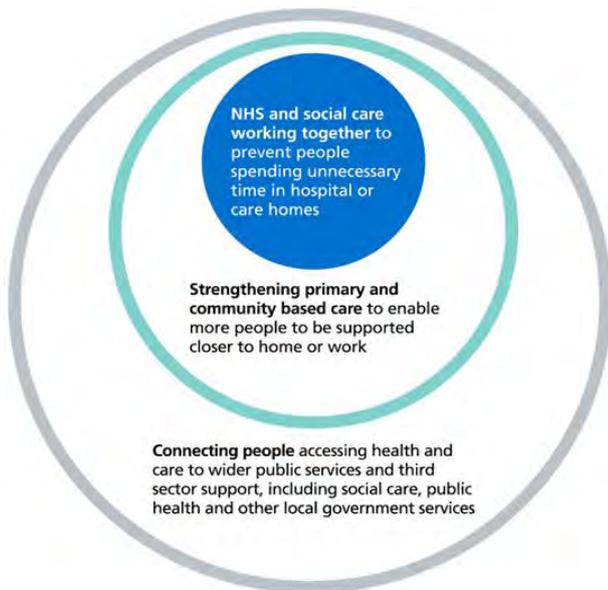


Figure 1: National Neighbourhood Health Model

2.4 The government’s ambition for Neighbourhood Health is significant; to reimagine the NHS as a neighbourhood health service that fits around people’s lives, reduces avoidable hospital admissions, prevents complications and addresses the fragmentation that frustrates both patients and professionals.

2.5 Integration is at the heart of this approach. Neighbourhood teams will bring together NHS services, social care, local authorities, voluntary and community organisations and wider community assets. These teams will typically include GPs, community nurses, social prescribers,

pharmacists and other professional working collaboratively to deliver joined up, person centred care. Crucially, Neighbourhood Health also recognises and tackles the wider determinants of health, including housing, education, employment and social support, given their profound impact on wellbeing and health inequalities.

3. Local Context

3.1 The [Leeds Ambitions](#) provide a shared goal for Leeds to reach its full potential for everyone who lives, works, studies or visits our city. Our four ambitions set out the priorities that will help us achieve our mission of reducing poverty and inequality. They sharpen our collective focus on the areas that will make the biggest difference to improving people’s lives (see appendix 1 for more detail on the four ambitions).

3.2 To deliver these ambitions, neighbourhoods will work together to tackle poverty and inequality and to improve the quality of life for all. Through *Team Leeds*, partners are creating the conditions for integrated working, championing community power and delivering proactive, person centred care close to home.



3.3 Neighbourhood Health aims to create healthier, more resilient communities, helping people of all ages to live active, independent and healthy lives for as long as possible. It aims to improve people’s experience of health and social

care while increasing their agency in managing their own wellbeing. This will be achieved by continuing to build on the strong foundations already in place across Leeds to better connect and optimise health and care resources.

3.4 Leeds is drawing on the success of its longstanding multi-disciplinary working, including the 15 Local Care Partnerships (LCPs) to integrate health and care at a neighbourhood level. This involves expanding approaches that link health with housing, debt advice, physical activity initiatives, and other community-based support, while promoting proactive, patient centred care. Together these efforts will enable us to deliver a more connected, responsive and preventative neighbourhood model.

3.5 Leeds has strong foundations on which to continue to build. A decade of locality working has shaped how the city addresses inequality, strengthens communities and brings services closer to people and place. Rooted in the Leeds Ambitions, this approach reflects a commitment to partnership, prevention and empowerment. Progress is evidenced in the [2025 Indices of Deprivation](#) which show an improvement in Leeds' relative deprivation since 2019, with seven areas now in the most deprived 1% (down from 12 in 2019 and 16 in 2015).

3.6 Aligned with national and local ambitions, Neighbourhood Health will become the standard approach across every part of Leeds within the next two years. Integrated, multi-disciplinary teams will deliver end-to-end care, connecting people to public services and community resources. The opportunity ahead is to improve local coordination and deliver fully integrated, person-centred models, improving outcomes, reducing avoidable hospital admissions and helping people live healthier lives in thriving communities.

4. Developing Neighbourhood Health Plans in Leeds

4.1 National policy, the NHS Planning Framework and the 10 Year Health Plan set clear expectations for the development of Neighbourhood Health Plans across systems. These plans will form a core part of integrated planning and are being taken forward in advance of anticipated future statutory requirements. As part of this approach, the Better Care Fund (BCF) will be fully integrated into the Neighbourhood Health Plan to strengthen alignment across local services and support more coordinated delivery. Although not yet mandated in legislation, NHS England has confirmed that each area is expected to incorporate its neighbourhood health planning into existing local health and wellbeing strategies.

4.2 Neighbourhood Health plans must be developed collaboratively by local government, the NHS and system partners under the leadership of the Leeds Health and wellbeing Board. Plans must set out how partners will work together to design and deliver neighbourhood health services. These plans must:

- Define neighbourhood footprints and governance arrangements
- Articulate population needs, priority cohorts and intended outcomes
- Specify the scope of services within integrated neighbourhood delivery
- Align to the six core components of the 2025/26 Neighbourhood Health Guidance
- Demonstrate use of evidence, baselining and measurable outcomes
- Show alignment to wider system and strategic plans

4.3 Whilst we await final guidance from the Department of Health and Social Care on the national requirements and timelines for developing plans, work has started in developing our plans and will be shared with Leeds Health and Wellbeing Board.

4.4 A significant programme of work is already taking place across Leeds to build on the foundations already in place for Neighbourhood Health. Partners are strengthening multi-disciplinary working at neighbourhood level through the 15 Local Care Partnerships (LCPs), expanding links between health, social care, public health, housing, welfare advice, community networks and VCSE organisations to deliver proactive, person-centred support close to home. Through the Neighbourhood Proactive Care programme (part of HomeFirst Phase 2), all PCNs are improving early identification and proactive care for high-need cohorts, supported by care coordinators, personalised care planning and integrated MDT approaches. Leeds has also started work to understand the needs of Neighbourhood Health Hubs, testing co-located and hub-and-spoke models, including design work for the Reginald Centre and emerging multi-neighbourhood hub requirements.

4.5 In addition, the Locality Working Best Council Team is driving alignment across the council, partners and communities, alongside key reforms: democratic renewal through the [Community Committee Review](#); better service integration via the [Locality Building Review](#); neighbourhood regeneration via [Pride in Place](#); and a renewed focus on tackling poverty and inequality through [Priority Ward](#) expansion.

4.6 Appendix 2 includes the Leeds Neighbourhood Health Highlight Report which provides a snapshot of progress across areas, including illustrative road map of progress to date.

5. National Neighbourhood Health Implementation Programme (NNHIP)

5.1 Leeds, alongside Wakefield and Bradford, was successful in its bid to become one of 40 areas nationally selected for the first wave of the NNHIP. This programme forms a key component of our approach to developing neighbourhood health in Leeds and is designed to test, refine and scale innovative models across Leeds.

5.2 Leadership for neighbourhood health development in Leeds is jointly provided by Mariana Pexton (Deputy Chief Executive, LCC) and Tim Ryley (Place Lead, West Yorkshire ICB (WYICB)) acting as joint Senior Responsible Officers. Nicola Nicholson (Associate Director for Strategy & Programmes, Leeds ICB) has been appointed as Place Coach for the Neighbourhood Health Implementation Programme, supported by a wider cross-partnership team.

5.3 The programme adopts a ‘test, learn, grown’ approach, with an initial focus on:

- **Neighbourhood Health Hub models** – exploring options including single co-located hubs, hub-and-spoke models, and dispersed community-led asset networks, all codesigned with local communities and staff.
- **Neighbourhood Proactive Care Multi-disciplinary teams**
- **Workforce development**
- **Innovative funding and contracting models** – such as devolved or pooled budgets, risk/gain share approaches and new incentive-based contracting methods.

An overview of the NNHIP workplan can be found in Appendix 3.

5.4 The National Neighbourhood Health Implementation Programme (NNHIP) will accelerate the development of the neighbourhood health model in Leeds by providing national coaching, peer support and structured “test-learn-grow” methodologies that enable rapid evaluation and scaling of effective approaches. As a wave-one site, Leeds will use the programme to test key components of neighbourhood health, including Neighbourhood Health Hubs, proactive care MDT models, integrated working practices, and new financial and contracting mechanisms, while strengthening workforce development, data and population health management capabilities. This support will help Leeds build the infrastructure, partnerships and delivery models required for sustainable neighbourhood-level integrated care, aligned with local transformation programmes and the city’s wider ambitions.

5.5 Participating Primary Care Networks working with the programme in wave 1 include:

- **Chapelton PCN** – Chapel Allerton, Little London and Woodhouse
- **Beeston PCN** – Beeston and Holbeck, Hunslet and Riverside, Middleton Park
- **Middleton and Hunslet PCN** - Middleton Park and Hunslet and Riverside
- **East Leeds Collaborative (Cross Gates, Seacroft, York Road PCNs)** – Seacroft and Killingbeck, Gipton and Harehills, Cross Gates and Whinmoor, Temple Newsam, Burmantofts and Richmond Hill

5.6 To date, the NNHIP has delivered significant early progress in Leeds.

Wave-one neighbourhoods have established and strengthened proactive care MDT working, with partner teams linking across all PCNs and targeted OD support underway through SDF funding. The programme has also advanced the development of Neighbourhood Health Hubs, including design work on the Reginald Centre and emerging multi-neighbourhood hub requirements. Leeds is reviewing new financial flows and contracting models, with work progressing through the HomeFirst 2 benefits group and national workshops on incentives for neighbourhood-level care. Utilising our enhanced population health management capability, we have deployed new tools such as the Curiosity Tool and establishing measurement systems aligned with the national NNHIP framework. Collectively, these achievements demonstrate meaningful early progress in building the infrastructure, partnerships and operating models to underpin a sustainable neighbourhood health system.

6. Next Steps

6.1 The next phase of developing neighbourhood health in Leeds will focus on progressing the citywide Neighbourhood Health Plan, with an initial version expected by April 2026, subject to the publication of final national guidance. Building on work undertaken through the NNHIP, the programme will continue to co-design the model with communities, elected members and staff, ensuring lived experience and local insight shape priorities and delivery. Ongoing and regular engagement with system partners will continue as national guidance is released, enabling Leeds to refine local plans, align transformation programmes, and ensure collective ownership across health, care, local authority and VCSE partners.

7. Recommendations

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

- a) Note progress on further developing and embedding neighbourhood health approach in Leeds
- b) Continue to support system-wide development of Neighbourhood Health in Leeds
- c) Endorse the proposed next steps including the development of the Leeds Neighbourhood Health Plan by April 2026

8. Appendices

- 1) Leeds Ambitions
- 2) Neighbourhood Health Highlight Report and illustrative road map
- 3) National Neighbourhood Health Implementation Programme Plan Leeds

Appendix 1: Leeds Ambitions



Health and Wellbeing

HEALTHY

Leeds will be a healthy and caring city for everyone: where together we create the conditions for healthier lives so people who are the poorest improve their health the fastest, and everyone is supported to thrive from early years to later life.



Sustainable City

RESILIENT

Leeds will be the UK's first next zero and nature positive city, rapidly reducing carbon emissions and restoring nature, supporting people and businesses to make increasingly sustainable choices that improve their standard of living and create a regenerative thriving city.



Inclusive Growth

GROWING

Leeds will be a place where we reduce poverty and inequality by creating growth in our economy that works for all, where everyone gets a great education, businesses find the talent they need to start, innovate and grow, investment increases and together we deliver an inclusive, healthier and more sustainable future.



Strong Communities

THRIVING

Leeds will be a welcoming, safe and clean city where people have the power to make the changes that are important to them, with cohesive and united neighbourhoods where people are living healthier lives and enjoying the city's vibrant social, cultural and sporting offer

Appendix 2: Leeds Neighbourhood Health Highlight Report



Progress Summary <i>To include a brief (one short paragraph max.) overall statement of where your place is on the journey of delivering INH, on the six core components, highlighting any milestones, areas to share, etc.</i>		
		Neighbourhood Health will contribute to the delivery of the Leeds Ambitions by creating a healthy city, where more people are able to be in work and maximise their independence to create thriving, growing and resilient communities. To deliver this all staff, organisations and sectors in the LHCP have a role to play. Our approach is to build on the assets we already have in the system such as the local care partnerships, neighbourhood networks and proactive care services creating greater value by working together, coordinating and focusing around our priorities. Alongside this movement there are 2 LHCP programmes of work specifically focused on developing & delivering elements of neighbourhood health approach: Neighbourhood Proactive Care (within HomeFirst phase 2) – Through the DES all PCNs in Leeds have been asked to focus and improve proactive neighbourhood working for a cohort of their population. We are focusing in detail on the highest users of health & care to develop integrated care models for specific populations of focus– End of Life, 3+ mLTC & MH, Frailty & Falls. Work is ongoing to develop a Shared Care Record starting with the RESPECT form, which will support true integrated working for people at end of life. NNHIP - 6 PCNs in Leeds are working with the NNHIP to progress the proactive care work more quickly to inform the development of system infrastructure for neighbourhood health and build out from proactive care to prevention working with council, public health and VCSE services. Project plans developed to design, test INT approaches with all 6 PCNs. 5 strategic questions to support scale & spread of NH being worked through by with the partnership leadership team.
● Population health management	Green	Curiosity tool developed to support PCN to understand service use for their population with LTC. Reidentification process has been streamlined and PCNs are proactively managing 2-3% of their moderate-severe frail population
● Modern general practice	Yellow	68/87 received MGP funding, 49 practices undertaking PLS.
● Standardising community health services	Yellow	WYCC have commissioned a review of community services and productivity – initial focus Speech & Language, MSK, Podiatry.
● Neighbourhood MDTs	Yellow	Neighbourhood Proactive Care overarching model agreed for the city.
● Integrated intermediate care	Green	City wide rollout for Active Recovery complete. Refine Pathway 3b to support people needing 24-hour nursing care post discharge
● Urgent neighbourhood services	Yellow	2h response standard achieved. LCH developing responsive portfolio & working with YAS to navigate patients to the best care for them.

Progress against INT Blueprint Plans <i>You can find each of the place plans that were set out in the INT Blueprint from 49 to 66 using this link.</i>	
Priority Action	Progress
#1 Engagement	Engagement continues across the city as well as with peers across West Yorkshire and the wider national community of practice. Workshops have been held in November to engage on multi-neighbourhood specialist services model, estates and NH. Work continues to prepare for a city-wide launch event 5 th Feb 26. We are waiting for the delayed national guidance on four areas: Model Neighbourhood and Health and Wellbeing Board responsibilities, Contract forms (SNP/MNP and IHO) and the Neighbourhood Health Centre framework. A series of 6 steps are described in the draft guidance and baselining documents, and we are working on each of these.
#2 Agreeing the Scope & Baselines	All PCNs have identified initial focus areas through the proactive care work and have baseline information of health & care use. Re-identification of cohorts underway for remaining PCNs. Proactive Care & NNHIP evaluation framework agreed and baseline assessment of key metrics underway. Next steps: It has been noted that in comparison to other NNHIP areas the cohort of focus within Leeds looks small, however we have discovered many other areas are also looking at small cohorts to test models of care effectively before wider spread. A NNHIP Measurement Guide was published in late December, and we are working with WY ICB Data Analysts to ensure we have the mechanisms to collect data and evaluate effectively.
#3 Developing Teams & Relationships	Work underway in all PCNs to link partner teams and continue to build relationships as part of Neighbourhood Proactive Care. Work underway to consider neighbourhood footprints for service delivery. Focused OD work scheduled with NNHIP neighbourhoods funded through the SDF allocation to Health & Care Academy.
#4 Developing workforce ecosystems	Joint steering group for Workforce Ecosystems and Partnerships Leading Care programme has been established. Phase one literature review by academic partner has been completed and workshop held with East Leeds.
#5 Developing Neighbourhood Hubs	Requirements for Neighbourhood & Multi-neighbourhood hubs are emerging through working groups. Local ambitions being developed. Design workshop planned to optimise the floorplan of the Reginald Centre based on the integrated care models
#6 Developing Financial Flows & Contracting models	HomeFirst 2 Benefits group agreed benefits of proactive neighbourhood care and will track delivery. Work ongoing with NHS DoF discuss incentives for Neighbourhood Health and delegates from Leeds attended national workshop on financial flow models. An outline Benefits case has been developed and will be tested with DoFs and other stakeholders as well as linking to evidence from other geographies which shows a promising and realistic scale of impact on key measures in the Leeds system.

Appendix 2 cont. Leeds Neighbourhood Health Highlight Report

North Star Metrics Progress (Narrative) *To include a brief (one short paragraph max.) update on progress made in your place in relation to the North Star Metrics commitments that were made in May 2025.*

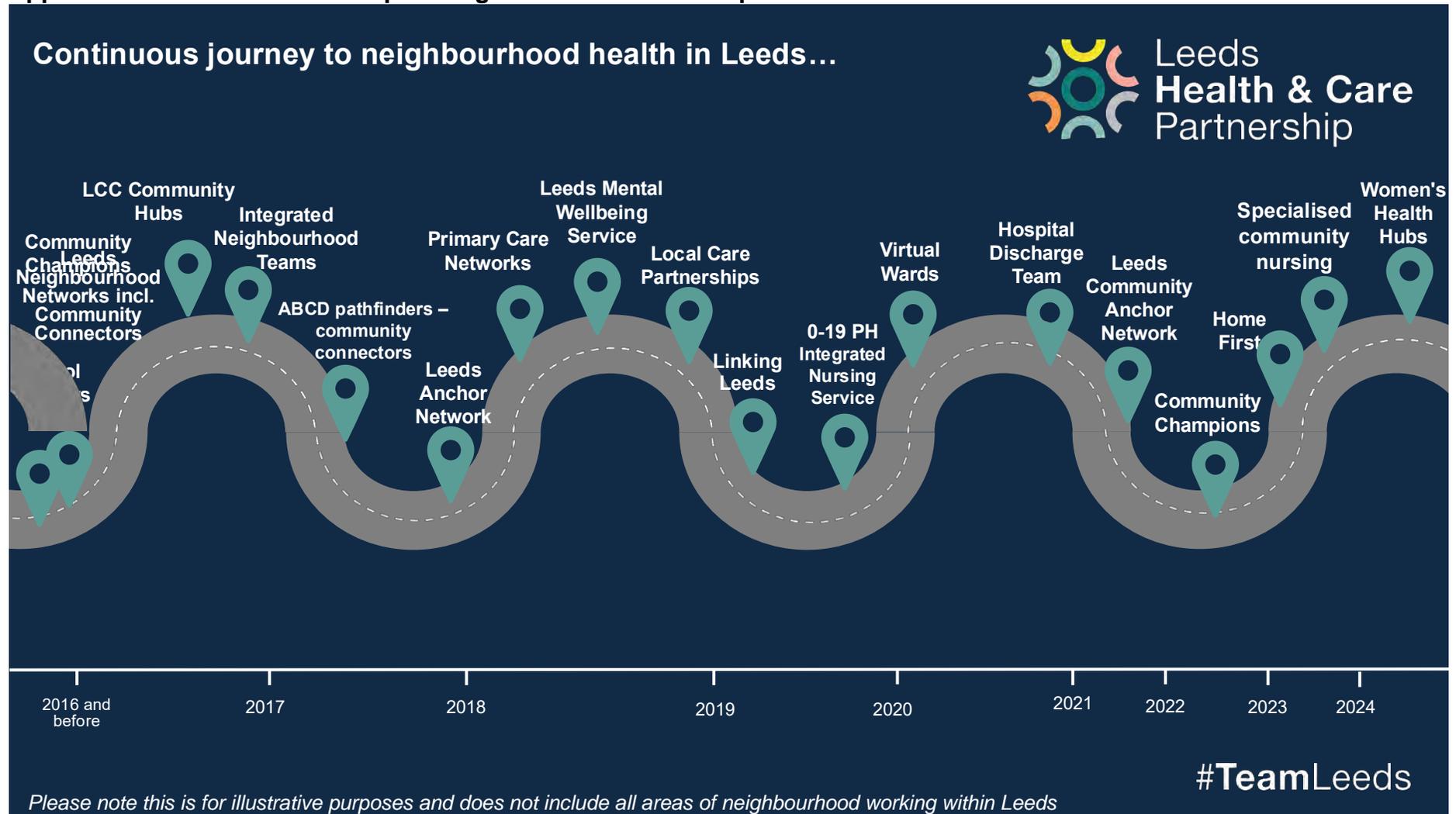
The North Star metrics align to the Healthy Leeds Plan ambition, which has been signed up to by all system partners. In Leeds we see unplanned care use as the 'failure demand' measure for the system and alongside this track a range of metrics looking at care use within each partner organisation balanced with people's experience of care. The Benefits of Neighbourhood Health will be driven through the integrated ways of working being developed within the HomeFirst programme and will be evaluated through our ODA team through the proactive care evaluation. Baseline measures for Leeds have been agreed for this programme and will be tracked through the Benefits Group. It is recognised that there is a bigger opportunity available if we are able to scale the delivery models to more of the population. Work is ongoing to develop incentive mechanisms that support partners in the system to adopt neighbourhood ways of working

North Star Metrics Progress *To include as much of the detail as possible, and where not available please use the section above to set out any challenges and/or when you expect the info to be available.*

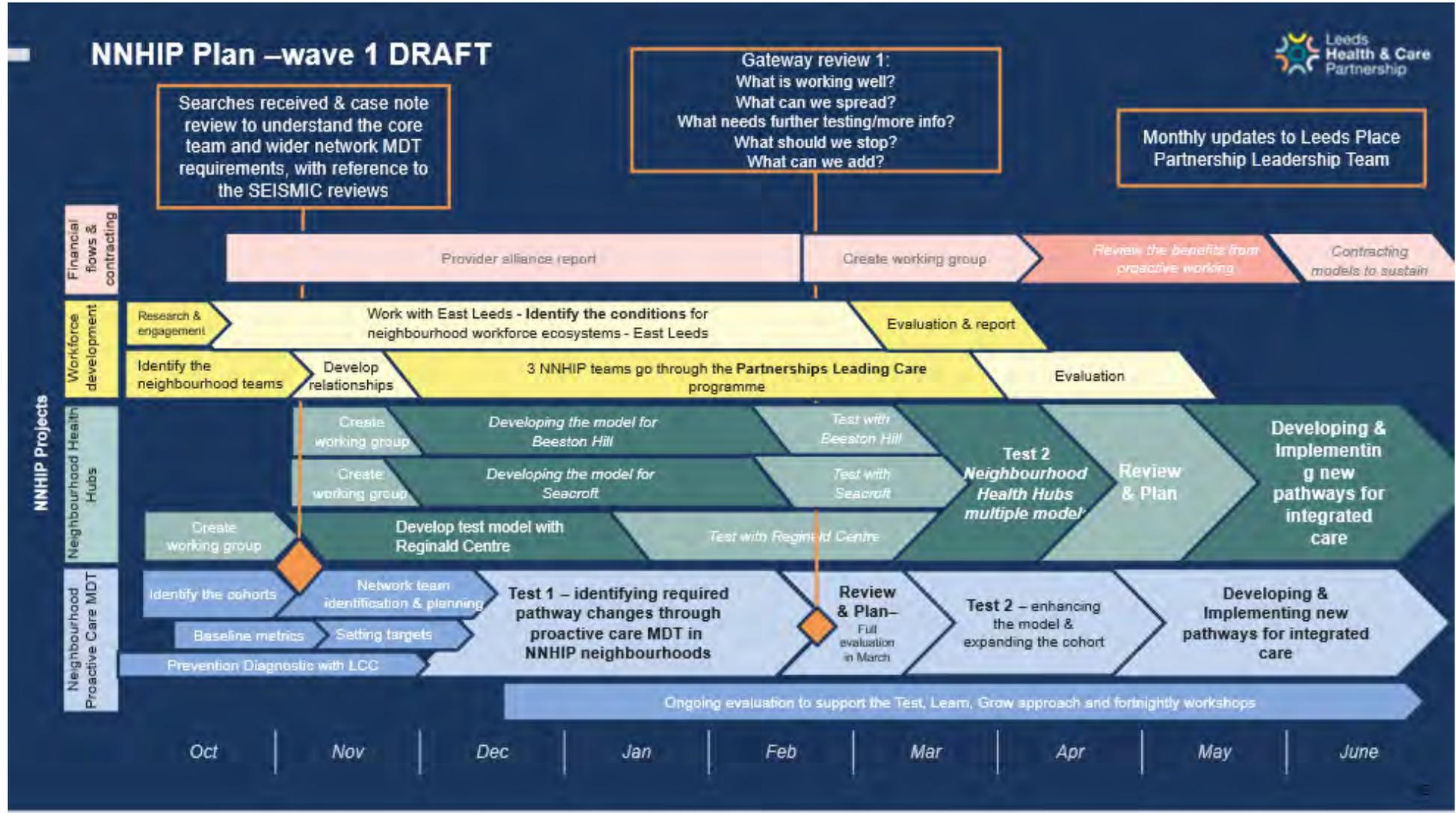
Priority Cohort	Baseline Rate of Unplanned Demand	Target Rate of Unplanned Demand	Baseline Cost (£)	Projected Benefit (£) (24/25)	Current Demand Trajectory	Current Benefit Trajectory (£)
Proactive Care (PCN variations in cohort of focus across multiple LTC & frailty)	A&E attendances 24/25: 790 Unplanned bed days 24/25: 4659	A&E attendances 25/26: 671 Unplanned bed days 25/26: 3354.5	A&E attendance: £379,58 Unplanned bed day: £398,44	A&E: £44,963 Bed days: £519,770 Total: £564,733	Increasing	Work still in its early stages with LCPs/PCNs – evaluation of phase 1 due Apr 2026

Risk	Summary/Description	Mitigations	R-A-G
Primary care engagement	Perceived threat to primary care business model. Risk of non-engagement and inability to deliver on neighbourhood health model. National contracting requirements from 1 st Oct further impacting relationships with potential for collective action	Engagement with the LMC and GP Confed. Agreed communication channels through the GPPC to provide assurance. Regular communication planned. Primary care relationships as an ICB priority. Tracking the activity to evidence no left-shift of work without resource.	
Pace of reidentification due to IG process	Whilst there is an overall data sharing agreement in place for all Leeds PCNs, the reidentification process is lengthy and not agile. This limits the pace of work and the engagement with the approach.	Process has been streamlined and timelines are improving Daily chasing of reidentification requests and close contact with primary care and WY teams	
Shared Care Records	There is not a proactive care plan for people that everyone working with a person can see or input into. Community teams cannot see the Social Care or Mental Health Trust systems.	Hospital teams can see the last 3 entries from community services, so staff are proactively updating a record if they know they have been admitted to hospital. Staff relationships have been developed to allow information sharing. Learning from rollout of single approach to ReSPECT will inform future approach to Neighbourhood shared care plan – scoping in progress.	
Alignment of incentives including primary care	Currently the incentives across the Leeds Health & Care Partnership are not aligned towards Neighbourhood Health. The NHS Operating Framework and performance measures are focusing on individual service outcomes rather than population health. The timeframes for NOF delivery do not align with the expected benefits of preventative, proactive care and therefore the focus within organisations is on shorter term wins. The incentives within primary care are not strong enough to support a move from the current ways of working.	There is a uniting strategy across the NHS and LCC in Leeds, which supports good partnership working, this would be enhanced by shared success measures. Programme supported and sponsored by the Leeds Partnership Leadership Team. Working with the national team to build these considerations into future contracting models	
System financial challenges	Immediate financial challenges can create short-term decision making and the inability to take risks that will result in longer term benefits to the system as a whole.	Working with the Directors of finance across the city to mitigate the risk of siloed thinking and limiting the opportunities for city benefit. Rapid work ongoing to develop the neighbourhood requirements particularly regarding estates to help inform organisational decision making.	

Appendix 2: Illustrative road map of Neighbourhood Health Implementation to date



Appendix 3: National Neighbourhood Health Implementation Programme Plan Leads



Meeting name:	Leeds Committee of the West Yorkshire Integrated Care Board
Agenda item no.	14
Meeting date:	11 February 2026
Report title:	Health Inequalities Update
Report presented by:	Tim Fielding and Ruth Burnett
Report approved by:	Tim Fielding and Ruth Burnett
Report prepared by:	Leeds Health and Care Partnership colleagues

Purpose and Action			
Assurance <input checked="" type="checkbox"/>	Decision <input type="checkbox"/> (approve/recommend/ support/ratify)	Action <input type="checkbox"/> (review/consider/comment/ discuss/escalate)	Information <input checked="" type="checkbox"/>
Previous considerations:			
<p>The Leeds Committee has previously received a series of updates outlining the city’s approach to tackling health inequalities, framed both by statutory ICB responsibilities and Leeds’ designation as a Marmot City. Earlier reports to the Committee emphasised that Leeds continues to take a whole-system, partnership-driven approach, with a strong focus on deprivation and the wider social determinants of health. This work is underpinned by the Leeds Health and Wellbeing Strategy and informed by the Marmot indicator set, which provides the city with a consistent way to monitor inequality at a high level and direct action where it is most needed. The Committee has also been assured that the Marmot City programme has strengthened collaboration across health, public health, the voluntary sector, and local government, supporting a “join-up, scale-up and be bold” approach to equity. In addition, complementary oversight mechanisms, such as the Healthcare Inequalities Oversight Group, have been highlighted as key enablers for embedding equity across decision-making, resource allocation, and service delivery, ensuring alignment between neighbourhood-level interventions, transformation programmes and systemwide priorities</p>			
Executive summary and points for discussion:			
<p>This paper brings together the three reports presented to the Adults, Health and Active Lifestyles (AHAL) Scrutiny Board on 10 February 2026 and is now submitted to the Leeds committee under a single agenda item. Bringing these papers together provides alignment across meetings, ensures consistency of messaging and avoids duplication within the system. The content remains unchanged and reflects the agreed intention agreed across partners to use a single, shared evidence base to describe the city’s approach to tackling health inequalities.</p> <p>Collectively, these papers provide a comprehensive overview of the current position in Leeds, drawing together population-level public health intelligence, the health and care system’s responsibilities and actions, and the lived experience and needs of unpaid carers. Together, the three sections set out the breadth of work underway across the Leeds Health and Care Partnership and through the wider Marmot City programme to address inequalities through a whole-system, evidence-driven and community-focused approach. The critical role of the Third</p>			

Sector in addressing health inequalities is central to, and reflected throughout, all of the appendices.

Appendix 1: Public Health and Marmot City

This paper summarises the city’s whole-system approach to addressing health inequalities, highlighting that outcomes are shaped primarily by the social determinants of health: housing, income, education, employment and access to services. It outlines the current pattern of inequalities in Leeds, including persistent gaps in life expectancy and healthy life expectancy between the most and least deprived areas, alongside recent improvements and challenges across key indicators. It also describes Leeds’ Marmot City commitments, the use of Marmot indicators in the Leeds Ambitions Scorecard and the partnership work underway to address the social determinants of health as well as the contribution across the breadth of public health programmes.

Appendix 2: Healthcare Inequalities

This report provides an update on the system-wide action within the Leeds Health and Care Partnership to reduce healthcare-driven inequalities. It highlights strengthened leadership through the Leeds Healthcare Inequalities Oversight Group, development of the Health Equity Index, and progress across the Partnership’s major transformation programmes, each contributing to improved early identification, equitable access, prevention and coordinated care. It also summarises Trust-level equity strategies, primary care improvements, and ongoing work to standardise and strengthen Equality Impact Assessments and understand inequalities within waiting lists.

Appendix 3: Support for Carers

Unpaid carers, over 61,500 people in Leeds play a critical role in the health and care system, contributing economic value equivalent to a “second NHS” nationally, yet often experience poorer health, financial insecurity and social isolation. This paper outlines the work of the Leeds Carers Partnership to reduce these inequalities through strengthened identification, improved access to information and support, culturally appropriate engagement, respite options and workforce development. It also sets out statutory duties relating to carers and provides recent performance insights showing improvements in satisfaction and involvement, but continued challenges around isolation and carers’ own quality of life.

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

- Improve healthcare outcomes for residents in their system
- Tackle inequalities in access, experience and outcomes
- Enhance productivity and value for money
- Support broader social and economic development

Recommendation(s)

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

1. **Note the consolidated update** across Public Health, Healthcare inequalities and unpaid carers, and the decision to present them under one agenda item for alignment and reduced duplication
2. **Endorse the continued whole-system approach** to tackling health inequalities, including delivery of the Marmot City programme
3. **Support the continued development and implementation** of the Health Equity Index and the strengthened role of the Healthcare Inequalities Oversight Group in providing system leadership and assurance

4. **Support ongoing system work** to reduce inequalities in access, outcomes and experience, including targeted prevention, equitable waiting list management and strengthened Equality Impact assessment processes.
5. **Note and support the refreshed improvement plan for unpaid carers** and the refresh of the Carers Partnership Strategy to strengthen identification, access to support and carers' involvement across services.

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 assurance that action to address health inequalities continues across the Leeds partnership, underpinned by robust governance and the consistent application of equity in decision-making and place-based delivery. This includes alignment with Leeds' Marmot City ambitions and a continued focus on groups at greater risk of inequality, including unpaid carers. The Healthcare Inequalities Oversight Group provides focused scrutiny and assurance on priority programmes, while regular reporting through partnership governance ensures that inequality risks are actively monitored and mitigated.

Appendices

Appendix 1: Public Health and Marmot City

Appendix 1b: Marmot Indicators

Appendix 2: Healthcare Inequalities

Appendix 3: Support for Carers

Acronyms and Abbreviations explained

ABA Leeds – Association of Blind Asians (Leeds)

AHAL – Adults, Health and Active Lifestyles (Scrutiny Board)

AMR – Antimicrobial Resistance

ARF – Accelerating Reform Fund

ASC – Adult Social Care

ASCOF – Adult Social Care Outcomes Framework

BAF – Board Assurance Framework

BHR – Burmantofts, Harehills & Richmond Hill (active travel project area)

CQC – Care Quality Commission

CVD – Cardiovascular Disease

DPH – Director of Public Health

DN – (Local context) "Digital Newsletter" or "Directory" usage in Carers Leeds comms

EQIA / EIA / EHIA / E&HIIA – Equity & Quality Impact Assessment / Equality Impact Assessment / Equality & Health Inequalities Impact Assessment

FTCi – Fast Track Cities initiative

HCP – Healthy Child Programme

HEAT – Health Equity Assessment Tool

HIOG – Healthcare Inequalities Oversight Group

ICB / WYICB – Integrated Care Board / West Yorkshire Integrated Care Board

ICS – Integrated Care System

IHE – Institute of Health Equity

IMD – Index of Multiple Deprivation

IPC – Infection Prevention and Control

LCC – Leeds City Council

LCH – Leeds Community Healthcare NHS Trust

LCPs – Local Care Partnerships

LD – Learning Disabilities

LGBTQ+ – Lesbian, Gay, Bisexual, Transgender, Queer/Questioning and others

LHCP – Leeds Health and Care Partnership

LTHT – Leeds Teaching Hospitals NHS Trust

LYCSS – Leeds Young Carers Support Service

LYPFT – Leeds and York Partnership NHS Foundation Trust

Marmot City – Leeds’ designation under the Marmot programme

MiiCare – Digital monitoring system used in falls prevention pilot

MMRV – Measles, Mumps, Rubella, Varicella (vaccine)

NHS HCP – NHS Health Check Programme

NPC – Neighbourhood Proactive Care

OHID – Office for Health Improvement and Disparities

PCNs – Primary Care Networks

PCREF – Patient and Carer Race Equality Framework

PH – Public Health

PHINS – Public Health Integrated Nursing Service

PLT – Partnership Leadership Team

PTL – Patient Tracking List

SMI – Severe Mental Illness

TEC – Technology Enabled Care

THOG – Tackling Health Inequalities Oversight Group (older terminology)

VCS / VCSE – Voluntary & Community Sector / Voluntary, Community and Social Enterprise

YCF – Young Carer Friendly

YCF Programme – Young Carer Friendly accreditation programme

YCSS / LYCSS – Young Carers Support Service

What are the implications for?

Residents and Communities	A sustained focus on improving outcomes for residents and communities most affected by health inequalities. Action is aligned on wider determinants, equitable access and carer support through neighbourhood based and community led approaches.
Quality and Safety	This is embedded throughout the health inequalities work, including earlier identification of risk, improved care coordination and more equitable waiting list management. Support for carers further strengthens safe care and discharge.
Equality, Diversity and Inclusion	Addressing inequality is central across all three papers. Protected characteristics, deprivation, inclusion health groups and carers are explicitly considered through Marmot-aligned indicators, impact assessments and targeted, culturally appropriate support.
Finances and Use of Resources	The papers demonstrate that tackling health inequalities supports value for money through prevention, early intervention and neighbourhood care. Supporting unpaid carers reduces avoidable demand and enables more targeted use of resources.
Regulation and Legal Requirements	The papers provide assurance of compliance with key statutory duties, including the Care Act, Equality Act and Health and Care Act. They show appropriate identification, assessment and involvement of carers, with governance in place to support legal compliance.
Conflicts of Interest	No conflicts of interest have been identified. All work is delivered through established partnership governance with appropriate oversight.
Data Protection	The papers use aggregated and anonymised data and comply with information governance requirements. Appropriate safeguards are in place for personal and sensitive information.
Transformation and Innovation	The papers highlight transformation through neighbourhood health models, the Health Equity Index, equitable waiting list approaches, and innovative support for carers, strengthening system resilience and equity.
Environmental and Climate Change	Public Health work includes action on environmental determinants such as housing, air quality and heat resilience, supporting climate adaptation while addressing inequalities.

Future Decisions and Policy Making	The papers provide a strong evidence base to inform future decision-making, prioritisation and risk management within strategic planning
Citizen and Stakeholder Engagement	Meaningful engagement with carers, communities and the voluntary sector is embedded throughout. Co-production strengthens trust, accountability and service relevance.

Progress in addressing health inequalities: Public Health (including Marmot City).

1.0 Purpose of report

- 1.1 In November 2024, Public Health Leeds CC, Adult Social Care and Forum Central presented a paper to the Adults, Health and Active Lifestyles Scrutiny committee which outlined the position regarding health inequalities in Leeds ([link to November 2024 meeting papers](#)).
- 1.2 The purpose of this report is to provide an update on the current position in Leeds both in terms of the approach the city is taking to address health inequalities and progress on outcomes.
- 1.3 Due to the wide range of factors that influence people's health, partners in Leeds - particularly Local Authority, education, NHS services and the Third Sector - all have different but important roles to play in tackling health inequalities. In line with previous reporting on whole-system approaches, this report is therefore presented alongside reports from across the health and care system – namely the ICB in Leeds and Adult Social Care.

2.0 Defining Health Inequalities

- 2.1 Health inequalities are systematic, unfair, and importantly, avoidable differences in health outcomes, across the population and between different groups in society. Whilst individual behaviour is often cited as a key driver of poor health and therefore health inequalities, in fact, behaviour has a much smaller effect (around 20% of total impact) on health outcomes than the conditions in which we are born, grow, live and work (the building blocks or social determinants of health) which account for up to 80% of health outcomes.
- 2.2 There are many interrelated 'causes' of health inequalities; these include (but are not restricted to) being from an inclusion health group and experiencing structural and interpersonal discrimination; access to good quality housing; early life experiences; education, housing, employment and barriers to accessing healthcare services. As the causes of health inequalities are complex, so action to address them must be whole system, at a sufficient intensity to meet need and involve many stakeholders.
- 2.4 Partners in Leeds (in particular, the Local Authority, education, NHS services and the Third Sector) work together to reduce health inequalities – with NHS services primarily focused on healthcare inequalities and the Local Authority responsible for improving the social determinants of health. The Third Sector plays a key role across all areas; increasingly, through the Leeds Anchor's programme, private businesses are also now contributing.

3.0 Leeds partnership approach to addressing health inequalities

- 3.1 As noted above, there is robust and compelling evidence to suggest that at least 80% of health and health outcomes are related to 'the social determinants (or building blocks) of health' – to factors such as housing, access to green spaces, employment and poverty, with only around 20% attributable to healthcare services.

- 3.2 Local authorities largely have responsibility for the building blocks of health. This means that the contribution of Leeds City Council – across all directorates, services and teams – is significant.
- 3.3 However, all sectors in the city have an important role to play and work together through city-wide strategic partnerships and operational groups to deliver co-ordinated action that: improves the building blocks of health; reduces risk factors/increases protective factors through targeted action in communities or on specific topic areas and improves health outcomes in health services
- 3.4 The Leeds Ambitions set out the plan for the city to reduce poverty and inequality and drive improvements across the four ambitions for the city and people of Leeds to be healthy, growing, thriving and resilient. The plan provides a significant partnership opportunity to reduce health inequalities through its focus on key social determinants of health – including the economy, strong communities and sustainability - alongside a commitment to improving health and reducing poverty and inequality. The commitment to Leeds being a Marmot City is central to the Leeds Ambition plan.

4.0 Health Inequalities in Leeds

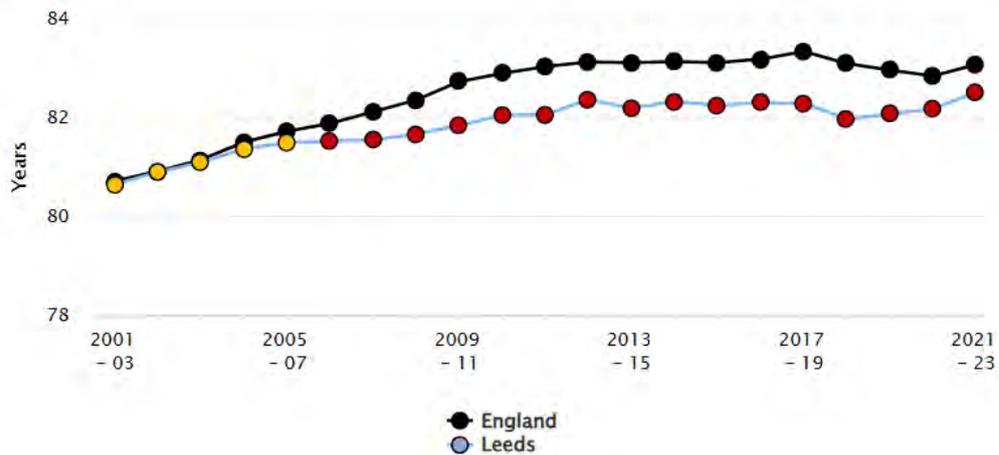
- 4.1 Leeds has a relatively young population and is one of the fastest-growing cities in England. However, not everyone benefits from the city’s thriving economy in the same way. Economic and social inequalities are entrenched in some parts of Leeds and have been exacerbated by the pandemic and the cost-of-living pressures.
- 4.2 The most deprived neighbourhoods are home to the youngest and most ethnically diverse communities. The differences in geography, economic and social conditions across the city lead to large inequalities in health and wellbeing. People living in the most deprived wards in Leeds live more of their life in ill-health and die around 12 years earlier than people in the least deprived, whilst the gap is 9 years between the most deprived 10% of neighbourhoods (i.e. IMD1) and those living in the least deprived 10% of neighbourhoods (i.e. IMD2019).
- 4.3 As a large, global city, Leeds is also home to significant numbers of people from communities with specific health needs, for example refugees and people seeking asylum, specific ethnic groups including Gypsy, Roma and Traveller communities, LGBT+ communities, people who are homeless and a large student body. This brings a range of assets and opportunities to the city; it also means that there are large numbers of people who benefit from tailored support on priority health issues.
- 4.4 Public Health monitors progress on the reduction of health inequalities through analysis of a range of population health outcome and service level indicators. These are reported to Leeds Scrutiny Board every six months, most recently in January 2026 ([link to the January 2026 Scrutiny papers](#)).
- 4.5 Life expectancy at birth
Life expectancy at birth is an important indicator of the health of the population and is reviewed closely as part of this monitoring (see Figure 1).

Fig. 1. Life Expectancy at Birth, 3-year average, Leeds compared to England

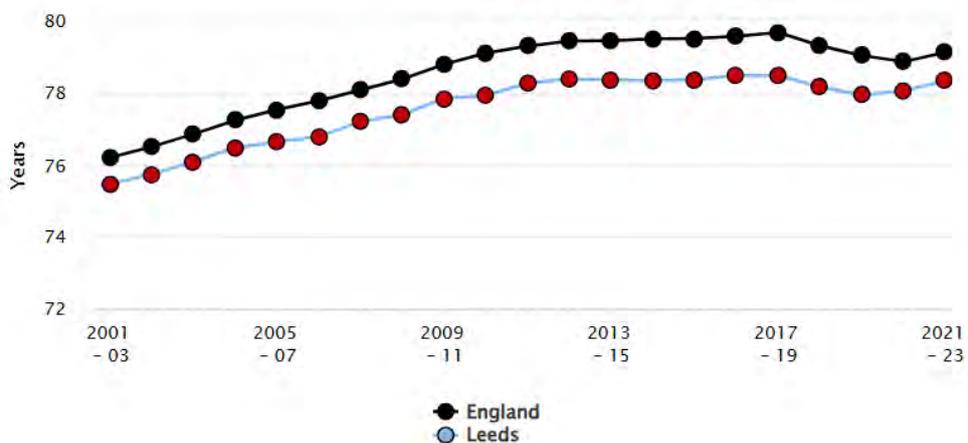
[Fingertips | Department of Health and Social Care](#)

(nb. Lower/blue line is for Leeds. Yellow data-points indicate that the Leeds rate is 'not significantly different to the England average'. Red data-points indicate that the Leeds rate is 'significantly worse than the England average'.)

Female



Male



- 4.6 In line with the national picture, overall life expectancy in Leeds was increasing year on year until 2013 when improvements began to 'stall'. It is widely accepted that the global economic downturn and subsequent policies of austerity had a negative impact on the 'building blocks' of health which contributed to this loss of progress.
- 4.7 From 2017/19 life expectancy in Leeds showed a decline associated with COVID 19. Most recently, there has been a small increase in life expectancy at birth for both men and women – this will be monitored over the coming months to establish whether it is the beginning of a positive trend in the city.
- 4.8 Importantly, Figure 1 illustrates that the trend in life expectancy, and the inequality gap, are not static and do change depending on wider circumstances. Both the

overall trend and the gap in inequality are amenable to and influenced by policy decisions at a local and national level.

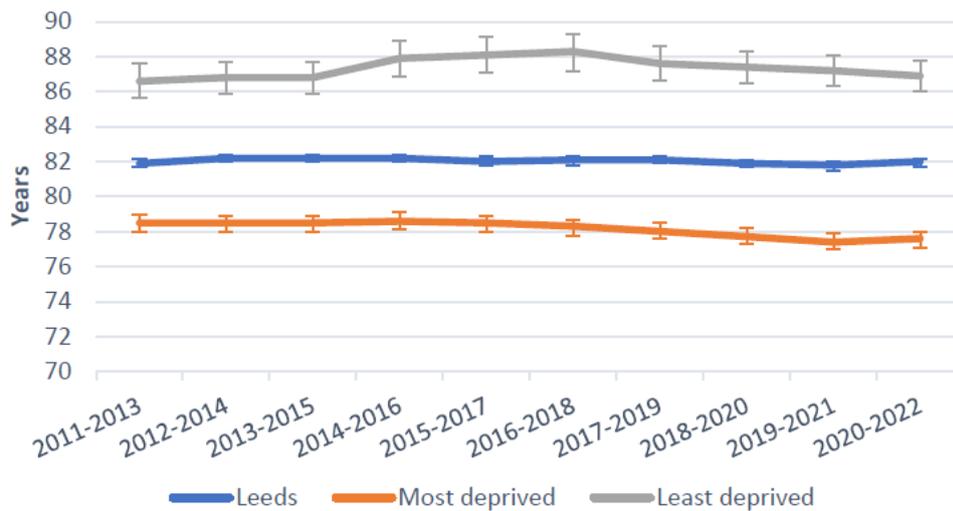
4.9 Throughout this period there has consistently been a gap between the average life expectancy at birth in Leeds compared with the average national rate. The local data for Leeds (Figure 2) shows that in addition, there is a significant and consistent inequality gap between people living in the most deprived neighbourhoods and those living in the least deprived neighbourhoods.

Fig. 2. Life Expectancy at Birth, 3-year average, Leeds most deprived (IMD1) compared Leeds least deprived (IMD10)* and England

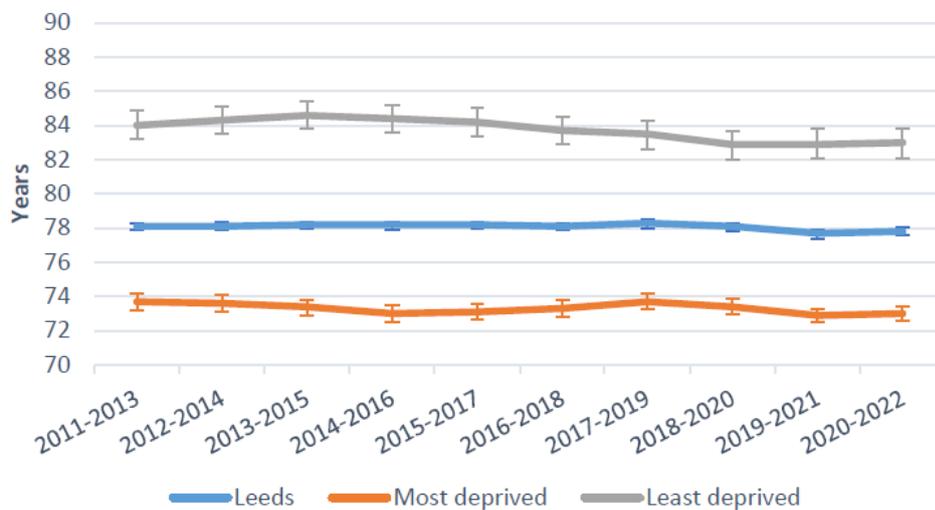
[Public Health Performance Report, January 2026](#)

(* "Most Deprived" is the population of Leeds living in an area ranking in the 10% most deprived nationally, "Least Deprived" is the 10% least deprived nationally.)

Female



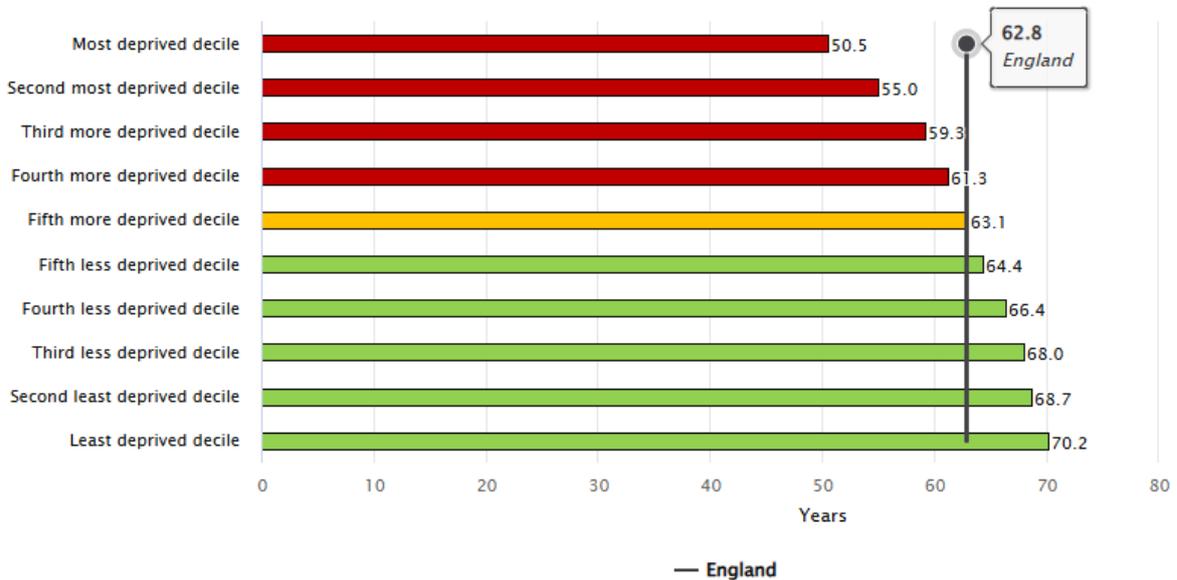
Male



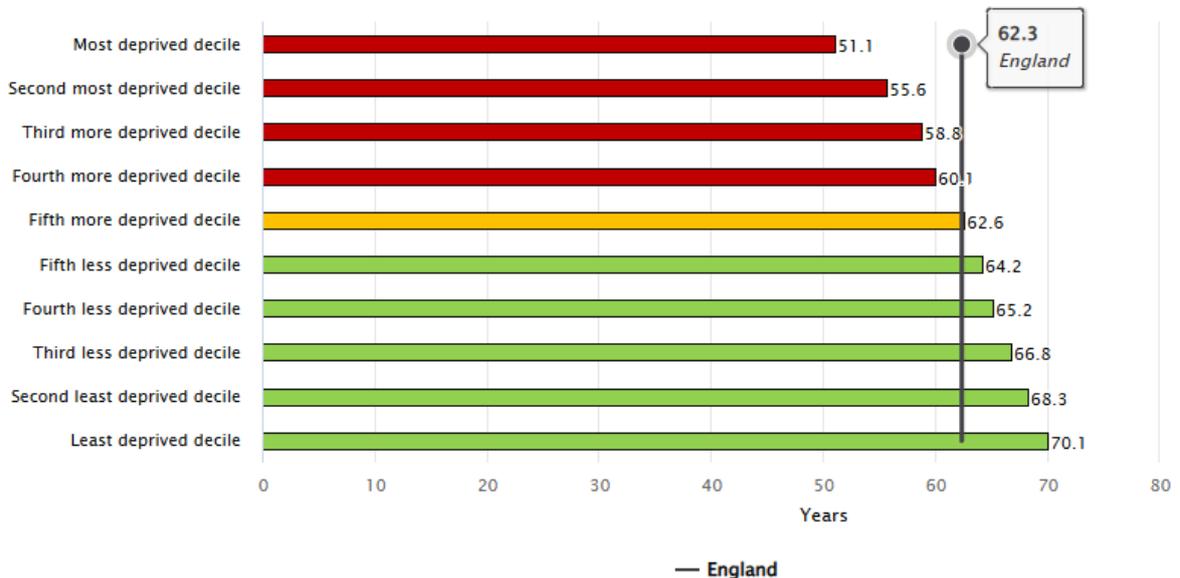
4.11 Healthy life expectancy

Fig. 3. Healthy Life Expectancy at Birth (2020-22), England

Female



Male



4.12 Average Healthy life expectancy rates are similar overall between Leeds and England. While it's not possible to breakdown the rate within Leeds to look at inequalities by deprivation, Figure 3 shows the inequalities for England. It can be expected they will be comparable for Leeds.

4.13 Figure 3 shows that there is approximately a 20-year difference in healthy life expectancy between people living in the most and least deprived neighbourhoods.

- 4.14 Healthy life expectancy is a key indicator that details the age at which different communities or parts of the population start to develop chronic or life-limiting illnesses – as such, along with overall life expectancy it is an important measure of inequality.
- 4.15 Trends in other health indicators:
- A social gradient (where the rate is progressively worse the more deprived a neighbourhood is) exists across almost all indicators of health, access and outcomes.
- 4.16 There have however been positive improvements in inequalities across a range of health indicators in Leeds in recent years including. These are associated with largescale and well-established public health programmes/interventions.
- Breastfeeding maintenance rates show a significant narrowing of the gap as well as an improvement for Leeds overall. These changes are driven by continued improvement in breastfeeding maintenance in the most deprived parts of the city.
 - Respiratory mortality rates have improved, and the gap has narrowed due to greater improvements in the most deprived neighbourhoods.
 - Cancer mortality rates have improved, and the gap has narrowed due to greater improvements in the most deprived neighbourhoods.
 - The inequality gap in alcoholic liver disease mortality has reduced due to greater improvements in the most deprived neighbourhoods, despite the overall rate increasing
 - Admission episodes for alcohol-specific conditions have improved and the gap has narrowed due to greater improvements in the most deprived neighbourhoods.
- 4.17 Despite these improvements, there remains a gap in inequalities for the above indicators. Other health indicators show more persistent or increasing inequalities, including:
- Excess weight and obesity
 - Physical inactivity
 - Prevalence of severe mental illness
 - Circulatory disease mortality
 - Diabetes
- 4.18 Changes to the Index of Multiple Deprivation (IMD)
- Recent Index of Multiple Deprivation reporting has indicated that there has been a shift to lower deprivation in Leeds when compared to other areas. However, it is not possible to state that absolute deprivation is reducing, because the measurement of deprivation in IMD 2025 is different to that used in 2019.
- 4.19 Compared to other areas nationally, Leeds has improved its position in the new ranking system, but this may not mean that people in the poorest areas are experiencing 'less' deprivation or improved health.
- 4.20 Data in this report (and the January 2026 Performance report) are based on IMD 2019.

4.21 Marmot indicators and Leeds Ambition reporting:

Alongside the indicators reviewed as part of the Public Health Performance report the Marmot City programme has created an 'indicator set' to provide a high-level indication of the direction of travel of Leeds regarding health inequalities across the breadth of the Marmot principles. Critically, they also include a clear illustration of the extent of the inequality relating to each indicator, which is not the case in all data/performance reporting.

4.22 The Marmot indicator set includes 15 indicators that align with Marmot principles and that can be disaggregated by either ward or Index of Multiple Deprivation decile, ethnicity, sex etc.

4.23 The indicators, and the principle of disaggregating the data by inequalities, have been adopted into the Leeds Ambition scorecard. They enable a high-level view (across both the social determinants of health and healthcare inequalities) of progress the city is making in addressing health equity and reducing health inequalities.

4.24 The indicator set is included as an appendix below.

5.0 **Fairer, healthier Leeds: A Marmot City**

5.1 In 2023 Leeds became a Marmot City, partnering with Professor Michael Marmot's team at the Institute of Health Equity (IHE) to identify how Leeds could build on existing approaches to go further and faster to address health inequalities in the city.

5.2 This programme aims to work with partners – driving a '**join up, scale up and be bold**' approach to addressing health inequalities through a focus on the building blocks of health.

5.3 A recent Public Health peer review process concluded that the Marmot City programme has enabled a focus on reducing health inequalities to be better understood across the council but that there were further opportunities to build connections across the full breadth of services/ directorates

5.4 Full details of the reports co-produced with the IHE are available on the IHE website: [Fairer, Healthier Leeds: Reducing Health Inequalities - IHE](#)

5.5 The IHE made 45 recommendations across the '*Fairer, Healthier Leeds – reducing health inequalities*' report, and across targeted work on Housing and 0-5s year olds. These recommendations are being delivered by the Marmot Strategic Delivery Partnership, the Leeds Health & Housing Steering group and the Best Start & Beyond.

5.6 The work is council and city-wide but is being led and coordinated by the Public Health – Health Inequalities team with governance through the Health and Wellbeing Board.

5.7 Considerable work and progress has taken place during the first phase working with the Institute of Health Equity and responding to recommendations Below is a summary of some of the key workstreams.

5.8 0-5 years priority workstream:

The 0-5 years are widely recognised as being critical to development and a period where much subsequent inequality can stem from, or where it can be avoided through the development of strong foundations. There was strong support in Leeds for this being a priority for the Marmot City work. Prior to this in Leeds, there were two distinct and separate partnership structures and strategies, one for Best Start (0-2 years) and one for Early Years (3-5 years). One of the key developments from this stream of work has been the formation of the Best Start and Beyond alliance. This new partnership structure addresses previous issues by bringing together the focus across 0-5 years old under one focus, has joint leadership from Children and Families Directorate and Public Health, includes partners from across the system, is action and outcome focussed. This is covered below under the Children and Families workstream summary below.

- 5.9 The establishment of the Best Start and Beyond alliance has brought a new level of coordination and ambition. It serves two main functions:
- I. Delivering a comprehensive action plan across the eight priority areas below
 - II. Providing system leadership across more than 30 partnerships that impact children aged 0-5, helping to break down silos and align efforts
- 5.10 The alliance has developed a Strategic Framework including actions across eight priority areas:
- Publishing a clear Start for Life offer,
 - Preparation for parenting, and parenting support,
 - Healthy preconception and the first 1001 days,
 - Speech language and communication,
 - Oral health
 - Healthy weight,
 - Early years education attainment and
 - Housing.
- 5.11 One of the high-level 'Marmot Indicators' and one of the key indicators for the Best Start and Beyond alliance is 'Good level of development at the end of Reception/age 5'. The progress and work that had already occurred in Leeds through the Marmot City programme has meant that the foundations were in place to be able to respond to a national rapid programme of work being rolled out by The Office of Health Improvements and Disparities (OHID). This is covered further in the section below on Children and Families.
- 5.12 Housing and health priority workstream:
- From the outset of Leeds deciding to become a Marmot City, housing was recognised as one of the highest priority 'building blocks', Housing impacts on people's health and is a cause of health inequalities in a wide variety of ways including issues of homelessness, insecure housing, poor quality housing leading to physical and mental health issues, housing affordability, and issues relating to the local area and neighbourhood.
- 5.13 The IHE made 15 recommendations on housing. These are influencing action across a range of areas. The Housing and Health Steering group identified several recommendations to focus on this year, including:
- 5.14 Refugee and Asylum Seeker populations:

Scoping has been carried out with Leeds City Council and Third Sector partners. Actions (to be co-ordinated through Public Health) include:

- Tenants' rights awareness and outreach housing advice to be mapped and evaluated. Best practice to be scaled up to inform development of an information pack.
- Leeds Asylum Seekers' Support Network (LASSN) is creating an information pack for faith groups and landlords regarding refugee housing needs. Public Health to support delivery through commissioned contracts and partnerships.
- Better connection with selective licensing scheme to improve understanding and address health needs regarding refugees and asylum seekers.

5.15 Gypsy and Traveller populations:

- Scoping has been carried out with partners. An agreement has been reached to focus on re-invigorating the Leeds 'Negotiated Stopping' policy due to the positive impact on the health of Gypsy and Traveller communities. It has also been raised as part of the consultation on the Leeds Plan.

5.16 Develop stronger partnership approaches between housing, mental health and wellbeing, public health and Third Sector:

- A mental health training programme for housing staff has been developed with capacity to train 250 housing workers - scaling up existing work delivered through an existing Public Health contract. Once finalised, the mental health and housing training package will be linked closely into and delivered through the existing 'health and housing' training work programme which so far, has been accessed by 300 staff across the health and social care sector.
- Action to develop solutions that support people with serious mental illness to access LCC housing more effectively.

5.17 Selective Licensing:

Public Health has also contributed significantly to the further development of selective licensing in Leeds – through delivering a summary evaluation of the health impact of the programme, bringing the health and housing workforce together and providing support for the business case to expand the scheme.

5.18 Public Health has now convened a multi-agency group to maximise the impact of selective licensing on health through building stronger relationships between health and housing staff; developing a city-wide model that supports improved referral and support processes between housing, social prescribing, third sector and primary care, and strengthened monitoring and evaluation.

5.19 Addressing racism and discrimination and their impact on health (Marmot Principle 7)

A small network has been formed made up of a diverse group of leaders from across the city who have experience of working on, or who have an interest in, the impact of structural racism on health. The vision and approach have been agreed, and several products are in development to support the work going forward - including analysis of local data related to structural inequality and collating local and national case studies. Next steps include: 'socialising' the wider system to the findings included in the data pack and agreeing on an area of focus. Drawing on learning from similar work

elsewhere (i.e. London and Birmingham) it is likely that these areas are likely to be housing, education or employment.

5.20 Regeneration and place-making

Public Health and Asset Management & Regeneration are working together to trial using the HEAT tool (Health Equity Assessment Tool (HEAT) - GOV.UK) within the Heart of Holbeck development. Stage 2 (gathering data and identifying key needs/issues) has been completed, a Theory of Change has been drafted which outlines health needs in the area, how these relate to the social determinants of health or 'causes of causes').

5.21 A wider workshop with partners is being held to review 'Stage 3' of the tool. The outputs from this will be a series of recommendations for consideration by the Heart of Holbeck Board. If the tool and wider process are judged to have been useful, then the approach could be adopted more widely across regeneration projects.

5.22 The use of the HEAT tool in the Heart of Holbeck project has engaged a wide range of partners and identified key health equity issues and priorities which are being used to shape and inform the consultation and design of the regeneration project. One example of the priorities arising is health and community safety concerns for women and girls and the impact this has on health.

6.0 Public Health and Health Inequalities

6.1 Public Health works to protect and improve the health and wellbeing of all communities in Leeds, with specific focus on reducing health inequalities.

6.2 A significant proportion of Public Health activity is legally mandated whilst other activity reflects identified local health needs and priorities.

6.3 Public Health activity is dependent upon close partnership working with LCC directorates, the NHS and the Third Sector, as well as a range of other partners, and delivers activity through four key domains:

- Assessing the health of the population and evidence of what works to improve this
- Partnership working and system leadership.
- Commissioning, delivering, managing, and influencing a wide range of public health services, programmes and interventions to improve health and reduce health inequalities based on evidence of what works
- Measuring and evaluating performance and outcomes and share learning to inform future developments and decision making.

7.0 Public Health Grant

7.1 Public health is funded through the Public Health Grant which is NHS funding via the Department of Health & Social Care and provides local authorities with the funding to discharge their public health functions. The grant is ringfenced and the 'Conditions of the grant' include statutory duties to improve and protect the public's health, and specific mandated functions. These include the Director of Public Health's statutory responsibilities to improve and protect the health of the population, reduce health inequalities and the provision of vital preventative and treatment services.

- 7.2 The 2025-26 Public Health Grant provided by the DHSC for Leeds is £53.5m. An additional, £10.1m is provided for drug and alcohol treatment as part of the Government's 10-year plan to cut crime and save lives by reducing the supply and demand for drugs and delivering a high-quality treatment and recovery system. This funding is non-recurrent, confirmed on an annual basis and has strict grant conditions. £962k is also provided for additional local stop smoking services and support over the next five financial years, starting from 2024-25 until 2028-29.
- 7.3 Grant levels locally are based on inherited spend on public health upon transfer from the NHS to local government in 2013. The Leeds allocation of £64.48 per head of population is the lowest allocation across all nine core cities, with Nottingham ranked at the top with £120.80 per head of population.

8.0 Update on Public Health Programmes

Work programmes in Public Health are organised by a combination of population group or topic area – all having a core focus on reducing Health Inequalities.

8.1 Long term Conditions and Cancer

The commissioning of the NHS Health Check programme successfully continues to apply a focus on health inequalities with over half of all NHS Health Checks completed in 2024/25 were to people from 'most likely to benefit groups'. This includes those living in most deprived neighbourhoods, culturally diverse communities, smokers, and those who are obese (BMI>30).

- 8.2 The testing of community-based approaches to delivering NHS Health Checks specifically targeting Health Inclusion Groups continues. The programme comes to end in 2026 with a full evaluation to follow.
- 8.3 The Public Health commissioned Leeds Health Awareness service continue to deliver a broad range of activity targeting areas of highest deprivation and specific communities. In 2024/25, the LHAS had 5,502 brief advice conversations with people, covering a variety of health topics and reaching people from different communities and cultural backgrounds.
- 8.4 A broad range of activity has been delivered through the Public Health led Cancer Health Inequality tasks groups. These groups focus on improving access to services and cancer outcomes for people with Learning Disabilities (LDs), Severe Mental Illness (SMI) and Culturally Diverse Communities. Recent activity includes:
- Primary Care Learning LD bowel screening flagging pathway established - 100% practice sign up and early indications of an increase in uptake since the pathway was launched.
 - Training developed for frontline Primary Care staff around cervical screening and LD accompanied by the development of easy read resources for patients.
 - Developed and tested a new LD cervical screening pathway in one PCN area.
 - 6 monthly Cancer Health Inequality task group shared learning network events to share learning and best practice and develop collaborative working opportunities
 - Development of breast screening round profile to support the breast screening service to effectively target promotion
 - SMI bowel screening pathway established in 7 mental health in-patient settings.
 - Development of Cancer and SMI toolkit

- 22 Migrant Community Networkers trained to deliver key messages and awareness for prevention of cancer and LTCs to their communities. 16 events held reaching 385 people face to face from a broad range of communities.
 - Cervical screening invite letter translated into a range of different languages with QR codes linking to audio versions
- 8.5 In 2024/25, two community-based blood pressure testing and awareness raising projects to support early identification of high blood pressure and access to support were delivered in Seacroft and Inner South Leeds respectively. Both projects worked with the third sector and primary care and targeted areas of high deprivation and priority groups to help reduce health inequalities.
- 8.6 Public Health: Children and Families Update
- Leeds 0-19 Public Health Integrated Nursing Service (PHINS) Stakeholder Review:
- The Leeds 0–19 Public Health Integrated Nursing Service (PHINS) plays a vital role in delivering the national Healthy Child Programme, offering health and developmental reviews, health promotion, parenting support, and promotion of screening and immunisations. Commissioned by Leeds City Council and delivered by Leeds Community Healthcare NHS Trust, the service provides both a universal offer and targeted support for families with additional needs. As part of future planning ahead of the contract ending in March 2027, the Council commissioned Enventure Research to conduct an independent stakeholder engagement exercise to assess service strengths and development opportunities.
- 8.7 The Director of Public Health has now given authority to undertake a competitive procurement process. The full authority to procure report can be found here [Council and democracy](#)
- 8.8 0-19 PHINS Direct Referral Service for Welfare Advice:
- A new initiative has been developed working with LCC’s Financial Inclusion team and Public Health Children and Families to deliver direct access to Leeds advice services and support for 0-19 Public Health Nursing Services (0-19 PHINS) ‘
- 8.9 The Service provides a direct referral route for front line workers in the 0-19 PHINS via a direct phone line, to support families who would not otherwise seek help.
- 8.10 Since mobilisation began in July 2025:
- 102 clients were assisted under the contract in Quarter 2 with a total of 167 contacts.
 - 67% of clients were from culturally diverse communities
 - Over £133,349 of income was generated for clients through benefits entitlement advice and grant applications.
- 8.11 Best Start and Beyond Framework:
- As part of the local response to the Leeds Marmot recommendations, a strategic framework called Best Start and Beyond has been developed. The strategy aims to bring colleagues together to deliver work in partnership to improve population health outcomes and reduce inequalities experienced by 0 – 5-year-olds in Leeds. The framework has been produced by a broad range of partners and led by Public Health and The Children’s Directorate. An update on delivering the Marmot recommendation

was given to the Health and Wellbeing Board and the strategy was launched during Baby Week.

8.12 Maximising the impact of the 2-2.5-year Health review through health visiting services:

One of the Government's five missions is to break down barriers to opportunity. As part of delivering this mission, the Government published a new national strategy, "Giving every child the best start in life". This strategy sets out the Government's plan for improving child development and meeting the ambition that 75% of 5-year-olds in England have a good level of development (GLD) by 2028. There is a commitment to setting up Best Start Family Hubs in local authority areas which had not previously received Family Hub / Start for Life funding. The Best Start Family Hubs are required to provide stay and play sessions and support for early childhood development through health, parenting and home learning programmes.

8.13 As part of the work to deliver the 75% of children reaching a GLD aged 5 by 2028, a rapid programme of work is being rolled out, by The Office of Health Improvements and Disparities (OHID) in the Department of Health and Social Care, to improve the uptake a quality of the 2-.2.5-year review that is mandated through health visiting services as part of the Healthy Child Programme (HCP).

8.14 The 2-2.5-year review is the last universal check of a child's development until the end of Reception, when a child is five. It is therefore an important mechanism for identifying families in need of additional support and children who have signs of developmental delays to help prepare them for school.

8.15 OHID have reviewed national local authority data on inequalities in school readiness, disadvantaged children and the uptake of the 2-2.5-year review and categorised authorities into three tiers. Leeds is one of 37 local authority areas, categorised as being in Tier 2, meaning we are required to develop an action plan to increase the uptake of the 2-2.5-year review.

8.16 An improvement plan has been developed that will be monitored until March 2026 through a strong governance process with OHID and links with the Best Start and Beyond Alliance; which has overall responsibility for improving population health and reducing health inequalities for children aged 0-5 in Leeds.

8.17 National Supervised Toothbrushing Scheme:

In April 2025 the government announced an investment of 11 million pounds to support a national roll out of a funded targeted supervised toothbrushing programme for 3–5-year-olds, living in areas of high deprivation. In addition, a new corporate partnership between DHSC and Colgate-Palmolive has been established which involves the donation of toothbrush/toothpaste packs over a 5-year period.

Leeds received £245,342.83 of government funding to support roll out targeted supervised toothbrushing programme for 3–5-year-olds, living in areas of high deprivation (IMD areas 1 & 2).

8.18 Mental Health Survival Toolkit:

Rates of children and young people with probable mental health conditions have increased substantially, with high demand for children's mental health services. The

use of self-help resources does not replace therapeutic support but can act as an empowering tool to help young people manage their own mental wellbeing.

8.19 Public Health are now working with the MindMate Ambassadors and the Time for Young People Service to develop this further into interactive off-line resources to be used in group work and mental health promotion activities, such as the School MindMate Ambassador pupil leadership programme.

8.20 Public Mental Health

Public mental health refers to the strategies and actions aimed at promoting mental well-being, preventing mental illness, and addressing poor mental health at a population level. In Leeds, the programme aims to strengthen factors that support good mental health while reducing the impact of risks that contribute to poor mental health.

8.21 Working with communities that live in the most deprived areas of Leeds and inclusion health groups, the programme focuses on reducing stigma and discrimination. The local authority plays a key role in coordinating suicide prevention efforts and minimising harm in communities.

8.22 Locally, Public Mental Health achieve this by:

- Commissioning a range of interventions including Being You Leeds, Unfolding and Mindful Employer. These programmes, in turn, work with communities most at risk by promoting protective factors, support volunteers to support others and bring local employers together to champion positive mental health at work.
- Advocating for and commissioning training to other organisations around self-harm, suicide prevention and mental health
- Supporting multiagency partnership work to reduce stigma associated with mental health.
- Co-leading work to address ethnic inequalities in mental health, which includes providing grants to community-based organisations.
- Leading the Leeds Suicide Prevention Action Plan, providing grants to organisations to prevent suicide and commissioning the Leeds Suicide Bereavement Service.

8.23 Successes over the last 12 months:

The 'Being You Leeds' service is delivered in the 20% most economically disadvantaged communities in Leeds and reaches those at highest risk of poor mental health. People accessing this service have reported improvements in wellbeing, measured using the validated and reliable Shortened Warwick-Edinburgh Wellbeing Scale.

8.24 Our two Small Grants Programmes, for suicide prevention and for addressing ethnic inequalities in health, continue to fund grassroots interventions for communities at highest risk of poor mental health. They focus on reducing stigma and isolation, delivering culturally appropriate early support, and building sector capacity, with clear positive impacts on mental health outcomes:

'We'd love to see continued investment in grassroots mental health initiatives like this, especially those tailored to underrepresented communities. Thank you again for believing in our work, it's had a lasting impact'.

(Shantona Women and Family Centre)

- 8.25 Over the past 12 months, the Mindful Employer Network has seen growing engagement from Leeds’ retail and manufacturing sectors, whose workforces are known to face higher risks of poor mental health.
- 8.26 Mental health and suicide prevention training is targeted at third sector organisations working with some of Leeds’ communities at highest risk of poor mental health. These have been well attended and positively evaluated, with independent evaluation of the Unfolding Programme showing it helps volunteers reduce burnout and better support their communities.
- 8.27 Challenges:
- Challenges persist in understanding the prevalence and impact of common and serious mental health conditions across communities in Leeds, primarily due to underreporting driven by stigma and barriers to accessing support
- 8.28 Healthy Living
- 8.29 Tobacco:
- Smoking is a major driver of health inequalities, with the greatest impact in deprived areas. It accounts for up to nine years difference in life expectancy between the richest and poorest. Smoking also creates significant financial and social challenges:
- People who smoke are less likely to be employed or own a home and more likely to live in social housing.
 - On average, around £40 per week is spent per person who smokes on tobacco.
 - 32% of households with a person who smokes fall below the poverty line; quitting could lift nearly 7,000 Leeds households out of poverty.
- 8.30 Smoking prevalence in Leeds has fallen from 18.8% (2021) to 15.6% (2025), with the largest decline in the most deprived areas (IMD 1: 30.1% to 25.2%).
- 8.31 Key actions:
- Refreshing the citywide action plan for the 2027 nicotine and vapes bill
 - Commissioning bespoke stop-smoking services
 - Delivering local and regional campaigns and the national ‘Swap to Stop’ programme
 - Tackling illicit tobacco
 - Launching a vaping/nicotine cessation offer (2026/27)
 - Collaborating with healthcare and research partners to improve access to support
- 8.32 Physical Activity:
- The Leeds Physical Activity Ambition addresses persistent inequalities in activity levels, particularly among people with disabilities, long-term health conditions, and those in socio-economic deprivation. It focuses on three priorities:
- Designing environments that enable daily movement
 - Creating a social norm where being active is the easy choice
 - Building partnerships for a healthier, greener city and stronger economy
- 8.33 A key example is a £1.3m Department for Transport-funded pilot (2022–2026) delivered with Active Leeds and partners, promoting walking, wheeling, and cycling in

Burmantofts, Harehills, and Richmond Hill (BHR)—an area in IMD decile 1 with high disadvantage.

8.34 Pilot impact to date:

- 171 referrals via health pathways
- 56 local walk leaders trained
- 10,000+ attendances at community events and engagement sessions
- Walking commissions with Health for All and Touchstone
- 104 women engaged in cycling at the Bilal Centre, Harehills
- Active Travel Master Plan used as evidence for further funding opportunities

8.35 Healthy Places:

The environments in which we live are inextricably linked to our health throughout our lives, impacting on mental and physical health and wellbeing outcomes. Working closely with colleagues in Planning Services, Public Health influences local planning policies and planning decisions for new developments, ensuring health is a key consideration in decision making, with a focus on the developments that are likely to impact Leeds' most deprived areas

- 2025 actions: Provided comprehensive comments on residential and mixed developments across Leeds (equating to 2,872 new homes).
- Challenged two controversial applications for Drive Thru's in Seacroft and Stanningley wards submitted by a large multinational corporation (1 successfully)
- Provided comments on the health impacts of diverse commercial sites such as Leeds Bradford Airport, Elland Road Expansion and a large datacentre.
- Provided a PH response to the Local Plan Consultation identifying opportunities for inequality and overheating to be included in policy in the future
- Liaised closely with colleagues in Planning, NHS and Leeds ICB and have identified the need for wider school & healthcare capacity considerations in large scale housing developments.

8.36 Monitoring:

New dashboards are being developed to track tobacco use, Body Mass Index (BMI), and physical activity by demographic and geographic profiles. By drawing data from primary care systems, they will also monitor links between unhealthy behaviours and long-term health conditions over time.

8.37 Ageing Well:

Reducing inequalities in later life (50+) is a cross-cutting theme underpinning the Leeds' [Age Friendly Leeds Strategy and Plan](#) for 2025-2030. Age Friendly is also one of the three goals underpinning the Leeds 'Healthy' Ambition, as well as an enabler contributing to delivery across the city.

8.38 Commissioned services are targeted (in areas in the city and towards groups of people) to enable people to age well in later life. Recent actions to reduce health inequalities include:

- Home Plus key performance indicators relating to inequality and equality have been established. These indicate that 28% of all clients live in the most deprived neighbourhood, increasing to 53% of clients for the fuel poverty and

warmth component of the service. An outreach worker has been recruited to increase this further.

- Increased capacity of Strength and Balance classes focussed in areas of the city with the highest levels of falls and IMD1/2 areas.
- Increased the proportion of funding to Lunch Clubs in IMD1/2 areas with 55% of the 92 grants being awarded to groups in in IMD1/ 2 areas.
- Development of a Service Level Agreement for the Public Health contribution to Neighbourhood Networks.

8.39 Implemented actions to address inequalities identified in the Director of Public Health Report [Ageing Well: Our Lives In Leeds](#) (reported [p69-71](#)).

Examples include:

- Work with Forward Leeds to develop and review [Alcohol in Later Life](#) resources. training and data to consider areas to address barriers in access to services.
- Development of an Active Ageing plan with partners to promote a coordinated and diverse offer and reduce barriers to moving more.
- Healthy ageing 'inequalities experienced by ethnically diverse communities'

8.40 Healthy Communities and Primary Care

This workstream takes an asset-based, community-focused approach to tackling health inequalities. The team has close working relationships with local partners and are specialists in locality public health, implementation, primary care and inclusion health.

Specific work to address health inequalities includes:

- Intelligence, advice and support to improve health and reduce health inequalities in priority wards, including Health Needs and Asset Assessments, advice and support on community centred approaches, leading public health input to inner city Local Care Partnerships, working with councillors.
- Leading and supporting projects with places of worship and culturally diverse communities.
- Specific projects in communities to reduce inequalities, e.g. Heating on Prescription.
- Commissioned services/funded projects – Better Together community health development; supporting health and wellbeing for Gypsy and Traveller communities; Roma grants; Women's health matters work with refugees and asylum seekers; Community Champions, small action focussed grants for the Health Needs and Asset Assessments.
- Strategic public health leadership for migrant health through the Migrant Health Board.
- Strategic coordination of Inclusion health across Public Health and alignment, and collaboration with system partners to champion the needs of inclusion groups that experience extreme health inequalities.
- Supporting primary care to understand and reduce health inequalities in their area through supporting PCNs to develop priorities for their local population and connect to wider determinants, and specific projects and tools for primary care (e.g. health inequality infographics, health inequalities toolkit, health equity work programme)
- Leading the supporting the Public Health role on the Neighbourhood health model

8.41 Health Protection

Reducing the impact of heat:

The Director of Public Health Annual Report: **'Heat in the City- Our Health in a Warming Leeds' 2025 was led by the Health Protection team**, now responsible for facilitating delivery of the recommendations. Within the report there is a strong focus on health inequalities and climate vulnerability in relation to impact of heat on health. LCC directorates as well as wider system partners have committed to the implement the recommendations.

8.42 Air Quality:

Indoor air quality projects supporting people with respiratory illness are commissioned and delivered with the third sector, highlighting improved respiratory outcomes from behaviour changes and low-cost interventions.

8.43 Healthcare Infections:

Leeds was identified as having an increase in infections caused by the bacteria MSSA within the community with potential links to intravenous drug use as well as people experiencing homelessness. In response this uptick and as part of the cooperation agreement with LCC, the LCH Infection, Prevention and Control Nursing Team worked with the organisation Forward Leeds to train staff in IPC interventions that could help reduce the risk of infections in service users.

8.44 Seasonal and life course vaccinations:

Public Health work closely with NHS England and the West Yorkshire Integrated Care Board, who are responsible for the routine and winter vaccination programme and are part of a system collaboration to deliver an accessible and equitable offer. Public Health has led on the development of an inequalities plan to improve uptake within communities and at-risk groups to support NHS priorities. Examples of initiatives include working in partnership with organisations to manage grants to deliver work in the lowest uptake areas in Leeds to help protect the most vulnerable communities.

8.45 Other examples include:

- Working with lowest uptake Primary Care Networks to identify trends in uptake and assist with wider interventions to support improvements.
- Development of accessible resources to improve awareness and understanding of the NHS vaccination programme.
- Winter vaccinations inequalities plan has been developed to increase targeted activity on low uptake eligible cohorts.
- Focussed working group to increase uptake of the MMRV vaccination, working across the system to identify opportunities to increase access, improve awareness/uptake. This supports our approach in preventing outbreaks in areas of deprivation.
- Working closely with the School Aged Immunisations Service to increase uptake of school aged vaccination uptake, improve consent, build on working relationships with schools to allow successful vaccination programmes to be delivered.

- Delivery and implementation of the community vaccination champions and grants programme to raise awareness and understanding of the NHS vaccination programme (priority MMRV vaccination), working with third sector organisations to deliver.

8.46 Anti-microbial resistance (AMR) & antibiotic awareness:

Several public awareness and education initiatives in 2025 with the aim of raising public awareness of antibiotic use and safe disposal and reduce health inequalities associated with antimicrobial resistance.

- Campaign targeting a high prescribing area in Leeds using multiple approaches across primary care, pharmacy, third sector and education.
- 2nd campaign focused on communities disproportionately affected by AMR, where access to prescribed antibiotics from primary care was lower but where anecdotal evidence suggested of inappropriate use and purchasing of antibiotics and reduced health literacy.

8.47 Investment in the 'Beat It' educational sessions, targeting primary schools in higher prescribing areas which are often in more deprived areas. Interactive lessons are delivered to key stage 1 & 2 children on infection prevention, self-care and the appropriate use of antibiotics. Children are also provided with information and activities to take home with them so they can discuss the topic with their families.

8.48 Weather Health:

Strategic programme of work across the public health directorate and with wider system partners to ensure that the UK Health Security Agency Adverse Weather & Health Plan recommendations are understood and actioned. Work is focused the prevention of weather-related illness and harm both within the general population but also within targeted cohorts such as older people, clinically vulnerable, children and babies. Examples of work include:

- Training for hospital discharge staff on preventative winter messages & services to prevent re-admissions/stay well at home.
- Training for 3rd sector providers to signpost to services including support around the fuel poverty, pension credit, Cost of living & mental health)
- Development of resources for use by home care providers when visiting vulnerable service users at home including winter wellness bags which contained thermal cups, information on services, winter wellness checklists and home thermometers.
- Winter wellness resources have also been provided to the community hubs this year including thermal cups and home thermometers for eligible service users.

8.49 Response to outbreaks of infectious disease:

Evidence highlights the burden of infectious diseases on people living in areas of high deprivation which can be seen in many outbreaks within Leeds such as Measles.

8.50 LCC works closely with system partners to address health inequalities in outbreak responses, including working with faith and community leaders, improving access to

vaccinations, and providing accessible information such as translated and audio materials.

8.51 Parasites (bedbugs & scabies):

Infestations of parasites such as bedbugs and scabies are most prevalent in areas of deprivation and are often a result of people living in deep poverty in houses of multiple occupation, without access or an awareness of the resources needed to clear infestations.

8.52 Health protection, IPC and environmental health colleagues have produced Translated resources have been developed for education and community groups.in 14 languages providing information on parasites, how to prevent them and where to access support.

8.53 Working with the WY ICB – treatment for scabies has been added to the local pharmacy first scheme to aid prompt, accessible treatment of infections without the need to access a GP appointment. Accessible, translated information has also been produced to support the application of treatment creams to ensure eradication of infections and reduce onward transmission.

8.54 Close working relationships with specialist community Early Help Teams have been established to promote health information and access to treatment.

8.55 Tuberculosis:

- Partnered with trusted community leaders and organisations to develop and disseminate 15 translated TB videos across Leeds communities, to increase awareness of TB and encourage uptake of screening for individuals who may have limited English proficiency.

8.56 Training:

- Delivery of health protection training sessions to the wider workforce to increase awareness of health protection priorities and their links to health inequalities, covering topics such as vaccinations, adverse weather, antimicrobial resistance and TB.

8.57 Sexual Health

Our aim is to improve sexual and reproductive health for everyone in Leeds by focusing on prevention and reducing inequalities. We do this by offering high-quality sexual health services in community, primary care, and clinical settings, supporting young people and vulnerable groups, enhancing HIV prevention and testing and helping the wider workforce develop the skills they need.

- Upskilling the workforce to meet the sexual health needs of young people seldom seen in universal services, based on a workforce needs audit.
- Refreshing LARC delivery model in primary care to improve equity of access for all women.
- Increased investment in Leeds Integrated Sexual Health Service, expanded clinical outreach to vulnerable and marginalised communities.

- Fast-Track Cities initiative: Launched a Health Improvement Fund (£150K from public health grant) to support innovation and cross-partnership projects addressing FTC goals.

Why did we choose these indicators?

This set of Fairer, Healthier (Marmot City) indicators was developed in partnership with the Institute of Health Equity during 2024/25. Further information about how the indicators were identified and the rationale for inclusion can be found at the link below.

Health Inequalities are often complex and entrenched. Action to address them needs to occur at many levels and often over significant periods of time. These indicators are therefore intended to be reviewed regularly over the next 5 – 10 years.

They operate as ‘Sentinel’ indicators. There are a number of measures that could have been chosen for inclusion– those that have been identified provide an overview of inequalities as observed across the social determinants of health and some key health outcomes.

A key criteria for inclusion was that measures could be disaggregated by ward or IMD decile. This means that the slope of inequality is clearly visible as an orange line in the majority of the indicators. Over time, this set of indicators will therefore enable stakeholders in the city to assess how well Leeds is achieving its goal of improving the health of the poorest the fastest.

The Best City Ambition (BCA) seeks to address poverty and inequality and has therefore adopted the Fairer Healthier Leeds indicators as a core part of the Ambition Outcomes Framework. In the BCA they sit alongside some wider social and economic indicators, but where possible the Marmot approach to disaggregation has been adopted to further embed the ethos of this work.

MARMOT indicator summary page

(Issued June 2025)

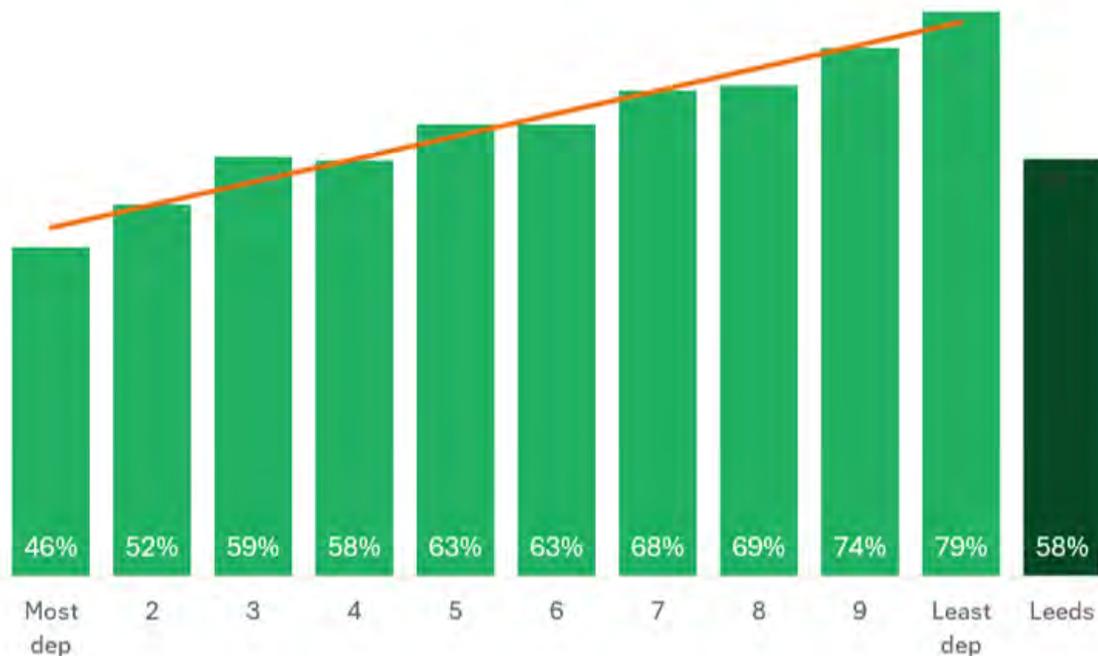
	Date	Leeds Marmot indicator	Unit
1	2020-22	Life expectancy at birth in years (male)	years
	2020-22	Life expectancy at birth in years (female)	years
2	2021-23	Babies with low birth weight , rate per 1,000 live births	per 1,000
3	2023/24	Children with a healthy weight , Reception (4-5 years old)	%
4	2022/23	Pupils achieving a good level of development at end of Reception	%
5	2022/23	Pupils meeting expected standards in reading, writing and maths (combined) end of Key Stage 2	%
6	2022/23	Average Attainment 8 score	%
7	2022/23	School children feeling happy every or most days	%
8	Dec-23 to Jan-24	16-17 year-olds not in employment, education, or training (NEET)	%
9	Jan-23	Common mental health issues, recorded by GPs, all ages*	per 100,000
10	Jan-23	Severe mental illness , recorded by GPs, all ages*	per 100,000
11	Jul-23	Physical inactivity , recorded by GPs, adults 50+ years	%
12	2024	People earning less than UK Real Living wage Full time / Part time	%
13	Q3 2024	Households in temporary accommodation	count
14	In development	Households in fuel poverty - annual	
15	In development	Workforce by ethnicity (TBC)	

About these slides - What are the charts showing?

How to read the Decile chart

The **decile** chart explores variation within Leeds through the lens of **deprivation**. Most health and wellbeing data varies strongly with deprivation, with the worst outcomes found in the most deprived areas.

The sloping orange line is the 'line of best fit' through the deprivation lens, its angle is the *average change for every change in deprivation*.



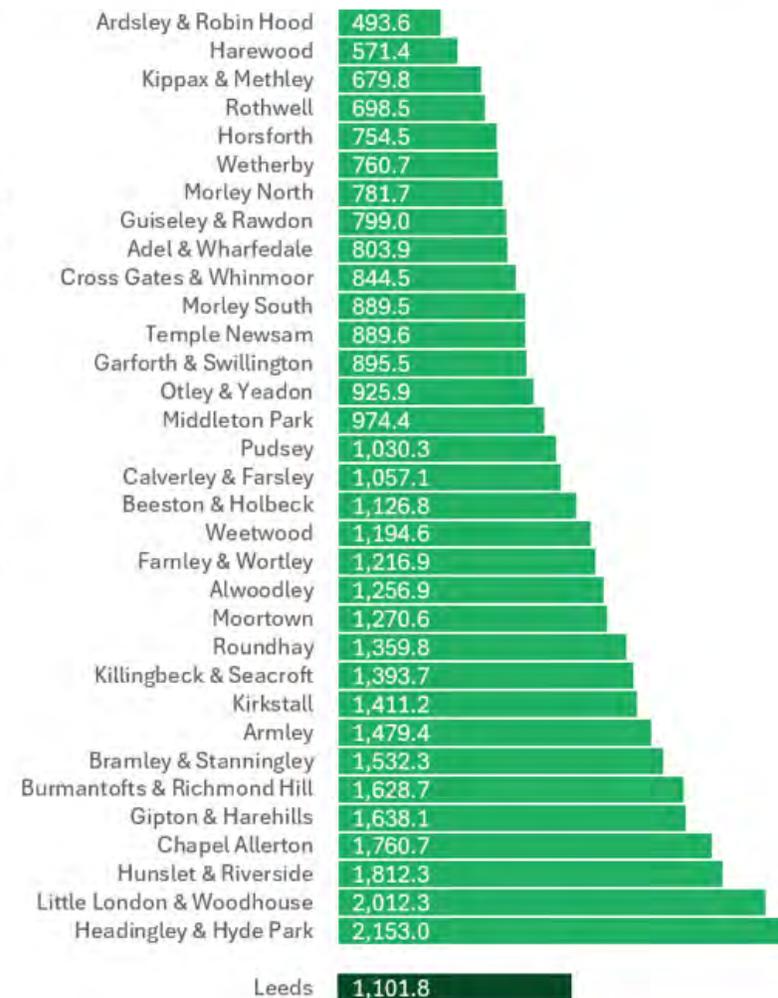
Reading the right hand chart

The right hand chart looks through an alternative lens, where possible this is of **ethnicity**, if this is not available then the data is shown by **ward**.

The chart shows how the indicator varies across Leeds.

Many indicators vary a lot within the city, and some areas and groups are much more seriously affected than others.

Bear in mind that ethnic groups can have considerable differences in population size.

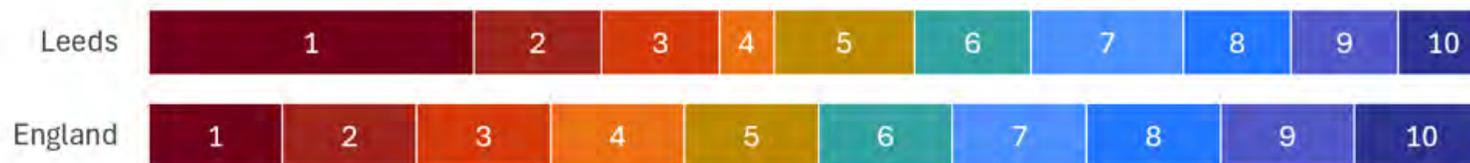


About these slides - Deprivation in Leeds is not the same as it is in England

Deprivation for everyone

A far greater proportion of our population live in areas within the most deprived decile of England, **24% compared to 10% in England overall**

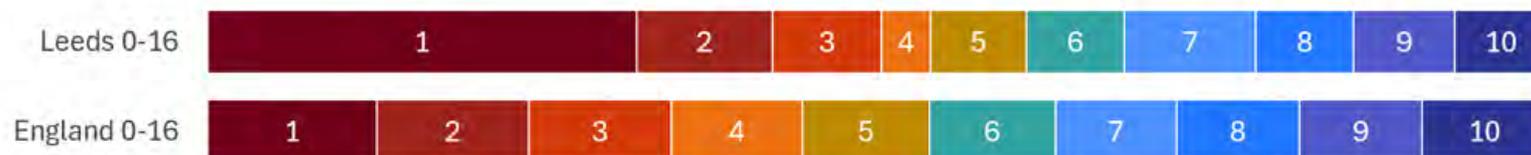
This chart compares the entire population of Leeds against England by deprivation decile, where 1 is most deprived and 10 is least deprived



Children and deprivation

For children in Leeds, the picture is even more extreme. **32% of children in Leeds live in the English most deprived decile, compared to 13% in England overall**

This chart compares the 0-16 populations of Leeds and England, where 1 is the most deprived and 10 is least deprived



Deprivation deciles

Are what happens when you divide *England* into ten areas from the most deprived 10% to the least deprived 10% etc...

If Leeds were the same as England, we would see 10% of our population in each deprivation decile.

Deprivation fifths

Two indicators in this report are displayed by deprivation fifths

These are areas of Leeds that result when it is divided into 5 equal groups, from the most to least deprived. They are used if an indicator cannot be produced by Deprivation Decile.

Sources

Comparisons on this page are made using ONS Mid year estimates 2022, alongside IMD2019 deprivation scores

About these slides - Ethnicity in Leeds

Ethnicity

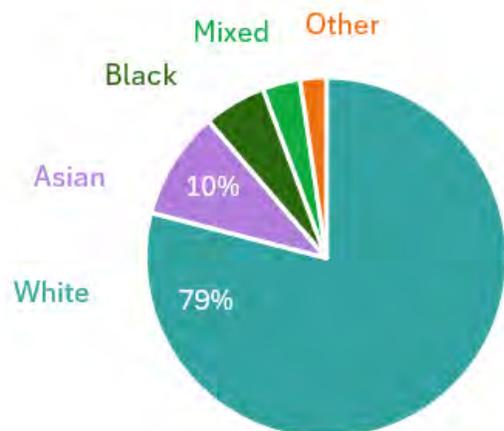
Ethnicity is often recorded at source.

It is useful to remember that some ethnic groups are much larger than others - rates for some ethnic groups will contain far more people than others

This page shows the Leeds population by ethnic category and group as reported by the 2021 Census. We are showing this here to give a general overview of the Leeds population

Sometimes where groups are very small ethnicity needs to be generalised or aggregated over time to keep groups a good size for reporting

Ethnicity categories in Leeds



Census ethnic category	Census ethnic group	Group total	Category total
White	English, Welsh, Scottish, Northern Irish or British	595,737	641,801
	Other White	36,684	
	Irish	6,892	
	Roma	1,610	
	Gypsy or Irish Traveller	878	
Asian, Asian British or Asian Welsh	Pakistani	31,405	78,503
	Indian	21,087	
	Other Asian	12,018	
	Chinese	8,117	
	Bangladeshi	5,876	
Black, Black British, Black Welsh, Caribbean or African	African	32,211	45,376
	Caribbean	7,889	
	Other Black	5,276	
Mixed or Multiple ethnic groups	White and Black Caribbean	10,028	27,388
	White and Asian	7,410	
	Other Mixed or Multiple ethnic groups	5,656	
	White and Black African	4,294	
Other ethnic group	Any other ethnic group	12,905	18,885
	Arab	5,980	
			811,953

Male life expectancy at birth

The orange line shows male life expectancy at birth increases with lower levels of deprivation

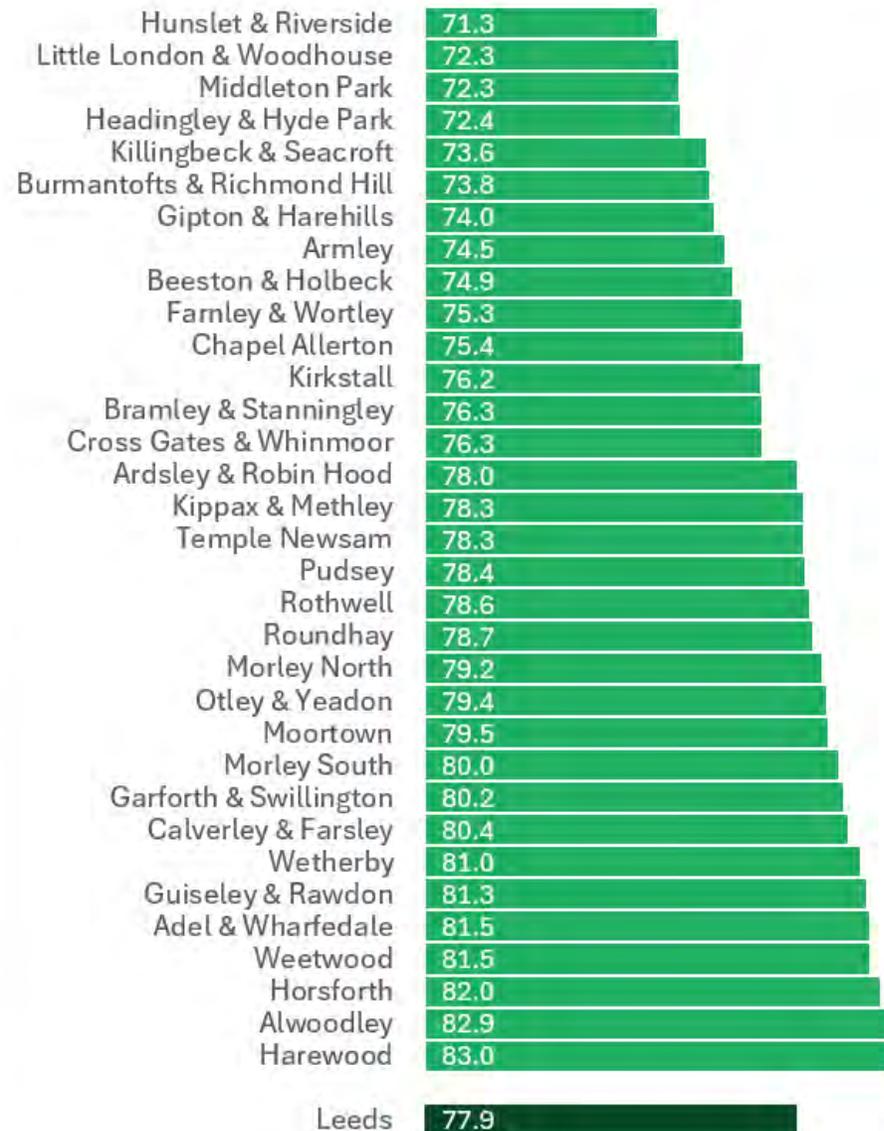
There are very large inequalities between the deprivation deciles of Leeds, overall they make an average Leeds male life expectancy of just under 78 years

At ward level life expectancy for men varies by more than 11 years

Male life expectancy at birth, 2020/22 by IMD decile, in years
(note the y-axis starts at 60 years)



Male life expectancy at birth, 2020/22 by ward (note y-axis starts at 60 years)



Female life expectancy at birth

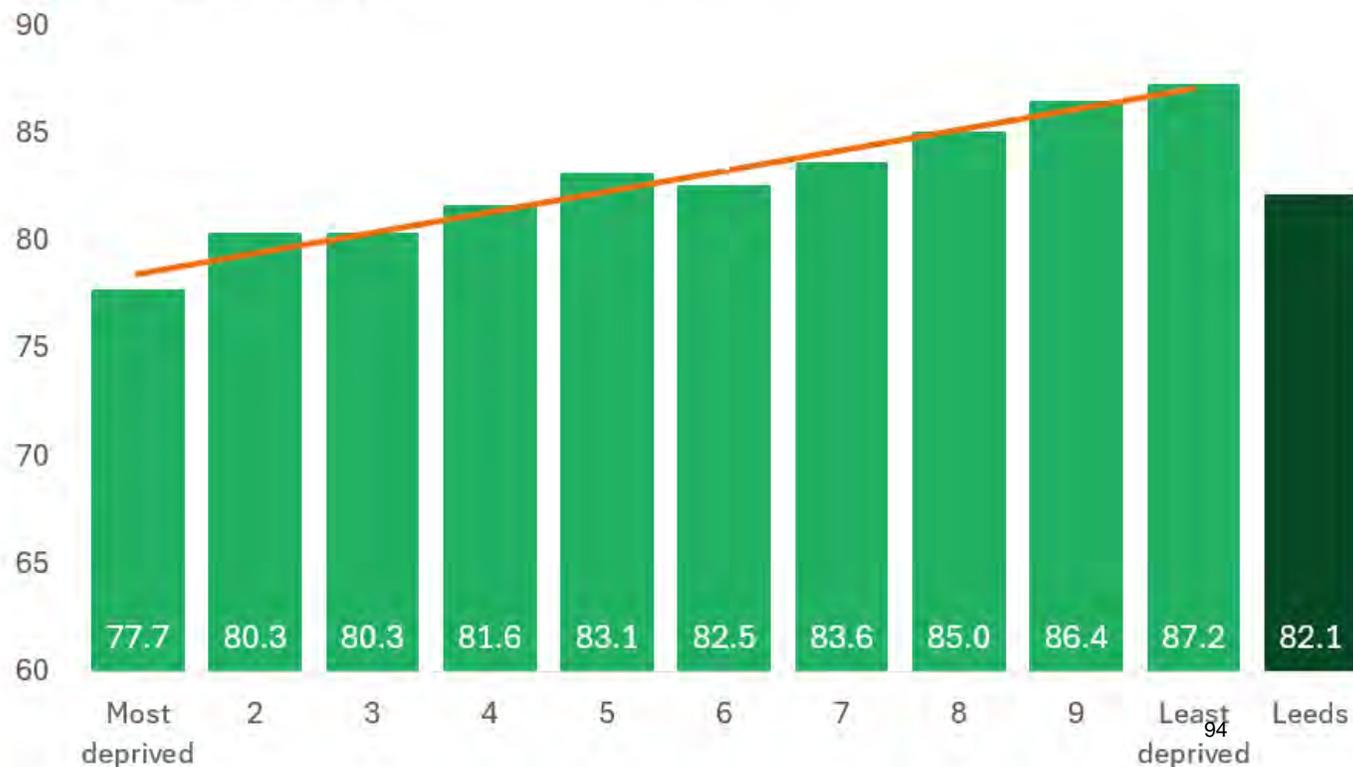
The orange line shows female life expectancy at birth increases with lower levels of deprivation

There are very large inequalities between the deprivation deciles of Leeds, overall they make an average Leeds female life expectancy of just over 82 years

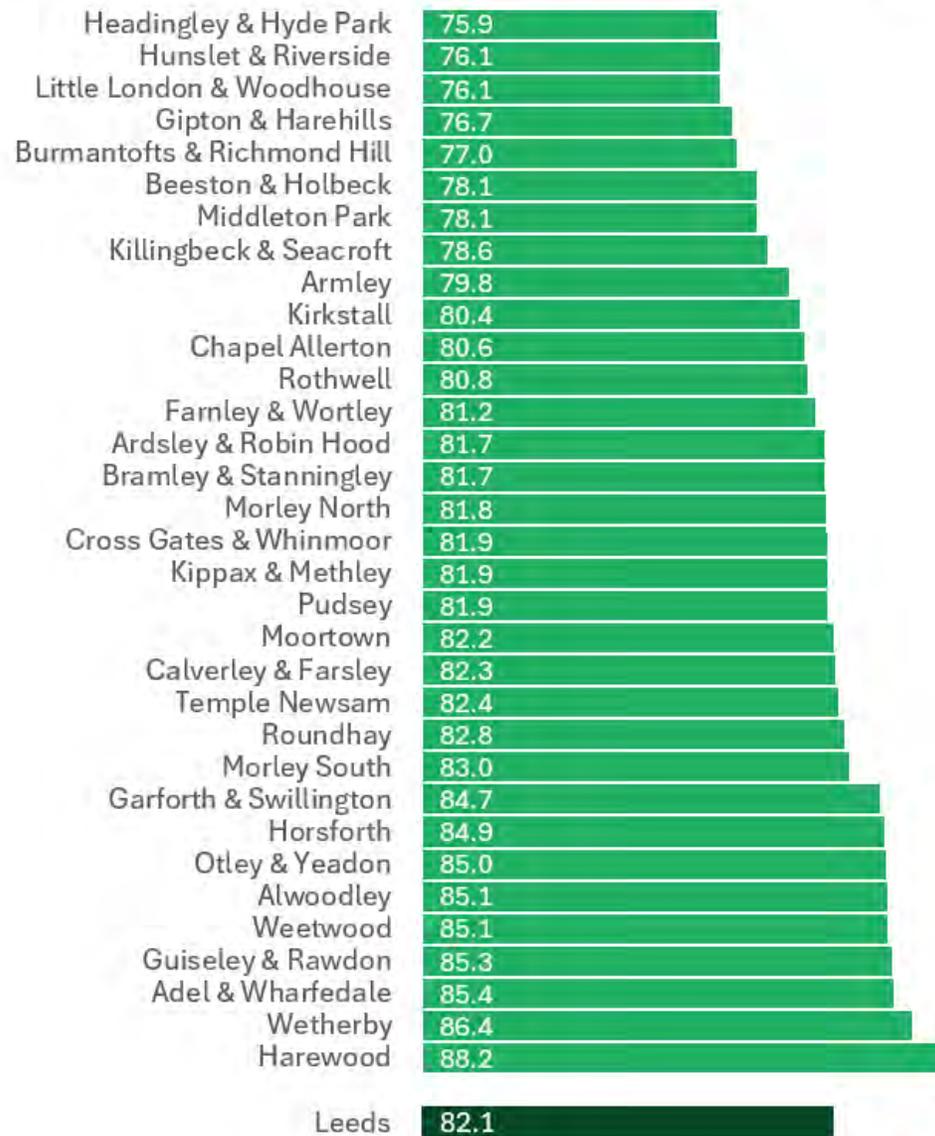
At ward level life expectancy for females varies by more than 12 years

Female life expectancy at birth, 2020/22 by IMD decile, in years

(note the y-axis starts at 60 years)



Female life expectancy at birth, 2020/22 by ward (note y-axis starts at 60 years)



Babies with low birth weight. Rates per 1,000 live births

(Issued June 2025)

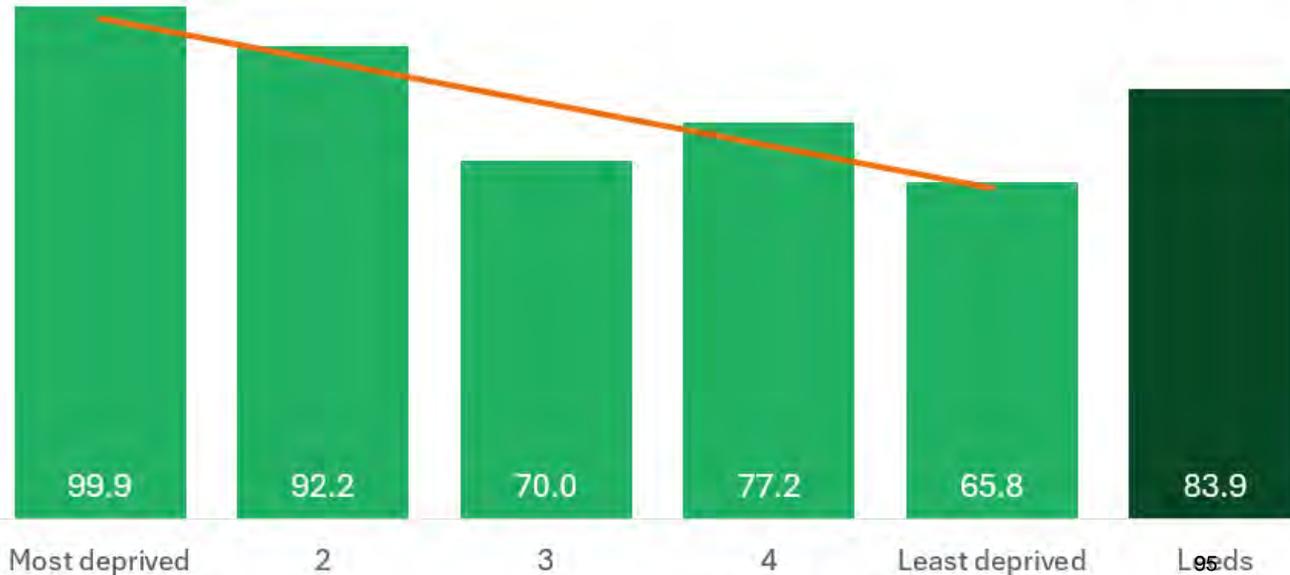
The orange line shows low birth weight rates tend to **improve with lower levels of deprivation**

The most deprived parts of Leeds have the highest rates of low birth weight, the Leeds average low birth weight rate is around 84 low weight births per 1,000 live births

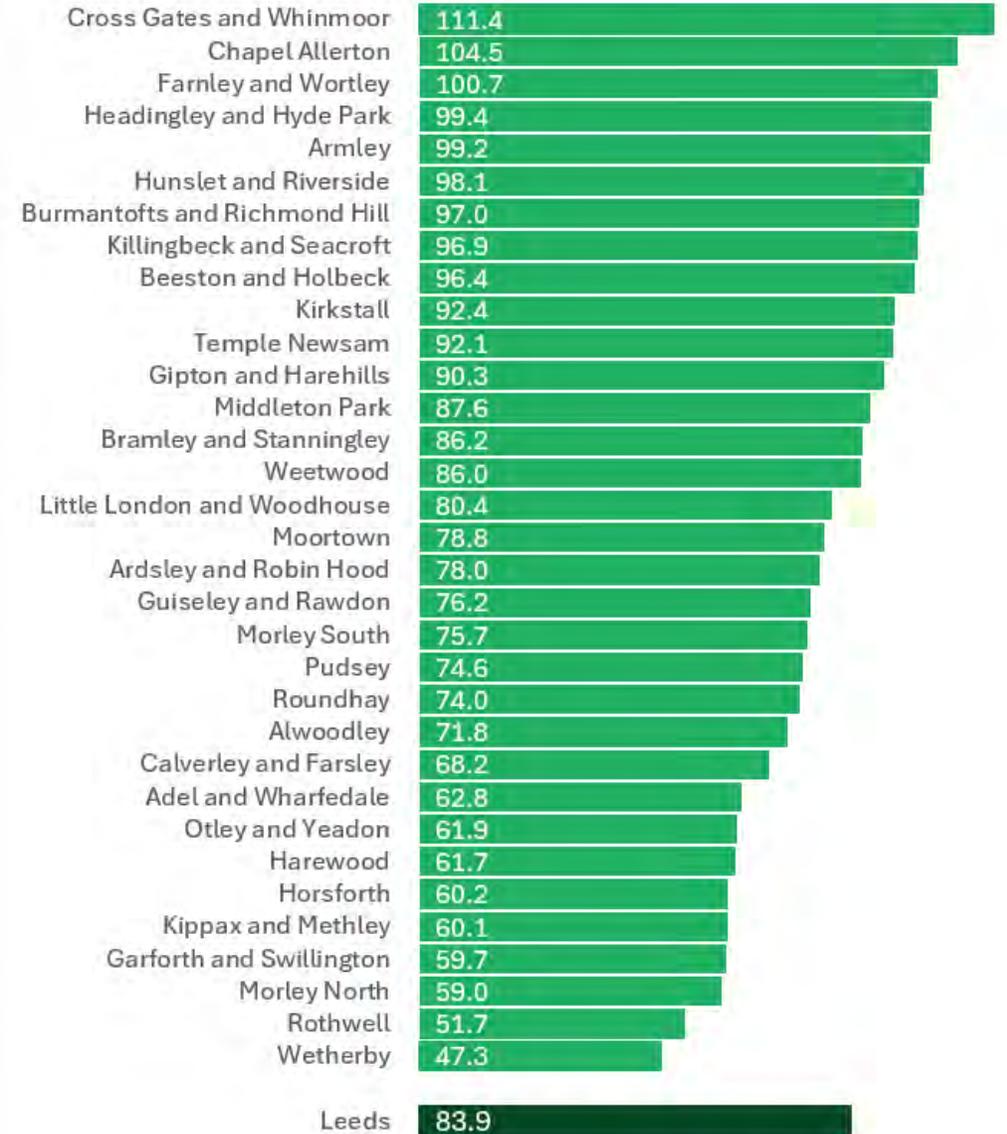
Wards vary greatly, Wetherby ward has a rate less than half that of Crossgates & Whinmoor

Low birth weight is associated with increased risk of infant mortality, developmental problems in childhood and poorer health in later life

Low birth weight, Leeds deprivation fifths, persons, 2021-2023



Low birth weight rates per 1,000 live births, wards, 2021-2023



Child healthy weight rates, Reception classes (ages 4-5)

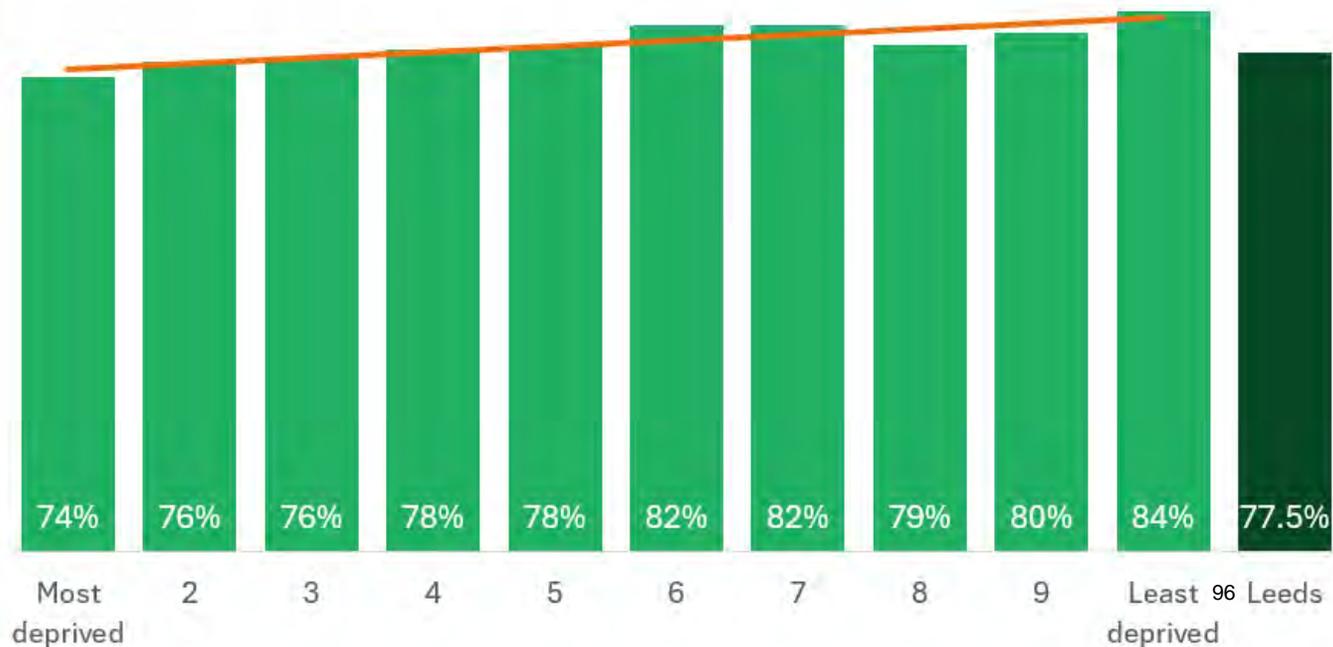
The orange line shows that child healthy weight rates tend to **improve with lower levels of deprivation**

Already, by 4-5 years of age children in more deprived areas are less likely to be an healthy weight, overall 77.5% of Reception-age children in **Leeds** are a healthy weight

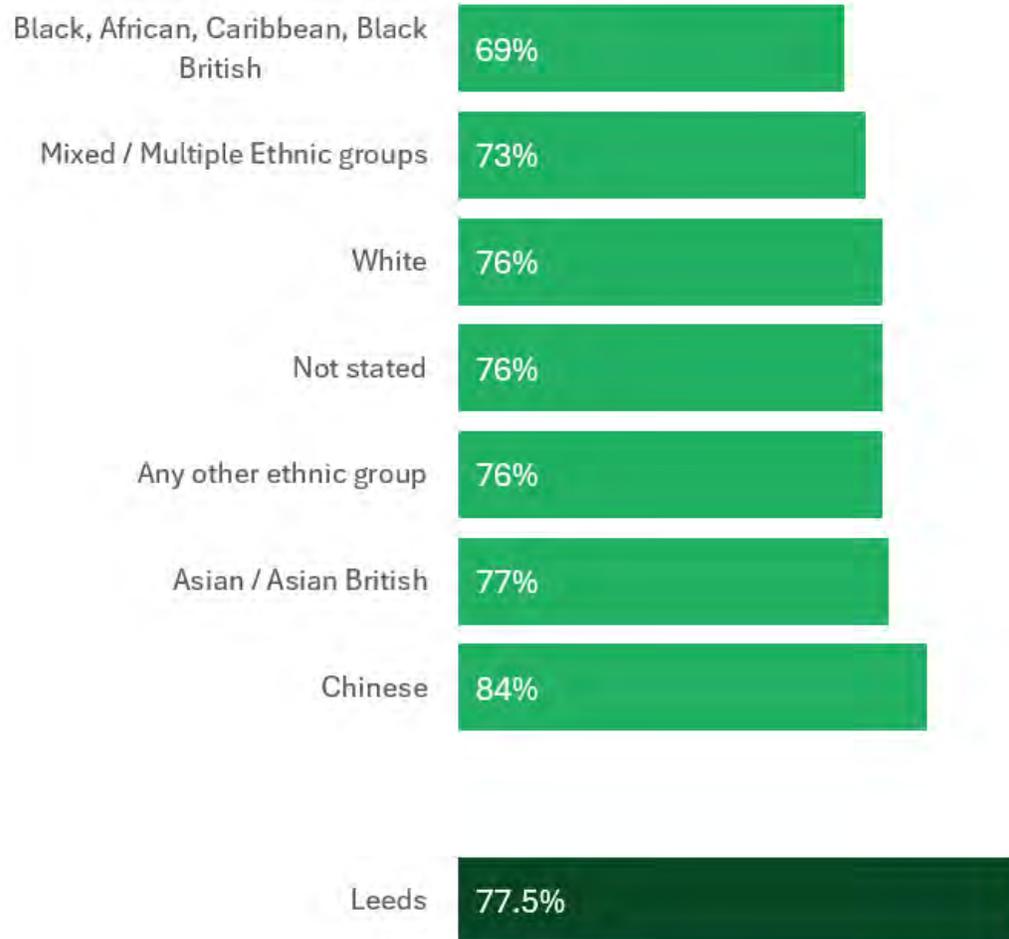
The 'Black / African / Caribbean / Black British' group has the lowest rate. Note that grouping by ethnicity requires a five year range to account for some small groups

Research shows children who stay a healthy weight tend to be fitter, healthier, better able to learn, and more self-confident

Child healthy weight rates in deprivation deciles, Reception class 2023/24



Child healthy weight rates by ethnic description, Reception 2019/20 to 23/24



Pupils achieving a good level of development at end of Reception (ages 4-5)

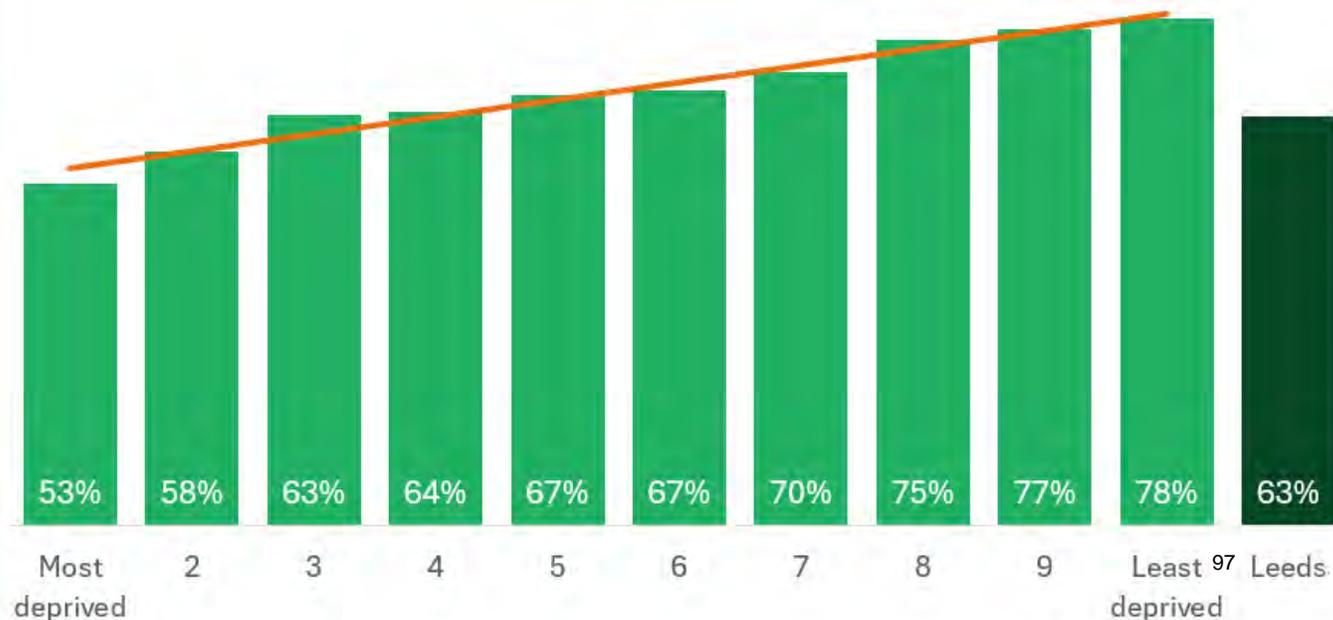
The orange line shows that development rates **improve strongly with lower levels of deprivation**

By 4-5 years of age children in more deprived areas are much less likely to have achieved a good level of development, overall 63% of Reception-age children in Leeds meet this level

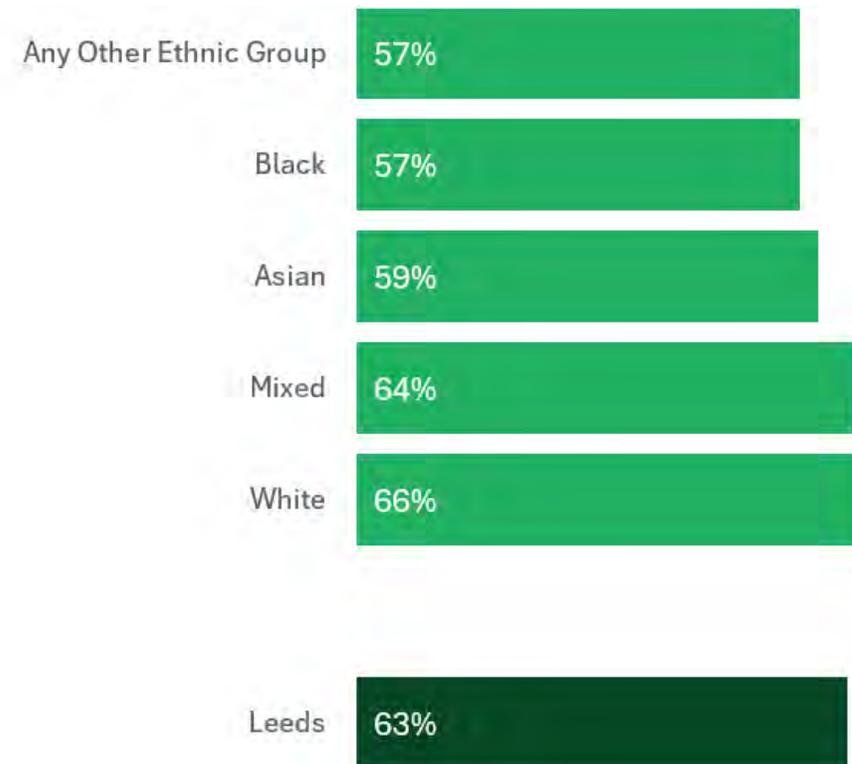
The 'Any other ethnic' and 'Black' categories have the lowest rates

Good level of development includes: communication and language; personal, social and emotional development; and physical development, and the specific areas of mathematics and literacy

Rates of good development at end of Reception year in deprivation deciles, 2022/23



Rates of good development, end of Reception year by ethnic category, 2022/23



Pupils meeting expected standards in reading, writing and maths (combined) end of Key Stage 2

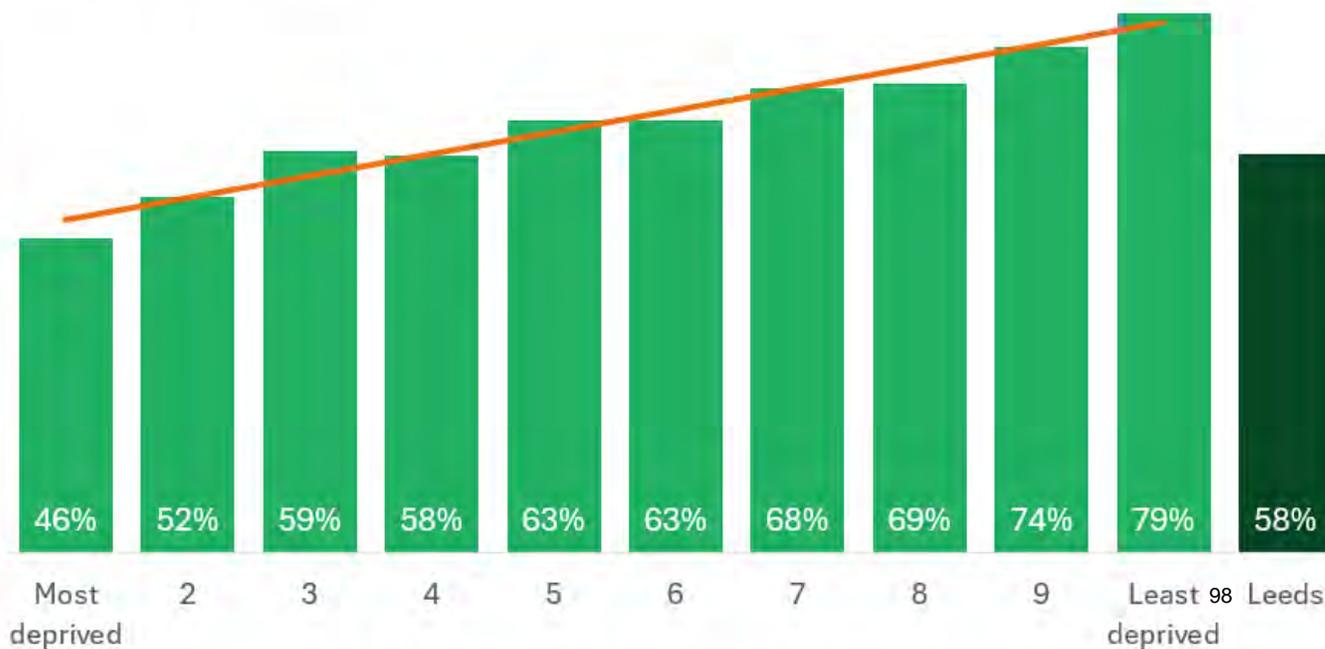
The orange line shows **more pupils meet expected KS2 standards as deprivation lowers**

Pupils in deprived parts of Leeds are much less likely to meet expected standards by the end of KS2. The Leeds overall rate of 58.3% hides these large disparities

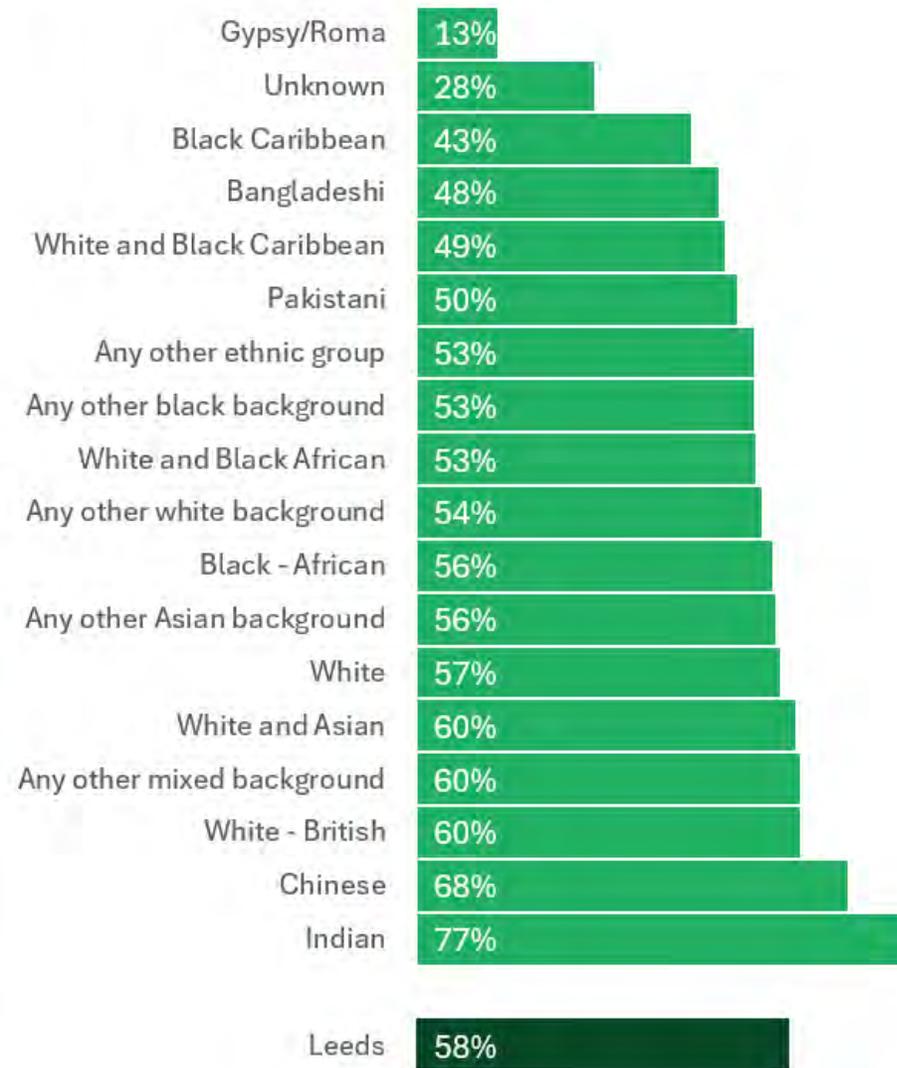
The 'Gypsy/Roma' group has the lowest rate (and a very low number of pupils compared to other groups)

Expected standards are where a pupil demonstrates competency in core subjects like English (reading and writing), maths, and science

Pupils reaching the expected standard in reading, writing, and maths. Percent, 2022/23, Deciles and Leeds



Pupils reaching the expected standard in reading, writing, and maths. Percent, 2022/23, Ethnicity and Leeds



Average Attainment-8 scores

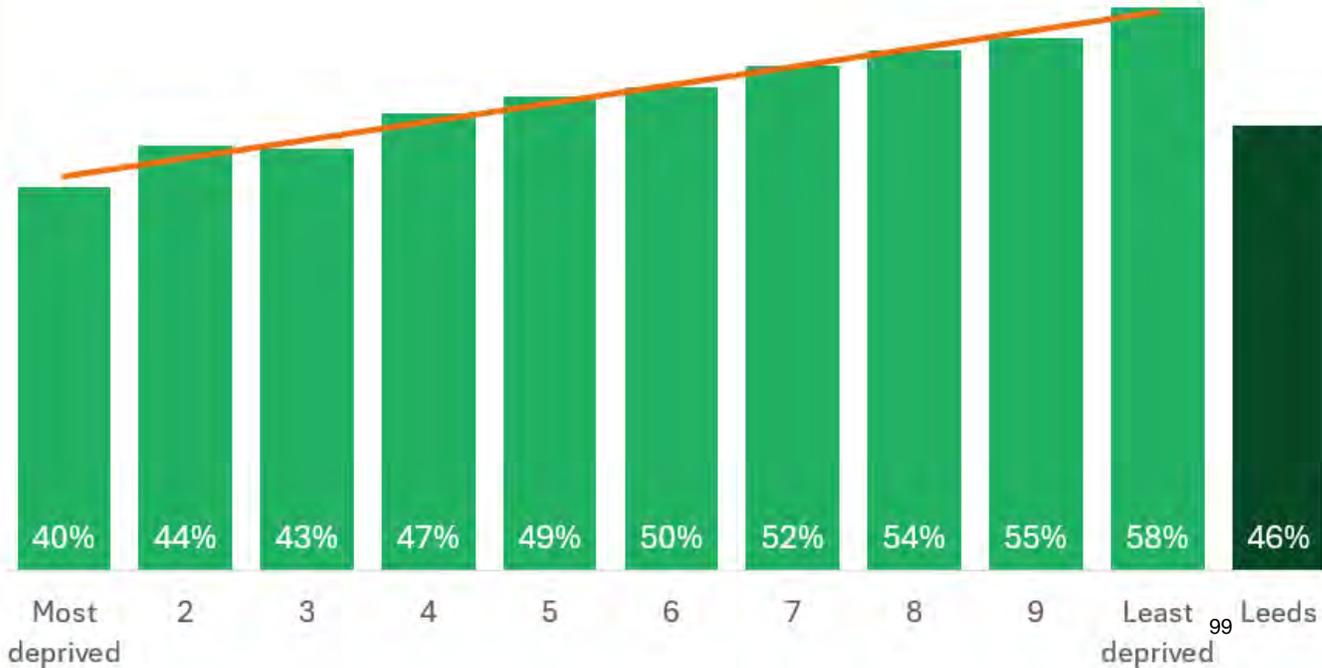
The orange line shows average Attainment-8 rates **strongly improve with lower levels of deprivation**

Attainment scores are much lower in more deprived areas, the Leeds rate of 46% hides very wide variation

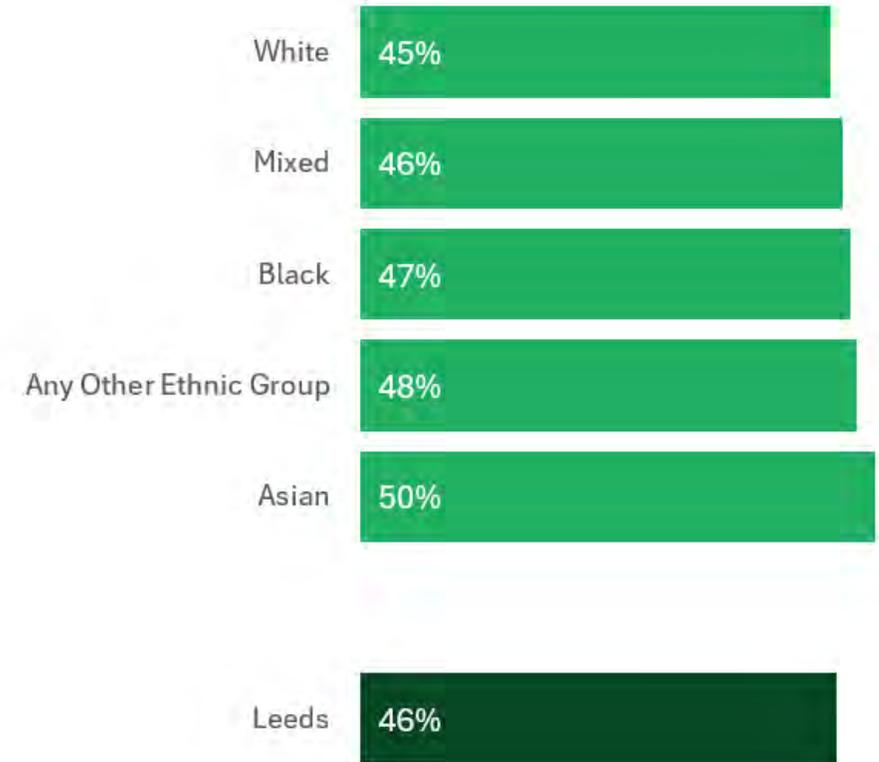
Ethnic categories do not vary as strongly as the deprivation deciles

Attainment 8 is a measure of a student's average achievement in eight GCSE-level subjects

Average Attainment-8 score, deprivation deciles, 2022/23



Average Attainment-8 score, ethnic categories, 2022/23

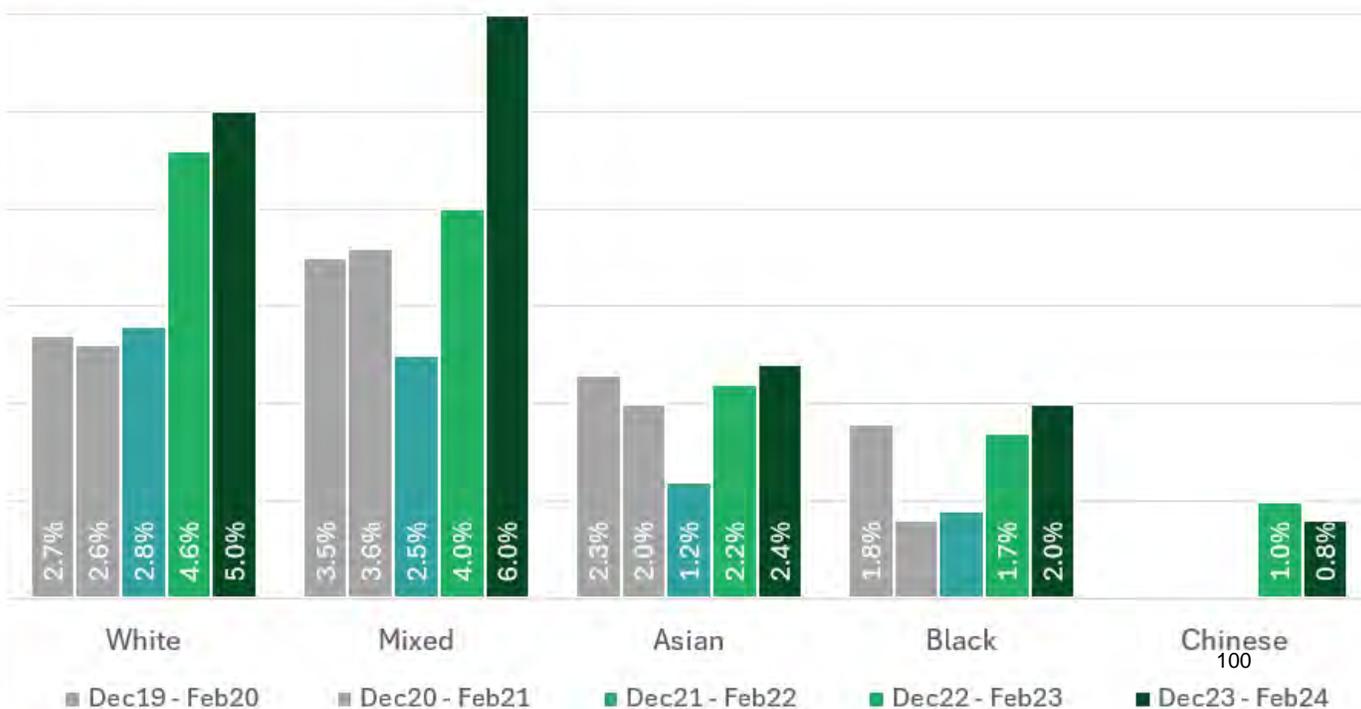


Proportion of 16 and 17 year olds known to be NEET

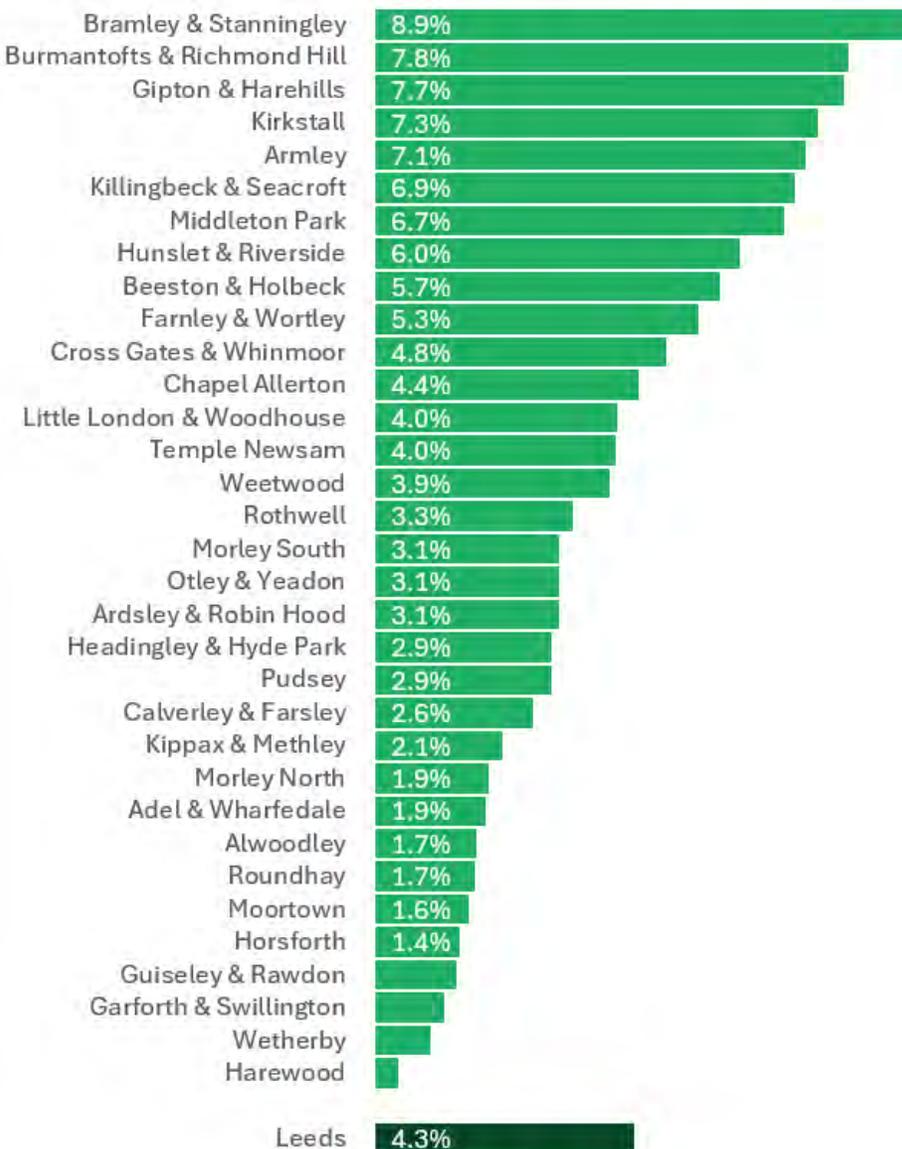
NEET rates have increased recently because LCC has worked to reduce the numbers of young people whose status is unknown. Rates vary enormously at ward level.

The law requires all young people in England to continue in education or training until at least their 18th birthday, although in practice the vast majority of young people continue until the end of the academic year in which they turn 18. Responsibility and accountability lies with local authorities who have a critical role to play in supporting young people to access education and training. This data is from the annual tracking performance indicator which is based on the average figures for December, January and February each year.

Proportion of 16 and 17 year olds known to be NEET, 3 month averages



Proportion of 16 and 17 year olds known to be NEET, 3 month averages

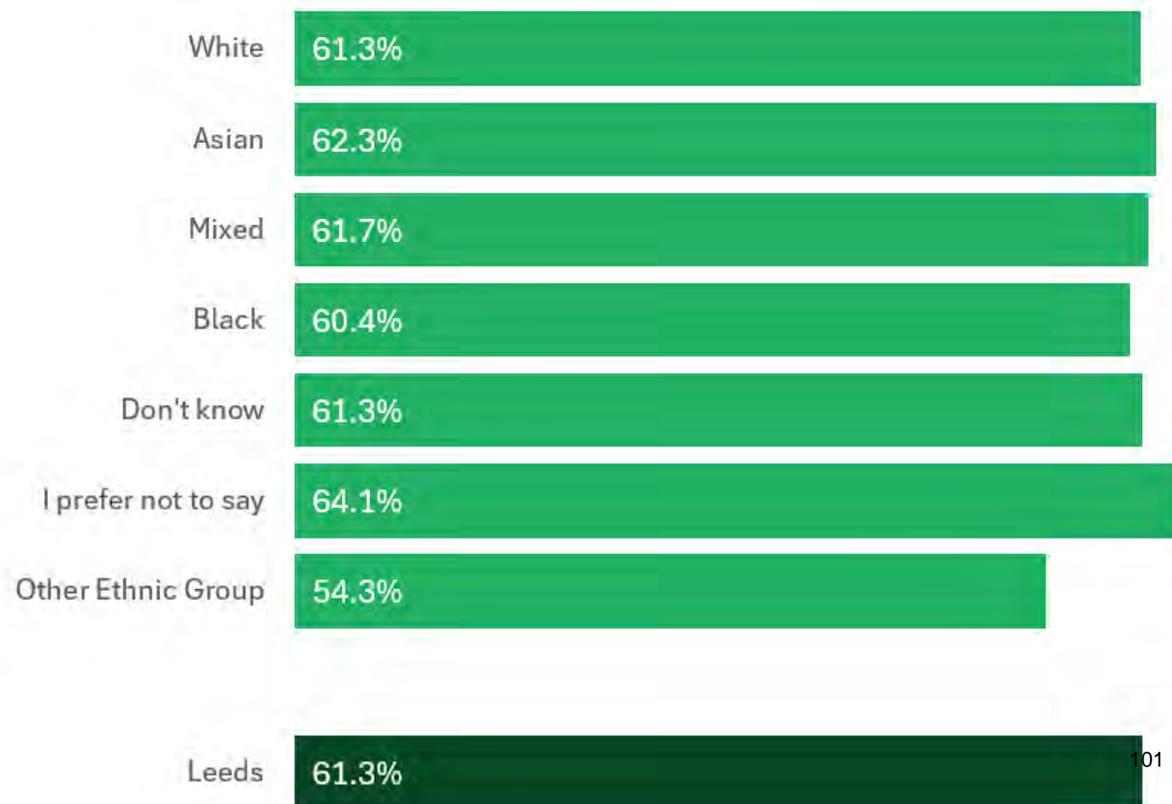


School children who reported feeling happy every or most days

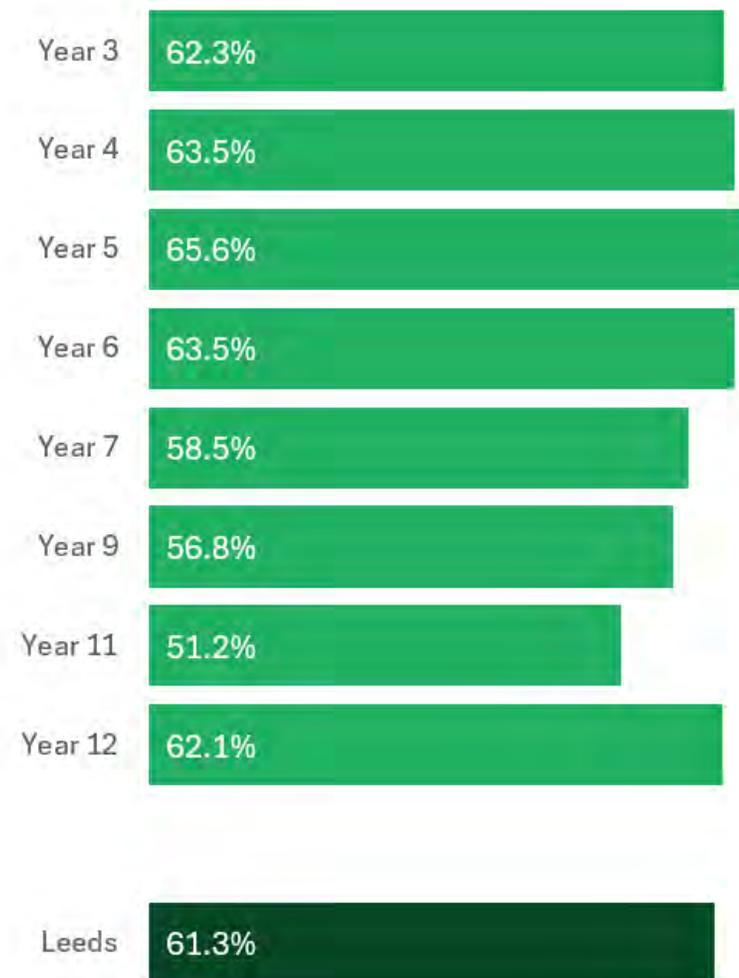
Ethnic groups show very similar rates

The chart shows groups with the most children first, the two groups that are most different to Leeds are the smallest in size. *Note that school survey data is not available at ward level and the school survey is not given to pupils in Years 8 and 10*

School pupils who feel happy most days or everyday (4-7 days a week) by ethnicity, Leeds, 2022/23
Sorted: groups with largest number of pupils are at the top of the chart



School pupils who feel happy most days or everyday (4-7 days a week)
School year, Leeds, 2022/23



GP recorded Common mental health issues, all ages, January 2023

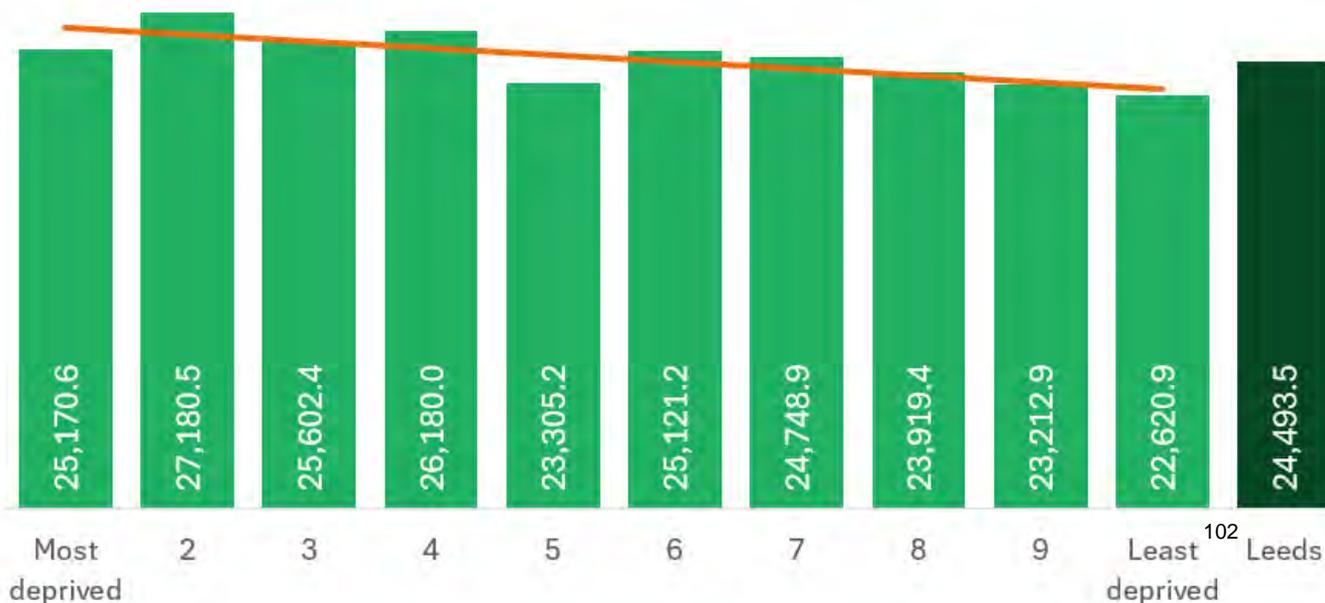
(Issued June 2025)

The orange line shows that rates of common mental health issues are higher in more deprived areas.

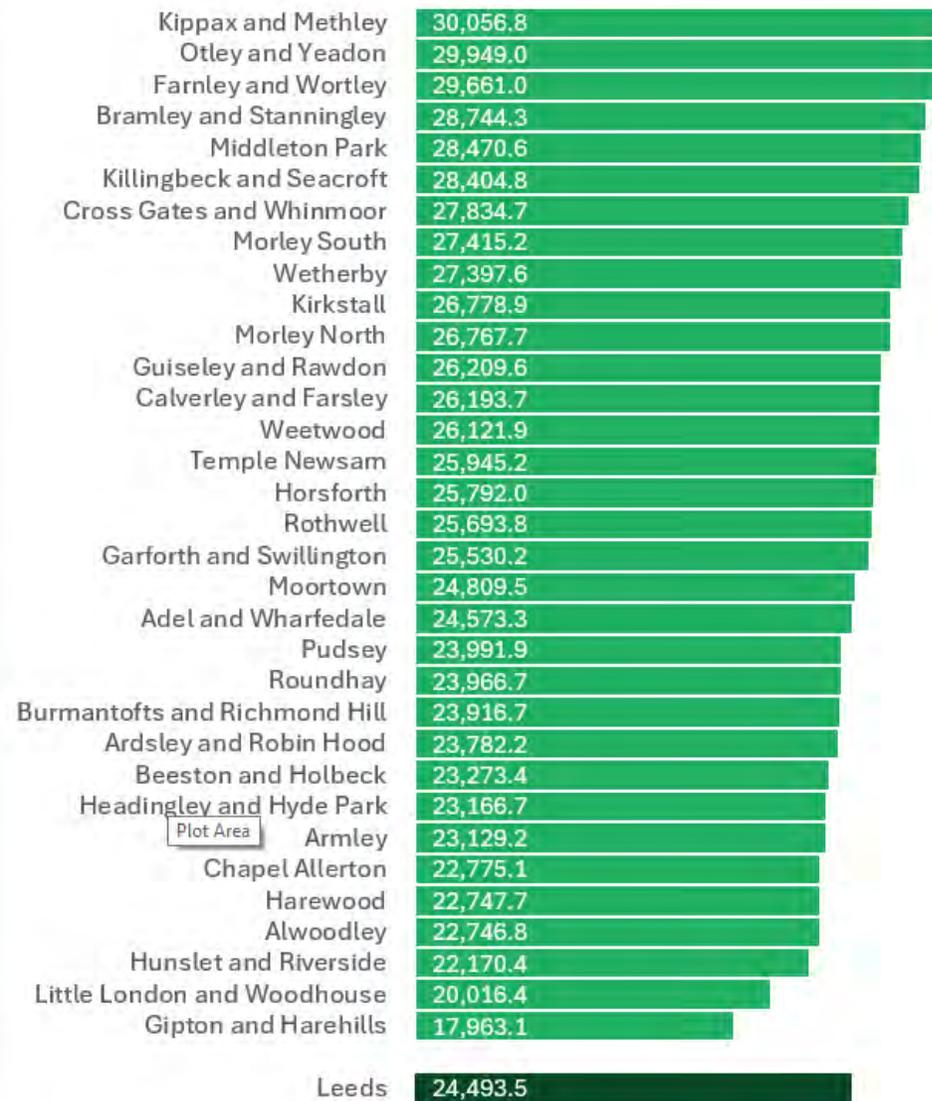
The extent of the inequality in Leeds is likely to be underestimated in the data below. Research suggests that people living in the poorest areas have at least double the risk of developing a common mental health issue but are least likely to receive a diagnosis (and treatment). These figures are therefore unlikely to reflect the total number of people experiencing the condition in the most deprived areas.

In the short term, a positive change in this indicator may be an increase in recording in decile 1 (i.e. for the orange line to be steeper). In the longer term, a positive change would be a decrease in rates across all deciles and a flattening of the orange line.

Common mental health issues, all ages, age standardised rate per 100,000 people



GP recorded Common mental health issues, all ages, ward age standardised rate per 100,000 people



GP recorded serious mental illness, all ages, January 2023

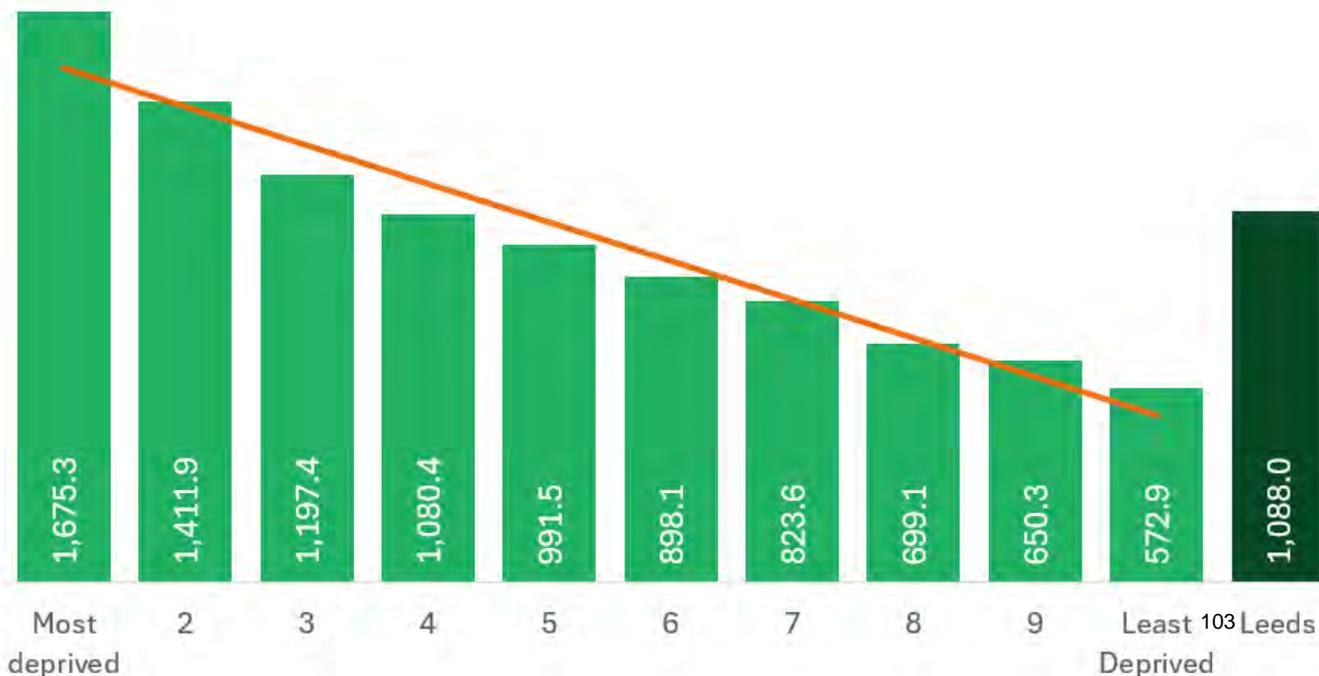
(Issued June 2025)

The orange line shows recorded serious mental illness rates are **higher in more deprived areas**

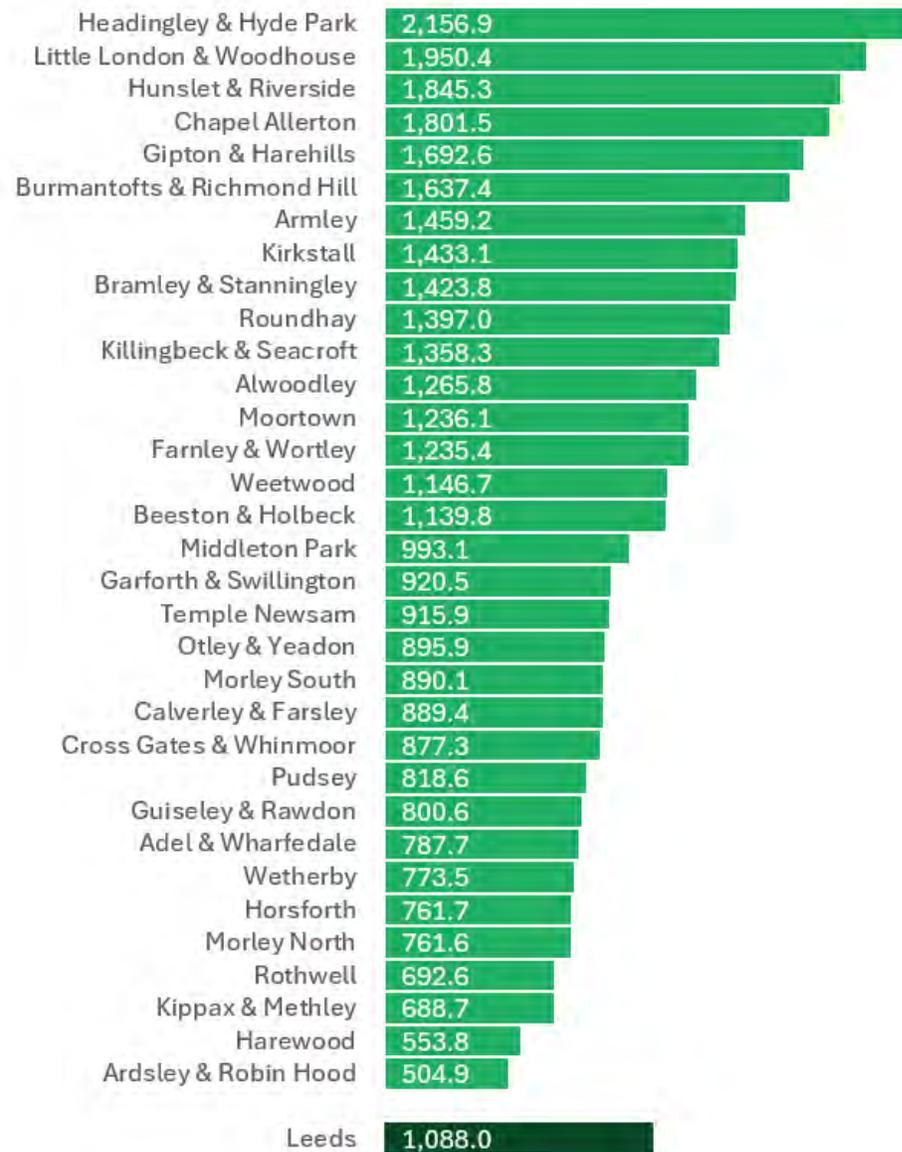
Risk factors for serious mental illness are higher in poorer areas (e.g. trauma and financial strain) and in some cases a loss of earnings is linked to the development of a serious mental illness. A need for supported housing can result in people moving to more deprived areas.

A positive change in this indicator would be a reduction in prevalence, particularly in the most deprived decile.

Serious mental illness, all ages, age standardised rate per 100,000 people



Serious mental illness rates, wards, January 2023



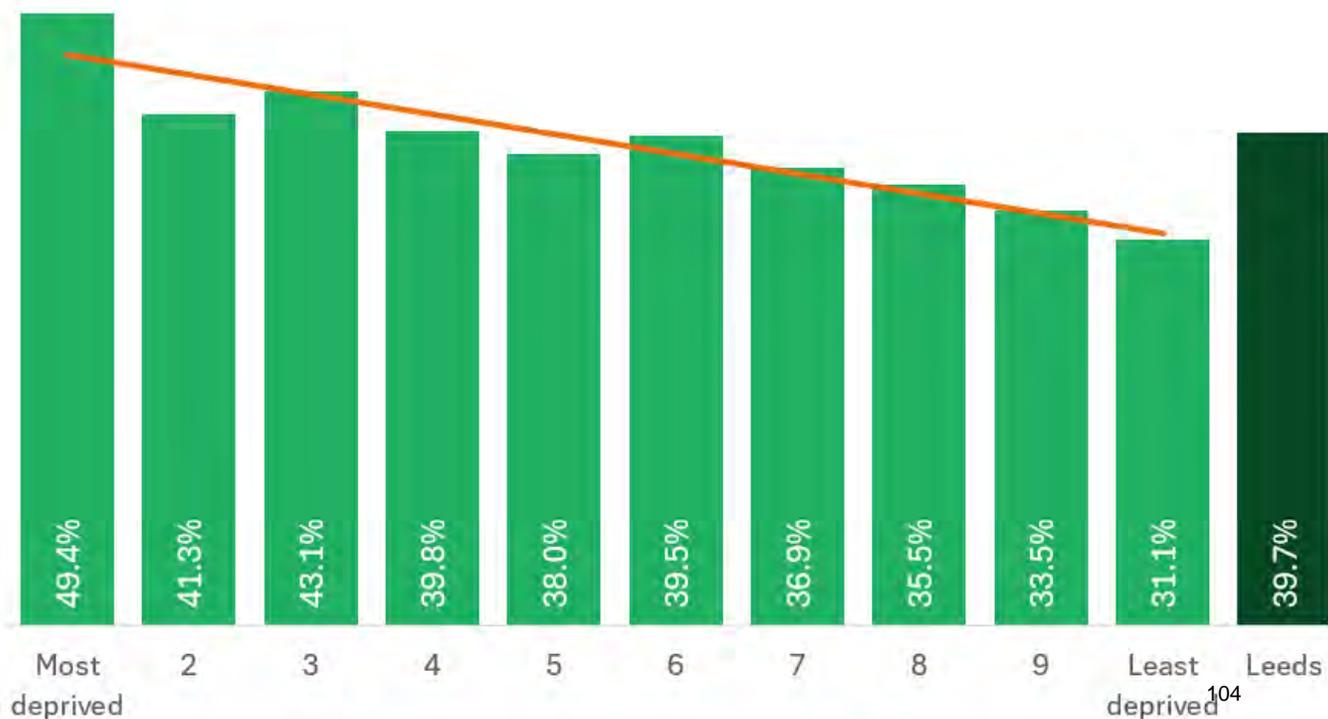
GP recorded physical inactivity. Adults over 50 recorded as being inactive, July 2023

(Issued June 2025)

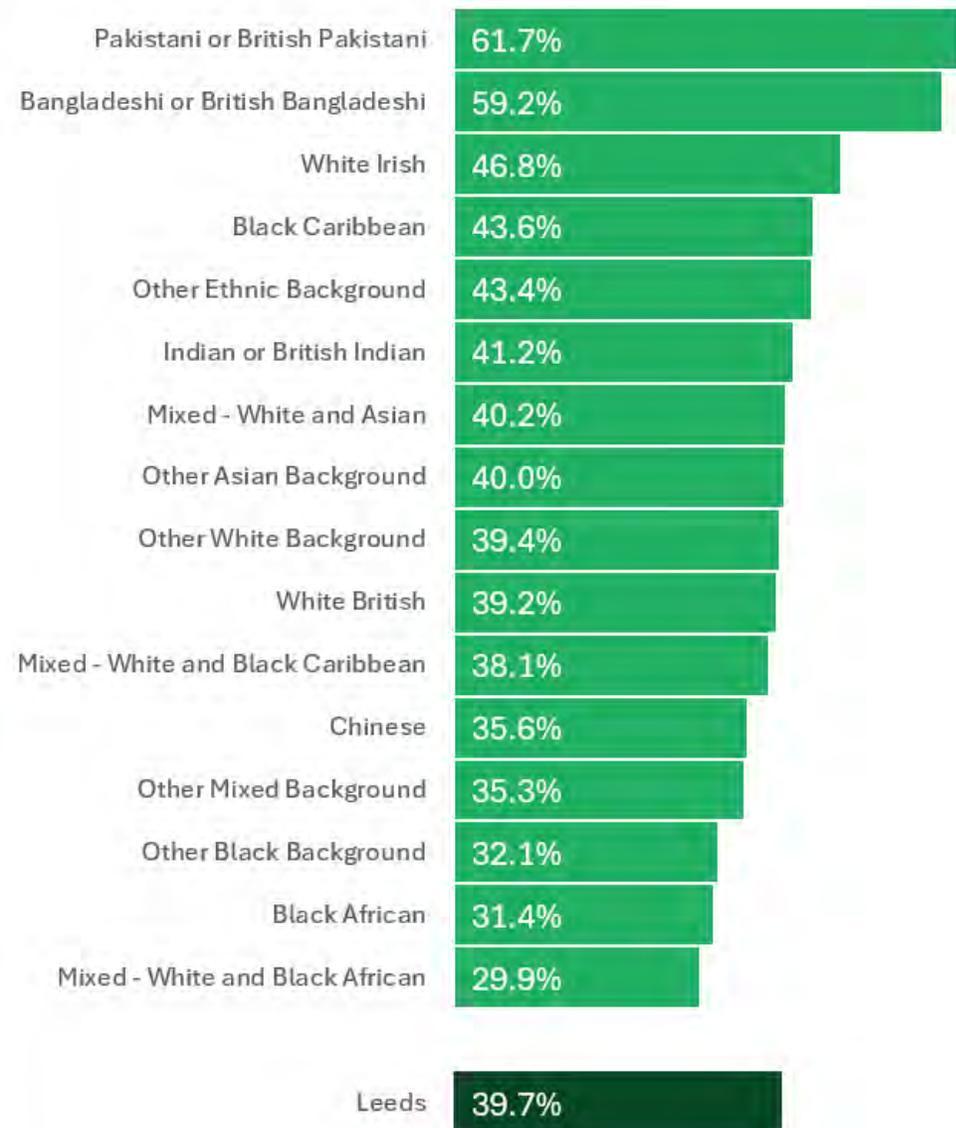
The orange line shows physical inactivity is **more likely in more deprived areas**

Physical inactivity varies drastically and consistently as deprivation changes in Leeds. Rates also vary by ethnic group

Percent of physical inactivity, recorded by GPs, adults 50+ years



Physical inactivity percentage, recorded by GPs, adults 50+ years, ethnicity



People earning less than UK Real Living wage

(Issued June 2025)

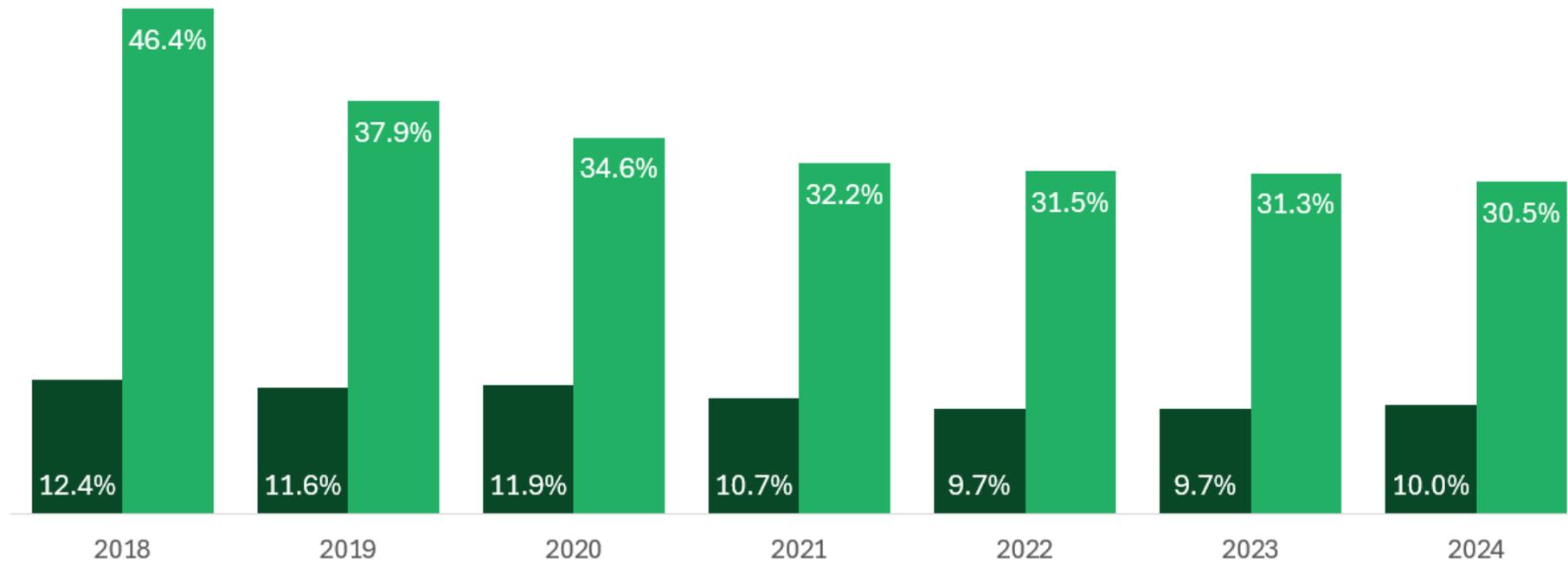
This data is created by the Office of National Statistics from a 1% sample of HM Revenue & Customs PAYE data, it does not cover the self-employed.

This should be considered an estimate with varying levels of confidence, it is useful to look at trends instead of specific values.

The Covid job retention scheme means data for 2020 and 2021 has more uncertainty but the results fit well within the general trend.

Workers earning below the UK Real Living Wage, by time worked, percent, Leeds

■ Full time ■ Part time



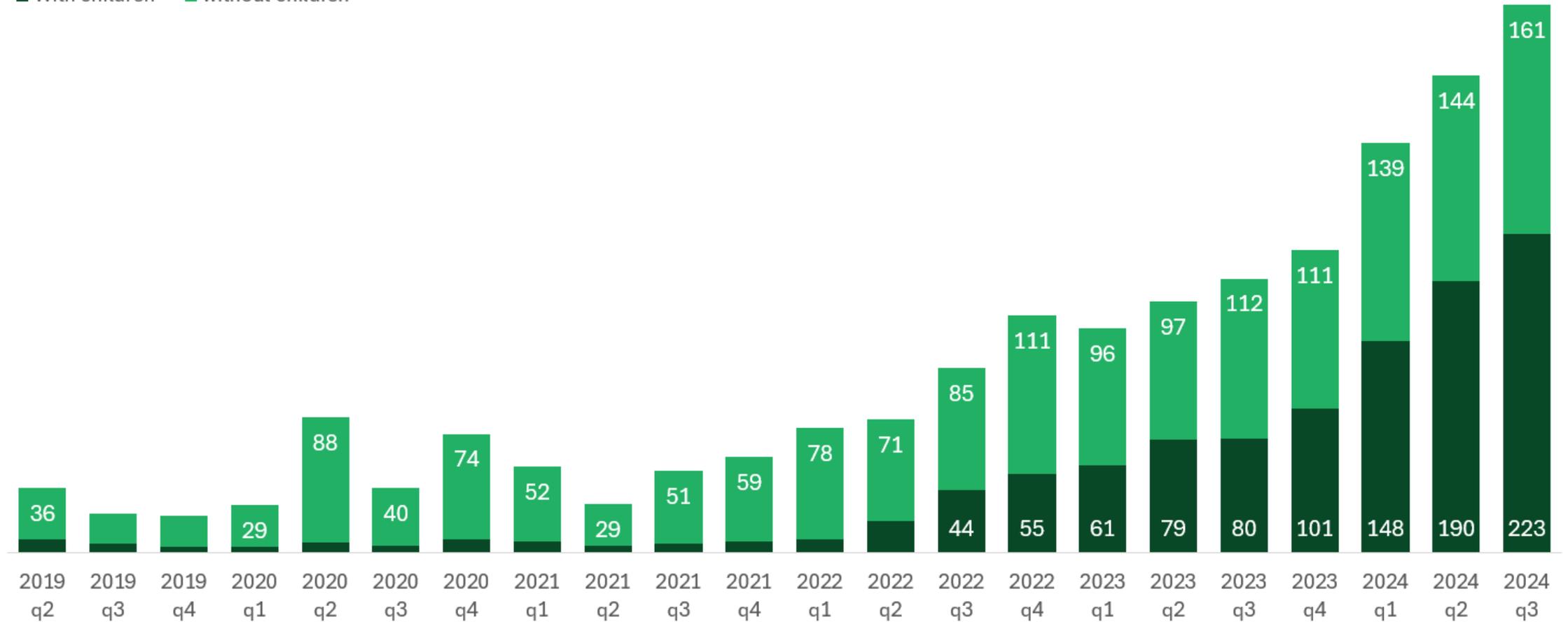
Households in temporary accommodation, counts with or without children

Numbers of households in temporary accommodation, with and without children, have grown quickly since mid 2022. A greater proportion are 'with children' since 2022. These are **snapshots** at end of quarter, they are *not* the total number of households that were in temporary accommodation during the quarter.

Households in temporary accommodation, with or without children, total number, Leeds

Source: <https://www.gov.uk/government/collections/homelessness-statistics>

■ With children ■ without children



Appendix 2: Progress in addressing health inequalities within the Leeds Health and Care Partnership

1. Introduction

1.1 In November 2024, the Adults, Health and Active Lifestyles Scrutiny Board held a themed meeting on the actions being taken to tackle health inequalities in Leeds. This report provides a progress update on the work being undertaken across the Leeds Health and Care Partnership (LHCP) to address health inequalities. As requested by the Board, it includes a specific focus on:

- NHS waiting lists,
- The impacts of cost improvement programmes (CIPs)
- Support for carers (see appendix 3)

2. What do we mean by health inequalities?

2.1 Health inequalities are systematic, unfair, and avoidable differences in health across the population, and between different groups in society. Health inequalities are ultimately about differences in the status of people's health. Inequalities can result from the conditions of where we are born, grow, live and work, and from our access and experience of health and care. Many contributing factors sit outside direct control of the health and care sector and relate to the wider determinants of health such as education, employment, housing and the economy.

2.2 However, health and care services do play an important role, making up around 20% of what makes us healthy and are a key building block. Partners in Leeds recognise their responsibility to maximise our contribution to reducing inequalities in the population that we serve. Health inequalities not only lead to earlier onset of poor health and worse outcomes but also shape how individuals access and experience health and care services.

3. The Leeds Healthcare Inequalities Oversight Group

3.1 In recognition of the need for stronger, system wide leadership on health inequalities and our commitment to working together to maximise our impact, Leeds Healthcare Inequalities Oversight Group (HIOG) was established, formally meeting for the first time in February 2025. This group functions as an expert advisory group and assurance function within the Leeds Health and Care Partnership (LHCP). These advisory groups provide four key functions:

- ensuring the decisions we build are data and insight driven,
- guidance,
- expert support, and
- assurance and scrutiny.

3.2 The primary purpose of HIOG is to support and capacitate the Leeds Health and Care Partnership and its sovereign organisations to ensure that tackling healthcare inequalities is embedded within every aspect of decision-making, resource allocation, and service delivery. It is ultimately about making equity core-business within healthcare.

3.3 Membership of the group comprises senior representatives from the Leeds Health and Care Partnership's constituent "organisations", including:

- Leeds Teaching Hospitals NHS Trust
- Leeds Community Healthcare NHS Trust
- Leeds and York Partnership NHS Trust
- Third Sector
- Leeds City Council
- Integrated Care Board in Leeds
- Primary Care

3.4 Expert Advisors and critical friends in attendance include:

- Public Health,
- Data Management and Analyst Specialist (Public Health Intelligence/ICB),
- Frontline Clinical Staff working with people at risk of poor health outcomes,
- Healthwatch Leeds
- Forum Central

3.5 The group's aim is to ensure that equity is sufficiently embedded into the systems and processes of healthcare so that it is consistently considered in decision-making, resource allocation and service delivery. While the group aims to improve outcomes for marginalised and disadvantaged communities, it is recognised that improvements will far outstretch the lifespan of this group.

3.6 HIOG focuses specifically on the role of the healthcare system in Leeds in reducing health inequalities, directly through service provision and indirectly as employers, educators, estate owners and purchasers. The focus is on the collective impact of health and public health provided or commissioned services, working closely with social care services wherever needed. The group works closely alongside the Marmot City programme, which focusses on tackling inequalities through the wider building blocks of health (social determinants).

3.7 This group considers inequalities experienced by multiple groups in society including people living in deprived communities, those with protected characteristics, inclusion health groups (e.g. people experiencing homelessness) and those experiencing multiple, overlapping disadvantages.

3.8 During 2025 the group established its key objectives to:

Provide strategic steering

- Define the vision and objectives for addressing healthcare inequalities within the Leeds Health and Care Partnership.
- Develop guidance on what constitutes “good” practice for reducing healthcare inequalities, guiding decision-making as a system, within sovereign organisations and decision building in population health boards.

Coordinate Efforts:

- Ensure alignment of health inequalities work across Leeds, and coordinate with relevant city, regional and national groups. Specifically, align and coordinate with the Fairer, Healthier Leeds (i.e. Marmot Place) programme in relation to addressing the social determinants of health inequalities
- Strengthen cross-organisational collaboration to tackle healthcare inequalities.

Establish Monitoring Systems:

- Support the development of data systems to track progress and impact in addressing healthcare inequalities across the system.
- Develop tools to ensure data-driven decision-making

Build Workforce Capacity:

- Build a critical mass of expertise and knowledge on health inequalities across all roles in the health and care system to enable widespread action.

Embed Health Inequalities into Business Processes:

- Provide expert guidance on embedding health equity into organizational processes (e.g., contracting, resource allocation, policy, risk management, and performance reporting).

Escalate Risks:

- Develop a risk monitoring and escalation process for healthcare inequalities, ensuring that the cumulative and collective impact of decisions on vulnerable communities is closely tracked.
- Recommend actions to mitigate inequalities risk and escalate issues to the Partnership Leadership Team (PLT) or relevant sovereign organisations where necessary.

Advise on service design:

- Develop Leeds wide standards for service design and delivery that reflect best practise in terms of promoting health equity.

3.9 Throughout 2025, HIOG worked with partners to progress several key areas, including:

- Supporting the LHCP transformation programmes (see section 4)
- Seeking to standardise Equality and Quality Impact Assessments (EQIAs) to improve understanding of the collective impacts across the partnership (see section 5).
- Developing the Health Equity Index

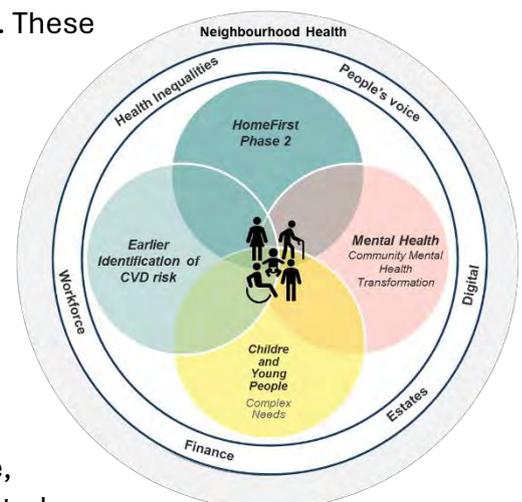
3.10 The Health Equity Index provides a strategic tool for measuring and embedding equity in healthcare performance. Designed to simplify and standardise health equity data reporting, it enables teams, services and organisations to interpret and compare equity data more easily, and to track changes over time. As a Leeds-wide initiative the Index will support:

- Monitoring and collective progress
- Identification of trends that may be worsening equity
- systemwide conversations on targeted action required
- alignment of provider-level and city-level accountability

4. Leeds Health and Care Partnership Transformation Programmes

4.1 The Leeds Health and Care Partnership continues to deliver five major transformation programmes designed to improve outcomes, reduce inequalities and ensure services are sustainable for the future. These programmes include:

- HomeFirst phase 2
- Community Mental Health Transformation
- Earlier Identification of Cardiovascular Disease Risk
- Children and Young People Complex Needs
- Neighbourhood Health



4.2 These programmes are supported by the system-wide enablers (Digital, Estates, Workforce, Finance and People's Voice), providing a coordinated framework for change across the city. Together they focus on supporting people with the highest needs, strengthening early intervention for conditions such as hypertension, advancing community and mental health transformation, improving support for children with complex needs, and putting in place the enabling

infrastructure required for a modern, equitable health and care system. Taken as a whole, these programmes represent the Partnership's collective commitment to redesigning care so that people receive the right support, in the right place, at the right time. Across the transformation programmes, several strands of work are already contributing to reducing health inequalities, particularly by improving access, targeting high need groups, and focusing on prevention.

4.3 **HomeFirst Phase 2** brings together programmes that focus on adults with the highest and most complex levels of need in Leeds, aiming to move care closer to home and ensure more timely, coordinated and preventative support. By targeting groups who disproportionately experience poorer outcomes, such as people living with frailty, individuals at risk of avoidable injury, those approaching end of life with respiratory conditions, and people requiring intensive intermediate care, the programme helps address the inequities that arise from late access, fragmented care and preventable hospital admissions. HomeFirst Phase 2 strengthens proactive, community-based interventions and multidisciplinary support, ensuring that people most at risk receive earlier identification, more personalised care planning and improved continuity across services. This shift not only reduces the likelihood of crises for vulnerable groups but also ensures that those who traditionally face barriers to accessing services receive coordinated, place-based care that better reflects their needs, circumstances and preferences. Through this targeted approach, HomeFirst Phase 2 plays a significant role in narrowing outcome gaps and improving health, independence and quality of life for communities who experience the greatest health inequalities.

4.4 The **Community Mental Health Transformation** programme in Leeds is focused on creating a joined-up model of primary and community mental health care that removes longstanding barriers to access and ensures people receive the right support as early as possible. The programme redesigns pathways for people with diagnosed or suspected severe or complex mental illness, bringing services closer to communities and establishing a "no wrong door" approach to care. This includes integrating new roles, strengthening collaboration between NHS Talking Therapies and Community Mental Health Teams, and tailoring support to reflect the needs of local populations. By improving early identification, expanding access to psychological interventions, and reducing reliance on crisis or acute services, the programme specifically addresses inequities experienced by people in deprived areas and those living with severe mental illness, who often have poorer physical and mental health outcomes. The programme directly targets inequality by improving access for people with severe or complex mental illness especially those living in the most deprived areas. Through this neighbourhood based, needs led model, the programme is helping to reduce gaps in access, experience and outcomes, ensuring that people with the greatest level of need are supported to live well in their communities and have equitable opportunities for recovery and wellbeing.

4.5 The **Earlier Identification of CVD risk** programme focuses on improving the timely detection of conditions such as hypertension by targeting communities who are at higher risk of cardiovascular disease and who historically experience poorer access to preventative care. This includes a specific focus on groups with known disparities in CVD outcomes, such as Black, Asian and minority ethnic communities and younger men, alongside people who may be identified through their workplaces or through community-based settings, addressing up to 113,000 people with hypertension, a risk factor disproportionately affecting deprived communities. The community-based settings are mostly located within the most deprived areas within the South and West of Leeds as we know there are greater risks associated with CVD needs here. By increasing systematic blood pressure checks, improving case finding in non-traditional locations, and using enhanced data tools and digital support to identify people earlier, the programme aims to close the gap between those who routinely engage with primary care and those who do not. Earlier identification enables faster treatment, reduces the risk of long-term complications and emergency admissions, and ensures that people from underserved groups receive preventative care at the same rate as the wider population. In doing so, the programme plays a critical role in narrowing cardiovascular health inequalities and improving long term outcomes for communities who have historically faced higher CVD burden in Leeds.

4.6 **The Children and Young People and Complex Needs** transformation programme focuses on improving outcomes for children and young people with complex needs (including our children looked after) who are most vulnerable to poor health, educational and social outcomes, including those with complex mental health, neurodevelopmental and social care needs and those without a confirmed diagnosis. By ensuring early identification of risk and escalation of needs, the programme aims to ensure that children receive timely, appropriate support regardless of where they live, their background or the complexity of their circumstances and reduces the need for crisis management. Through a more coordinated, multi-agency approach, the programme reduces inequities in access, shortens waiting times for assessment and intervention, and improves continuity of care for families who often face multiple barriers. By focusing resources on the children at greatest risk of poor outcomes and shifting the system towards prevention and early support, this programme plays a critical role in narrowing the inequality gap and improving long-term wellbeing for children and young people across Leeds and achieving longer term positive outcomes and stability into adulthood.

4.7 **Neighbourhood Health** in Leeds is a city-wide transformation programme designed to bring care closer to where people live, reduce avoidable demand, and ensure that support is shaped around the needs of local communities. Rooted in the strengths of Local Care Partnerships/Primary Care Networks and Community Power, the programme is building on the work already in place across Leeds that integrates health, social care, public health and the voluntary sector to deliver coordinated, proactive and person-centred care within defined neighbourhoods. By focusing on prevention, early intervention, and the wider determinants of

health, such as housing, debt, employment and community wellbeing, the programme aims to tackle the structural drivers of inequality. Neighbourhood Health prioritises those living in the most deprived areas and people with complex health and social care needs, ensuring they have earlier access to support, reduced barriers to services, and improved continuity of care. Through neighbourhood based multidisciplinary teams, accessible hubs, and strong community partnerships, the programme aims to reduce unplanned admissions, support independence, and amplify community voice. Collectively, this shift towards integrated, locality-based care plays a critical role in narrowing health inequalities and enabling people who are poorest to improve their health the fastest.

5. NHS Trust Level Actions to Addressing Health Inequalities

5.1 On the back of their original five year Health Equity Strategy (2000-2025) **Leeds Community Healthcare NHS Trust (LCH)** Board approved a new five-year tactical plan for health equity ([Trust-board-meeting-papers-for-6-November-2025.pdf](#) p31-49), to sit under the developing trust wide five-year plan. This plan seeks to continue the focus of moving from intent to action, by strengthening accountability and action for addressing inequity across the trust. LCH's Health Equity strategy and plans respond to how unfair and avoidable differences in the health of different groups and communities is addressed, by working with communities and partners to create equitable care and pathways. In five years, LCH aims for equity to be embedded in everything that they do. The Trust commissioned an Internal Audit into the Health Equity strategy and processes during 2024-25 to seek objective assessment and challenge.

5.2 In 2024, at the end of LCH's first Health Equity strategy, we reviewed our building blocks for equity in our care and pathways and agreed that these all remained important to achieving our ambition. We overlaid these building blocks with core priorities as follows:

1. Creating conditions for change
 - Governance and accountability
 - Equity within LCH strategies and plans
 - Capacity and capability to take action on equity
2. Supporting action
 - Equity data
 - Voice and influence
 - Equity in decision making processes
3. Reducing inequity in access, experience and outcomes
 - Inequity in access
 - Tackle known inequities faced by specific population groups
 - Prevention as a route to tackling inequality

5.3 The driver diagram below shares some examples of change ideas, and their delivery status, that contribute to LCH equity aims and objectives.

Overall aim	Primary drivers	Secondary drivers	Examples of change ideas and delivery		Complete	On track / ongoing	Minor risk to delivery /	Major risk to overall delivery	Action not started	
Identify and address inequity in LCH care and pathways	To improve access for people at risk of worse health outcomes	Equitable referrals	Referral data reporting by deprivation and ethnicity	Long-Covid review of referral routes and criteria	Fellowship: access to cardiac rehab			Development of trustwide opt-in and opt-out principles		
		Equitable waiting	Access LCH campaign and analysis	Citywide and LCH waiting list workshops	Waiting safely project			Fellowship: recording of housing status		
		Equitable missed appointments	Missed appointment data by deprivation, ethnicity and interpreter requirement	Health literacy awareness campaigns	Phone calls to people in IMD1 who have missed appointments	Information hub page on support to attend appointments				
			Review of Access policy and missed appointments process	About Me: comms needs & reasonable adjustments template, comms and training	Citywide and LCH missed appointments workshops					
	To improve experience for people at risk of worse health outcomes	Understand differences in experience	Healthwatch engagement: future of community services	Engagement as part of EQIAs	Recording demographic data in patient experience					
		Targeted improvements to experience of key groups	Racial equity workshop: culturally competent conversations about mental health	Oliver McGowan training for LD	Cultural conversations programme	Armed Forces Covenant accreditation				
			Equity Impact Assessments in clinical policies	Fellowship: trauma-sensitive care	Fellowship: cardiovascular disease in socially deprived ethnic minorities	Synergi anti-racist communication principles				
			Reasonable adjustments in Dental, Diabetes & Immunisation teams	CUCS project supporting survivors of sexual abuse						
	To improve outcomes in LCH for people at risk of worse health outcomes	Equitable safety	Falls, medication and pressure ulcers incident data by deprivation, ethnicity and interpreter requirements	PSIRP: engagement with people experiencing multiple adverse care events	Easy read falls prevention materials	Equity analysis in deteriorating patient				
		Equitable mortality	Fellowship: Preferred Place of Death in Black communities	Learning from LeDeR	Equity analysis in mortality report	Easy Read palliative care materials				
		Equitable outcomes	Fellowship: diabetes in homeless populations	Fellowship: reducing self-discharges from hospital for homeless population	EQIA process reviewed	Citywide work to understand cumulative impact	Recording Armed Forces status on SystmOne			

5.4 In line with the development of the Health Equity Index Year 1 business intelligence tactical plan Year one of the Trust (2026.27) includes implementation of KPIs that use the Health Equity Index to assess difference in waiting times by ethnicity, IMD, LD, armed forces and people with a disability.

5.5 Health equity is at the core of what **Leeds & York Partnership NHS Foundation Trust** do as a Trust. We serve a diverse population and a patient group at high risk of poor health outcomes and recognise that each person at the Trust has a part to play in supporting the delivery of health equity, with this in mind in April 2025, LYPFT launched their first [Improving Health Equity Strategic Plan \(2025/29\)](#), marking a significant step forward in our commitment to working to address the inequity in health outcomes within our communities.

5.6 We know tackling health inequality is a complex issue and will require co-ordinated system-level solutions, by working in partnership with local authorities, integrated care systems (ICSs) and voluntary, community and social enterprise (VCSE) sector organisations. Collaborative working is fundamentally embedded across the work of our Trust to enable us to deliver on this agenda.

5.7 Our Improving Health Equity (IHE) Strategic Plan largely focuses on improving equity in access, experience and outcomes within healthcare. We are particularly concentrating on the following groups:

- The systematic, unfair and avoidable differences in health between those with learning disability, neurodiversity, severe and enduring mental illness, and those without.

- Tackling racial health inequity within mental health services which have been evidenced to be extensive and persistent.
- Intersectionality: People at exceptionally high risk of poor health outcomes because they are a member of multiple groups and experience compounding disadvantage for example those with a severe mental illness and from a racialised community and who also live in a deprived community.
- Our service users who experience deprivation, with a particular focus on our service users living in the 10% most deprived communities nationally.

5.8 Foundational to our work is engagement and coproduction with our service users, their carers and lived experience partners. We continue to carry out widespread engagement to understand and shape the implementation with coproduction at the heart of our new strategic approach to improving health equity. Summary of key developments since launching our IHE Strategic Plan:

- Hosted Improving Health Equity launch and learning event
- Hosted racial equity open access webinar to launch the PCREF at LYPFT
- LYPFT selected to be one of the national early implementer sites partnering in the NHSE 'Advancing Mental Health Equalities Taskforce' and the IHE Team presented LYPFT work at National Peer Learning events
- Equity Data Dashboard designed and developed to review measures by a wide range of equity variables, including ethnicity. We started by including equity measures we have a statutory obligation report on such as detention rates and restrictive practises.
- LYPFT has contributed to a systemwide approach to improving equity within care through our statutory duties under the Equality Delivery System. This work focuses on assessment of equity within services and subsequent improvement activities.
- External audit carried out by Audit Yorkshire, with the outcome being we are providing significant assurance that the Trust is addressing health equity agenda.
- LYPFT is part of the new national programme to improve the 'Culture of Care' in Mental Health, Learning Disability and Autism inpatient care in England. The programme has been commissioned by NHS England and is a key element of their Quality Transformation Programme.
- As core members in Synergi Leeds we have supported the 'Remembering What's Forgotten' ([click here](#)) is a hybrid programme and exhibition championing community and lived experience narratives to tackle the overrepresentation of black and South Asian men detained under the Mental Health Act in Leeds.

5.9 As a result of prioritising coproduction at LYPFT, we have achieved many areas of improvement designed by service users, carers and our partners:

- The Improving Health Equity Team regularly attend FRESH (Forum for Racial Equity & Social Care and Health), as a result of this engagement we

coproduced eating disorder service leaflets in alternative languages to meet the community needs.

- As a result of engagement aligned to our IHE Strategic Plan, the IHE Team have secured 22 applications for a new pool of people with lived experience to be part of all our coproduction. Our new Lived Experience Advisors have already helped to coproduce LYPFT recruitment packs, LYPFT site patient induction packs, and Synergi partnership bid to the Solidarity Fund to access sustainable funding focussing on racial equity across the WY ICB area.
- Our lived experience advisors have also delivered service engagement events alongside LCH on understanding the pathways of care and the impact of health inequalities with a specific focus on racial equity.

5.10 In March 2025, the **Leeds Teaching Hospitals NHS Trust** Board approved a new [Health Equity and Public Health Strategy 2025-2028](#). The vision is ‘*to embed equity at the heart of everything we do and maximise the Trust’s contribution to improving health equity in the populations we serve*’.

5.11 The new strategy remains focussed on ensuring *equitable access, excellent experience* and *optimal outcomes* for those experiencing health inequalities, and the application of the Core20Plus5 framework aimed to target action on healthcare inequalities improvement. In addition, the strategy emphasises *who* we will focus on, the role of *prevention* and the adoption of annual *focal areas*. For 2025/26 these are: equity in our waiting lists, improving renal health and health equity within our workforce.

5.12 There are extensive activities, projects and programmes underway within LTHT to support our ambition to tackle health inequalities. A Health Inequalities & Public Health annual report will go to Trust Board in March, providing a comprehensive picture of such work (which can be shared). The update provided (below) gives a snapshot of progress against our 3 annual focal areas only: waiting lists, renal health and workforce health equity.

5.13 LTHT is working on the application of a deprivation score that can be applied to waiting lists alongside chronological waiting times and clinical priority scoring.

5.14 In 2025, the HEARTT tool (health equity and the right to treatment) was tested within the upper limb service at Chapel Allerton Hospital as part of a proof-of-concept trial (Sept-Nov 25). The service piloted the use of the deprivation score alongside chronological waiting time on the waiting list to determine whether we could use this data to provide visibility and support a reduction in the waiting times of patients from more deprived areas while waiting for elective care. Having completed the proof of concept successfully, the Trust is now moving towards sourcing an alternative system to HEARTT that will allow us to implement a system to support deprivation scoring and booking in a more equitable way for patients on our waiting lists.

- 5.15 In future, this will allow service units to review the deprivation score that has been applied directly to the Patient Tracking List (PTL) without the need for an additional system and can be managed in a more efficient and leaner way which will allow enhanced data-driven decision making applied to managing chronological waiting times then clinical priority (urgency of treatment required) then health inequity.
- 5.16 There are significant inequalities in renal disease experienced by certain groups in terms of disease prevalence, late presentation, missed appointments and longer waits. Renal failure can result in the need for dialysis which has an enormous carbon footprint, in part due to its high volume of water consumption. It is also extremely costly for the Trust, and the need for dialysis in Leeds is projected to dramatically increase over the coming years. However, renal disease is largely preventable and there is a great deal of work happening at the Trust and the region to minimise these health, sustainability and financial risks:
- Work to increase medical optimisation of chronic kidney disease patients which has been shown to dramatically decrease the need for dialysis.
 - Efforts to increase diagnosis and coding for chronic kidney disease, which has shown to improve outcomes.
 - Community engagement with ethnic minority communities, increasing awareness of renal disease, its prevention and importance of live donor transplantation.
 - Quality improvement work across Yorkshire to reduce missed appointment in renal care.
 - On-site partnership events promoting the importance of kidney health to LTHT staff, patients and visitors e.g. World Kidney Day, World Hypertension Day – including blood pressure testing, AF testing, smoking cessation support, diabetes prevention and dietetic information and advice.
 - Through the Future Leaders Programme (Health Education Yorkshire & Humber), the Public Health Team was successful in a bid to host a Clinical Leadership Fellow – Health Equity. The one-year placement includes developing a project that will focus on equity in renal health. A Fellow was recruited in December and will commence the role on 5 August 2026.
- 5.17 Progressing wider plans for how we can work across other NHS partners in Leeds to increase identification and early intervention in vulnerable groups with or at risk of chronic kidney disease has been limited due to the absence of the Healthcare Public Health Consultant to oversee and lead this workstream (from August 25).
- 5.18 Patterns of health inequalities within the community are reflected in our workforce. Some staff will experience poorer health outcomes arising from the conditions in which they were born, grew-up, live or work in now.
- 5.19 The NHSE Equality, Diversity & Inclusion Improvement Plan ‘high impact action 4’ requires all NHS Trusts to develop an improvement plan for workforce health

inequalities. In response to this, the LTHT Public Health Team has led the development of an insight report outlining workforce inequalities within LTHT, based on national evidence, local data and intelligence, including interviews with a wide range of key stakeholders. Six themes from this work, including: unmet basic needs; feeling safe at work; poverty; discrimination; targeting need; and missed opportunities for prevention. The findings have been shared through a range of internal forums and a Working Group has been established to drive progress on our agreed approach and to develop and deliver our workforce health equity improvement plan. The plan is to be approved by the EDI Strategic Group.

6. Healthy Communities & Primary Care Team (Public Health)

- 6.1 The **Health Inequalities Template** is now embedded in GP clinical systems across Leeds, enabling practices to systematically Read code and monitor inequality related factors, including wider social determinants such as damp, mould and fuel poverty. This supports more targeted, hyperlocal action planning and strengthens connections between primary care and relevant community services. For the first time, over 300 housing related issues have been recorded within clinical systems, allowing joint work with Housing to better support people with long-term conditions living in poor housing. Data is reviewed quarterly by a small working group and shared with practices to help identify solutions.
- 6.2 The team leads the **Health Inequalities Learning & Action Group**, which brings together the primary care workforce to learn collaboratively and address inequality driven challenges. Since August 2022, 25 sessions have been delivered. The most recent event was the Leeds Health Equity in Primary Care Conference in January 2026, attended by 55 colleagues from across primary care and the wider system, with presentations focused on Marmot City, Department for Work and Pensions support in primary care, and the links between health and housing.
- 6.3 Working with system partners, the team developed the **5 A's of Access** as a framework to improve how services across the city are designed and delivered. It provides a consistent approach to assessing and strengthening healthcare access, particularly for people who face the greatest barriers when navigating services. Applying the framework supports improved uptake and outcomes across the system.
- 6.4 Following the launch of the **Tackling Health Inequalities Toolkit** in 2021, the team has produced **practical guidance** for General Practice and Primary Care Networks. This helps General Practice embed health inequality considerations into everyday work, supporting both practices in areas of significant deprivation and those in more affluent communities to identify their priorities, use their skills effectively, and work more collaboratively across sectors.
- 6.5 The team has developed **health profile** infographics for all 19 Primary Care Networks in Leeds. These profiles summarise key information on chronic disease prevalence, socio-economic context, population demographics and patterns of

service access. They are being used widely to inform planning, support decision making and shape future work across the system.

6.6 Much of this work is commented upon in the [Fairer, Healthier Primary Care in Leeds](#) report

7. Equality and Quality Impact Assessments

7.1 We are aware that the way our services are designed is often less accessible for those with additional inequalities, and that there is a risk as we prioritise waiting list improvements and cost improvement programs this gap could widen. In addition to proactively seeking to positively impact on health inequalities, each Trust and the Leeds health and care partnership are working hard to ensure any potential negative impact is identified and mitigated. The main focus of this work is the use, embedding and refinement of Equality Impact

Assessments (EQIA): mandatory tools used by NHS organisations in Leeds to analyse policies and services changes for potential adverse effects on protected groups (age, disability, race, etc.), ensuring decisions advance equality, prevent discrimination, and meet the [Public Sector Equality Duty](#), with templates available and published assessments showing ongoing application. What they are:

- A legal requirement: NHS bodies must conduct EIAs as part of their Public Sector Equality Duty under the [Equality Act 2010](#).
- A proactive tool: They assess the potential positive or negative impacts of new or changing policies, services, or functions on people with different protected characteristics.
- Focus areas: EIAs look at age, disability, gender reassignment, race, religion/belief, sex, sexual orientation, marriage/civil partnership, and pregnancy/maternity as well as deprivation.

7.2 An Equality Impact Assessment (EIA) is a tool that helps us to place equality, diversity, cohesion and integration at the heart of everything we do and make sure our strategies, policies, services and functions do what they are intended to do and for everybody. Carrying out an EIA involves assessing the likely (or actual) effects of policies on people in respect of protected equality characteristics, proactively looking for opportunities to promote equality that may have previously been missed or could be better used, as well as negative or adverse impacts that can be removed or mitigated where possible. If any negative or adverse impacts amount to unlawful discrimination, they must be removed.

7.3 **Leeds Community Healthcare NHS Trust** uses a combined Equity & Quality Impact Assessment (EQIA) tool. The EQIA process, bringing together equity and quality impact assessments, began in 2021. Since then, continuous improvement approaches have focussed on:

- Process Refinement: Updated EQIA documentation to make completion easier, introduced quality assurance checks, panel reviews, and structured feedback mechanisms.

- Transparency: Improved sharing and oversight through MS Teams and SharePoint, ensuring full completion and visibility of documentation.
- Training: Implemented initial and refresher training for staff involved in EQIAs, supported by surveys to identify training needs.
- Audit: An audit is underway, with early indications showing more complete EQIA sections and easier identification of gaps during panel and QA reviews.
- Visibility: Increased awareness of EQIAs through a dedicated intranet page, regular communications, and the development of a screensaver to keep EQIAs front of mind for staff.
- Data: Work to strengthen the data included with and available to the EQIA panels continues, with increasing clarity regarding optimum datasets.

7.4 Refinements are ongoing, including improvements to data access, digital tools and thematic analysis of changes. We are working to enhance reporting systems to enable more robust analysis and have identified further work to improve engagement with stakeholders both into the EQIA process and afterwards to share changes and provide opportunities to feed into ongoing learning.

7.5 **Leeds Teaching Hospitals NHS Trust** uses a combined Equality and Health Inequality Impact Assessment (E&HIIA) tool. Utilisation of the assessment tool varies across the Trust and those leading the change hold responsibility for undertaking assessments where required. Areas within the Trust where E&HIAs are now embedded include: #

- From April 2025, E&HIIA incorporated into all Trust Board Committee paper templates. A review of this addition is now required for assurance of completion rates and quality.
- Policy and procedure development and review process.
- Corporate Planning Team undertake E&HIAs for all significant capital projects.
- Cancer Services undertake E&HIAs as standard practice and there is strong evidence of assessments leading to improved health equity within timed cancer pathways e.g. prostate cancer.
- The Trusts' Waste Reduction programme incorporates E&HIIA within the Quality Impact Assessment process, which is required for all proposed waste reduction projects (currently over 1000). QIAs are audited bi-annually.
- From April 2025, all Expressions of Interest submitted to Digital IT (DIT) for any digital project impacting on people are required to undertake an E&HIIA before they progress to implementation stage. Embedding this within the DIT process will ensure groups who experience health inequalities and those with protected characteristics are considered from the start of any new digital project and appropriate action taken to mitigate any potential negative impact identified during the assessment.
- A rapid review of our E&HIAs is currently underway. The focus is to help ensure the required process is accessible to staff and to consider small improvements to support those undertaking assessments and ensure they are appropriate and proportionate to the proposed change e.g. a simple screening tool will be developed as a first step.

- 7.6 **Leeds & York Partnership NHS Foundation Trust** developed and piloted a new Equality and Health Inequalities Impact Assessment (EHIA) policy and supporting toolkit. LYPFT is leading the ‘EHIA Working Group’ on behalf of the Health Inequalities Oversight Group to enable the Leeds system to join up on EHIA and work together to better share and mitigate any adverse impacts as a result of decision making.
- 7.7 In September 2025 **Leeds Tackling Health Inequalities Oversight Group** provided a focussed session on EQIAs at the September meeting. Each Trust and the ICB presented a summary of their approach and progress on EQIAs to date. Subsequently the Health Inequalities leads and EQIA leads for each Trust have met to compare process maps, templates and data capture; seeking to improve standardisation and enable comparable datasets along pathways.
- 7.8 Work is planned between this THOG workstream and Forum Central for 2026, seeking to find a way the risk register and information Forum Central hold on behalf of the 3rd sector can be incorporated as a key data repository available to staff compiling EQIAs. Information regarding the impact of other similar changes on different populations and communities within Leeds would provide a significant evidence base to proactively identify any likely negative or compounding impact on a particular community, increasing awareness and the need to consciously avoid or mitigate this impact prior to a change being implemented.

8. Understanding impacts within waiting lists

- 8.1 **Leeds Community Healthcare NHS Trust (LCH)** established a programme of work and a dedicated Steering Group in January 2025 to address long waits across the Trust since the Covid19 pandemic. Conscious that those populations impacted by health inequalities can find it more difficult to access health and care services and wait longer for access, the Trust regularly reviews waiting list data for patients living in IMD1 in comparison to those living in IMD2-10. This is presented regularly in our Integrated Performance Report, and challenged through our committee structure, ensuring that the focus on this as a priority is high. It is also routinely reviewed by services and through the Access LCH Steering Group.
- 8.2 Longer waiting times for people in IMD1 are part of monthly Access LCH meetings, identifying which individual services are contributing to this aggregated trust wide position. The greatest difference has been identified as two weeks and further work is being undertaken to understand the causes and solutions to this. Previous trust wide analysis identified that this was due to higher rates of cancellation and non-attendance by people in IMD1 rather than a difference in rates of invitations to appointments. This is being checked with more recent data. A range of improvement projects are being delivered to reduce missed appointments in IMD1 across the trust and services with longer waiting times for people in IMD1 are being prioritised for additional support to embed these. This

work is supported by a range of communications and reasonable adjustment improvement projects, and work to raise patient and carer awareness of [support to overcome barriers to attending appointments](#).

8.3 **Leeds Teaching Hospitals NHS Trust (LTHT)** has waiting lists as one of their three annual focus areas in their [Health Equity & Public Health strategy](#). The key area of focus during 2025 working on the application of a deprivation score that can be applied to waiting lists alongside chronological waiting times and clinical priority scoring. The HEARTT tool (health equity and the right to treatment) was tested within the upper limb service at Chapel Allerton Hospital as part of a proof-of-concept trial (Sept-Nov 25). The service piloted the use of the deprivation score alongside chronological waiting time on the waiting list to determine whether we could use this data to provide visibility and support a reduction in the waiting times of patients from more deprived areas while waiting for elective care. During 2026 the focus is on to implement a system to support deprivation scoring and booking in a more equitable way for patients on our waiting lists.

8.4 In 2025, **Leeds & York Partnership NHS Foundation Trust** reviewed the process for managing waiting lists across a sample of services. The findings showed there are occasions where demand continuously outstrips capacity and waiting lists occur. Services are now required to review their pathways at least annually to ensure their waiting lists are managed effectively, with each service having clear waiting time targets. Any changes to the pathways will be assessed using the Equalities and Health Inequalities Impact Assessment (EHIA). This is detailed within each service Standard Operating Procedure (SOP) for waiting list management.

8.5 Services are also required to manage their waiting list from a health equities perspective to understand the needs of all patients who are on our waiting lists. This approach is strengthened by the introduction of the Improving Health Equity Strategy withing the Trust. In doing so, services will ensure that there is a focus on improving equity in access, experience and outcomes, considering the nine protected characteristics, and identifying those patients who are risk of poor health outcomes because they experience high levels of deprivation.

8.6 We have introduced the concept of ‘waiting well’ as part of our waiting list management. Waiting Well is a way of helping patients to support their health and wellbeing whilst they wait for assessment and treatment. This may include providing information and advice regarding practical issues which can help maintain and improve people’s physical and mental health. The aim of waiting well is to encourage patients to take positive steps to help reduce symptoms, stop further problems from starting and prepare people for their initial assessment and treatment. The Trust has partnered with Chasing the Stigma to make the Hub of Hope available to people and this could be used to help people search for a find other support systems which can help them whilst they are on the waiting list.

9. Summary

- 9.1 The Leeds Health and Care Partnership has made clear, coordinated progress in embedding ways to improve health equity across the system. The establishment of the Health Inequalities Oversight Group has strengthened collective leadership, assurance and the use of data, supported by the new Health Equity Index which will enable more consistent measurement and targeted action.
- 9.2 Across all major transformation programmes, there is a strong and visible focus on reducing inequalities, whether through earlier identification of risk, neighbourhood health models of care, improved access to mental health support, or more coordinated pathways for children and young people with complex needs. These programmes are helping ensure that people with the greatest need receive timely, appropriate and preventative support.
- 9.3 Each NHS Trust has advanced its organisational approach, with refreshed equity strategies, improved governance, stronger use of equity data and targeted work on priority groups. Recent developments include LCH's new Health Equity Plan, LYPFT's Improving Health Equity Strategy, and LTHT's focus on waiting list equity, renal health and workforce inequalities.
- 9.4 Primary care continues to strengthen its role in tackling health inequalities, with improved identification of wider determinants of health, enhanced workforce learning, and new tools and profiles informing local planning and partnership working.
- 9.5 System partners have also strengthened Equality and Health Inequality Impact Assessment processes, improving standardisation, quality, data use and mitigation of risks, particularly important as services deliver cost improvements and elective recovery.
- 9.6 Addressing inequalities in waiting lists remains a shared priority, with each Trust enhancing its approach through improved monitoring, deprivation based prioritisation, pathway review and "waiting well" support.
- 9.7 Overall, Leeds continues to build momentum in tackling health inequalities. The next phase will require consolidating EQIA alignment, scaling equitable waiting list approaches, strengthening prevention capacity and implementing neighbourhood health, and fully embedding the Health Equity Index as the shared assurance and improvement framework.

Appendix 3: Support for Carers



Report of:

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1. Introduction

- 1.1 According to the 2021 census, approximately 61,500 people in Leeds stated that they provided unpaid care. This represents around 8% of the population of Leeds aged 5 and over. Unpaid carer support represents millions of pounds in avoided costs to health and social care systems. While unpaid carers provide immense economic value, many feel invisible and undervalued, often at great personal cost to their health, wellbeing, social connections, and financial security, as highlighted in the Carers Leeds report, The State of Unpaid Caring in Leeds 2025).
- 1.2 Research from the Centre for Care, has found that the economic value of contributions made by unpaid carers in the UK is now £184 billion a year. This new research shows there has been a huge increase in the value of unpaid care in the UK – up by £64.9 billion since 2011 – a 29% increase. The combined NHS budget across the UK in 2021/2022 was £189 billion – meaning that carers are providing the value of care equivalent to a second NHS. This research demonstrates the vital contributions of unpaid caregivers across the UK, illustrating how they save the public purse substantial amounts of money every week, day, and hour throughout the year.
- 1.3 Unpaid carers are individuals who provide care for family members, friends, or neighbours who couldn't manage without their help, this could be due to illness, disability, mental health problems or substance misuse and do so without financial remuneration. Unpaid carers are a group who experience health inequalities. Many unpaid carers face financial hardship, as caring responsibilities often limit their ability to engage in paid employment. This can lead to lower income, poorer housing, and reduced access to resources that promote good health. The demands of caring can lead to social isolation, known to negatively impact mental and physical health. Carers frequently struggle to access healthcare for themselves due to time constraints, lack of respite, or prioritising the needs of the person they care for over their own.
- 1.4 According to data taken from the Unpaid Carer Dashboard, (An online interactive tool to help explore patterns of unpaid care across England and Wales)- 7.1% of unpaid carers in Leeds (4,368 out of 61,500) are living in poor health compared with 5.1% of non-carers (36,109 out of 703,662), showing that people with caring responsibilities are more likely to experience poor health than those who are not caring.
- 1.5 This report summarises the support available for unpaid carers across the health and care sector and outlines the current work plan of the Leeds Carers Partnership. The partnership brings together:
 - Leeds City Council (LCC): Adult Social Care (ASC) and Commissioning

- West Yorkshire Integrated Care Board (WYICB)
- Leeds Community Healthcare (LCH)
- Leeds and York Partnership Foundation Trust (LYPFT)
- Leeds Teaching Hospital Trust (LHT)
- Family Action
- Carers Leeds



As well as other organisations and carers with lived experience. Its aim is to work collectively to address health inequalities experienced by carers and reduce the negative impact of caring on their wellbeing and quality of life.

- 1.6 Key actions in the work plan include developing a focused improvement plan informed by feedback from the Local Authority CQC assessment, the Carers Leeds Unpaid Carers Survey, and the city's wider strategies and ambitions. This will support the refresh of the Carers Partnership Strategy, ensuring it remains evidence-based and responsive to carers' needs.
- 1.7 This report outlines how the Carers Partnership is delivering actions in support of the Health and Wellbeing Strategy Priority 10—Supporting carers and enabling people to live independent lives—as well as the associated equality improvement priority. These priorities aim to reduce the negative impact of caring on carers' quality of life and wellbeing by establishing Leeds as a Carer Friendly City; one that recognises carers' contributions, provides accessible and equitable support, and places carers at the centre of decision making.
- 1.8 Health and care systems have a legal duty to support unpaid carers by consulting and involving them in decisions about service provision, treatment, and hospital discharge (Health and Care Act 2022), assessing their needs, promoting wellbeing, and providing information and advice (Care Act 2014). Local authorities must identify, assess, and support young carers and parent carers of disabled children (Children and Families Act 2014), while employers must allow up to one week of unpaid leave for caring responsibilities (Carer's Leave Act 2023). Carers are also protected from discrimination under the Equality Act 2010 and have rights to family life and dignity under the Human Rights Act 1998.
- 1.9 As part of its statutory duties, the council conducts a survey every two years, gathering feedback from carers known to Adult Social Care about the impact of services on their quality of life and wellbeing. While the survey provides useful insight to inform service development, its reach is limited. The most recent Adult Social Care Outcomes Framework (ASCOF) results show that overall satisfaction with social services rose to 39.7% (from 32.5%), and the proportion of carers who felt included or consulted in discussions increased to 60.7% (from 58.4%). The percentage of carers who found it easy to access information also improved slightly to 58.1% (from 57.1%). However, fewer carers reported having as much social contact as they would like, decreasing to 29.2% (from 30.8%), and the carer-reported quality of life score fell to 7.4 (from 7.1). The next survey is currently being undertaken.

2. Recent Care Quality Commission (CQC) Assessment

- 2.1 The CQC assessment examined whether the council is meeting its duties under the Care Act 2014, including promoting wellbeing, preventing or delaying needs, and integrating care with health services, as well as providing timely assessments for adults with an



- appearance of need, ensuring accessible information and advice, and involving individuals and carers in planning.
- 2.2 It highlighted that while some carers report positive experiences, others face delays, limited access, or a lack of awareness of available support
 - 2.3 The report identified key strengths around strength-based working and an inclusive approach with on going work to ensure underrepresented groups have equity in access to support services. The assessment found that ASC prioritises short break options and emergency respite; however, capacity is sometimes insufficient, meaning staff often provide initial emergency support while longer-term solutions are arranged
 - 2.4 Recognising these findings. ASC commissioned a diagnostic review, which included practitioner insight and detailed care reviews around the role of carers in terms of in preventing service escalations and how they can be supported further within their caring role.

Support for Carers in Leeds

3. Support for Adult and Parent Carers in Leeds

- 3.1 The following overview demonstrates how partners are working collectively to ensure carers are identified, informed, and supported in ways that improve their wellbeing and reduce the pressures associated with caring.
- 3.2 Carers Leeds is an independent charity commissioned by Leeds City Council (LCC) and West Yorkshire Integrated Care Board WYICB to provide information, advice, and support to unpaid carers. Carers Leeds offers a confidential Support Line, 1:1 support over the phone, online or face-to-face, peer support groups and work in the community and in hospital settings. Carers Leeds provide a direct service to over 10,000 carers a year and reach over 15,000 carers a year through their communications. In 2024/25 68% of carers who responded to Carers Leeds evaluation questionnaire said they felt less anxious and more socially connected because of the support.

"I'm so glad I was told about Carers Leeds. I think it really has all happened at the right time for me. It means such a lot to find a resource like this and people who understand and want to listen. I've had years of people glazing over, even therapists, as it's just such a twisty, difficult thing to explain and talk about. I have a good feeling about all of this new approach to dealing with it. I feel like I've been given a proper chance to deal with the trauma."

Unpaid Carer – Carers Leeds Impact Report

- 3.3 The Carers Assessment Team and other area social work teams undertake statutory assessments to identify carers' needs and ensure access to appropriate support,

including direct payments and community-based breaks. The outcomes of these assessments may result in support packages for carers including practical help such as cleaning, gardening, and wellbeing services. The dedicated team consistently receives positive feedback, highlighting how even small changes can make a significant difference such as household cleaning and gardening. Last year, a total of 2,347 carers assessments were completed by both the dedicated unpaid carers team and the wider ASC teams.



CQC Assessment: "Several unpaid carers told us they received direct payments and told us how this had supported them to maintain their wellbeing. A person we spoke to told us they had been supported to access direct payments which had enabled them to have more choice and control over their care and support needs."

- 3.4 Carers Leeds has a Liaison Worker who works directly with the LCC ASC workforce providing comprehensive training package for frontline staff to ensure high quality interactions with carers leading to appropriate support to sustain caring.
- 3.5 The Leeds Directory serves as a comprehensive online resource, listing over 2,000 local support services, groups, and activities for people and their carers. Carers Leeds wants its 'digital front door' to have parity with its Support Line and physical presence in the community and hospitals. As a result, it is integrating technology and digital solutions into its service offer. Carers Leeds has a monthly carers E-newsletter reaching 9000 subscribers, a website with key resources, how to guides and advice videos. Carers can book an appointment via the website, as well as over the phone. Carers Leeds launched a webchat in May 2025 where carers can 'live text' with someone from the Support Line during opening hours. Its digital offer is reaching carers who are less likely to access the Support Line or face to face. For example, from launch to present, 79% of carers on webchat were employed (compared with 21% by phone); 26% were 18–34 (compared with 17% by phone) and 17% were LGBTQ+ (compared with 1.3% by phone).
- 3.6 Respite provision remains a key priority, and a wide range of options (residential respite, day provision and shared lives) are available for all carers across the city. Short breaks help carers maintain social connections, pursue work, education or leisure activities, and take time to rest and recharge. Evidence consistently shows that access to regular breaks has positive outcomes for carers and can prevent them from developing their own needs for care and support. For example:
- The Community Based Short Breaks Service provides respite for unpaid carers by a suitably qualified individual visiting the home and providing support or a trip out while the carer is away for a few hours.
 - One of the council's in-house providers, Dolphin Manor, has recently been repurposed as a short-stay dementia hub. The centre allows carers to book a one-off short-break respite or schedule regular planned breaks over a set period to provide ongoing, predictable support.

- Commissioners, working alongside social work teams, continue to review and respond to the city's respite accommodation needs. This work has already resulted in an additional mental health respite unit and is informing future planning for learning disability respite across both health and social care.



3.7 The Leeds Neighbourhood Network Schemes (LNNS) are community-based organisations that support older people to live independently and stay connected within their local areas. They play an important role in supporting unpaid carers by offering opportunities for short breaks from caring through activities such as luncheon groups and shared social events. These provide carers with time away from their caring role, the chance to connect with peers, and access to practical support at an early stage before needs escalate. With 34 organisations operating across 37 neighbourhoods in Leeds, the Networks have a significant citywide presence, with a combined membership of 28,133 people.

A LNNS supported a carer when her caring role got too much and helped ensure the cared for got the services they needed. The network then supported the carer to adjust to living alone through being there for conversation over the phone, a home visit with a cup of tea and a listening ear or a place at one of our groups, which she has taken up.

3.8 The Accelerating Reform Fund (Department Health and Social Care (DHSC) monies focused on adult social care outcomes, with a WYICB footprint) has enabled the design and delivery of two innovative projects in Leeds which support unpaid carers. The first is an enhance digital offer for carers, through Carers Leeds employing a Carers Leeds Digital Carers Support Worker to experiment, implement and integrate digital information, advice and support tools and techniques into Carers Leeds service. The second is The Caring Kind Project, an initiative led by Carers Leeds in partnership with Bradford, Wakefield, Kirklees and Calderdale carers organisations and which covers the whole of West Yorkshire. The project launched in September and sources free breaks from West Yorkshire hospitality, tourism, leisure and culture businesses. Local carers organisations then match those breaks with unpaid carers. Over 600 breaks have already been gifted which include everything from coffee and cake at a local café, theatre tickets, local attractions and overnight stays.

"It was so nice to switch off for once and not have to have my phone going off constantly."

Unpaid Carer – Caring Kind Project

4. Underrepresented Groups



- 4.1 Around 15% of unpaid carers in Leeds are from diverse ethnic communities, broadly aligned with the 2011 Census but lower than their proportion in the overall population. In 2024/2025, 18% of carers accessing Carers Leeds service were from ethnically diverse communities, which is comparable with Census 2021 data; however, recognising that some groups remain underrepresented.
- 4.2 Building on this, the CQC assessment highlighted that uptake of carer support among ethnic minority communities remained low. To address this, the council and Carers Leeds delivered targeted roadshows to improve awareness and help people recognise their caring role, leading to the recruitment of more carers with lived experience. A Listening Forum and the Big Chat Leeds events further gathered insight into how communities prefer to access support, informing the Leeds Better Lives Strategy. A co-designed self-assessment form is also being tested with a voluntary community group to better support carers from diverse backgrounds.
- 4.3 Carers Leeds offer professionally designed, visually accessible materials translated into the six main community languages in Leeds and can translate their resources into any language on demand using AI.
- 4.4 Carers Leeds have strengthened partnerships with organisations such as Hamara, ABA Leeds and Touchstone to develop a shared approach to engaging ethnically diverse communities and are seeking joint funding to increase capacity for outreach work. Alongside this, Carers Leeds work closely with local LGBTQ+ organisations, including Out Together, MESMAC and Trans Leeds, to reach LGBTQ+ carers through targeted engagement and dedicated LGBTQ+ carer break grants.
- 4.5 Building on this foundation, the Carers Partnership group plan to expand the membership of the Carers Partnership to ensure broader representation across services and communities. This will include targeted engagement with third sector organisations supporting under-represented groups, and the recruitment of additional carers with lived experience to strengthen co-production and ensure under-represented groups have equitable access to support.

5. Primary, Secondary and Community Healthcare

- 5.1 Carers Leeds has had a presence in Leeds Teaching Hospitals Trust (LTHT) for 10 years and has an established base at St James Hospital, with two part time Carer Support Workers providing information, advice and support to carers in the hospital setting and support with discharge. The co-location of the team, means we are highly visible to LTHT staff, increasing referrals year on year. Carers Leeds has recently secured two years Leeds Hospitals Charity funding to employ an additional part time Carer Support Worker based at Chapel Allerton hospital.

Carers Leeds is an outside ear. They don't tell you what to do, they support you to make your own choices.

Unpaid Carer – Carers Leeds Impact Report



- 5.2 Carers Leeds has a presence in the Leeds Recovery Hubs in terms of two full time Patient Flow Carers Support Workers, funded by LCH. They support carers of people who will be self-funding packages of care on discharge, to navigate health and care services and self-funding arrangements.
- 5.3 Carers Leeds continues to work closely with Leeds Community Healthcare (LCH) and Leeds and York Partnership Foundation Trust (LYPFT), especially with the patient experience teams, to raise awareness of carers amongst their workforces. Carers Leeds actively participates in the LYPFT Triangle of Care Working Group, a national framework designed to help mental health trusts deliver services that recognise, include and value the role of carers in supporting people with mental health needs.
- 5.4 The Trust has launched its first Carer Passport for unpaid carers. The passport helps carers feel recognised and welcomed when visiting their loved one in hospital and offers access to a range of discounts. It also supports carers to be actively involved in their loved one's care plan, recognising the vital expertise they bring.
- 5.5 Carers Leeds have established relationships with primary care and have a named Carer Champion in each PCN and in 50% of GP practices. They distribute promotional materials to all GP practices to display in waiting areas and provide carer awareness training to clinical and non-clinical staff in primary care. Carers Leeds have an established primary care referral pathway, the Yellow Card.
- 5.6 Neighbourhood Proactive Care (NPC), is being rolled out to all Local Care Partnerships and Primary Care Networks in Leeds by March 2026, bringing together local health, care, and community professionals to proactively support people at high risk of a health or care crisis and their carers. By focusing on personalised goals, preferences, and priorities, NPC gives people and their carers more choice and control, with Care Coordination ensuring their holistic needs are met while reducing duplication across services. Although this group represents only 5% of the city's population, they account for 50% of unplanned bed days, 19% of outpatient appointments, 80% of social care packages, and an average of 15 GP appointments per year—often experiencing poorer outcomes.

6. Supporting children and young people who provide unpaid care

- 6.1 Leeds has adopted a version of the '[No Wrong Doors for Young Carers](#)' memorandum of understanding, developed by the [Carers Trust](#). This means that in Leeds, all agencies working with adults and children have a responsibility to identify any young person who lives with someone in their household with a caring need. When a young carer is identified there should then be a full family assessment, regardless of which service is contacted initially. Children & Families, Adults & Health directorates within the Council and NHS Leeds Integrated Care Board, commit through this memorandum to work together locally, adopting a whole system, council and family approach to providing support for young carers and their families in Leeds.
- 6.2 The Leeds Young Carers Support Service (LYCSS) support children and families. The service provides information and advice to young carers, their families, and practitioners. The service facilitates awareness raising and training opportunities including the "We Are Young Carer Friendly Leeds" Programme where settings across health, adults and children can be recognised as Young Carer Friendly through a set of quality markers and

on-going work with the service. LYCSS developed a brief assessment tool called “A Day in the life of” to support professionals to better understand the young carer and their family’s situation. Completing this informs which service may be best placed to provide support. LYCSS provides specialist family support, including an assessment of need, an outcome focused plan and possibly group work. The intended outcome of this work is to reduce the level of care a child or young person is providing, and to ensure the cared for person has the right support and care in place.



- 6.3 Government research shows that young carers miss around one month of school each year—significantly more than their peers—and national survey findings highlight the impact of caring on children’s wellbeing, with 29% reporting stress or worry, 36% feeling tired or worn out at school, and 29% not getting enough sleep. In Leeds, school census data continues to show low identification of young carers, although numbers have risen since the introduction of the Young Carer Friendly (YCF) programme—from 67 in 2023 to 96 in 2024 and 125 in 2025—as more schools engage with the approach. This reflects a national pattern of under-reporting but also demonstrates the growing impact of local awareness-raising and the YCF initiative.

"The support has been invaluable, and it's been so good having Jade advocate on behalf of us, making sure the right services are supporting us and properly"

"I worry about Mum less and now do less caring meaning I feel happier and focus on school more"

Young Carer – Leeds Young Carer Support Service

7. Unpaid Carers in the Workplace.

- 7.1 The council has recently been awarded Carer Confident Level 1 (Active), recognising the commitment to building awareness of carers in the workplace, supporting staff to self-identify, and establishing the foundations of a carer-friendly culture. Achieving Level 1 demonstrates that the council has the essential building blocks in place, and the next step is to work towards Level 2 (Accomplished) by strengthening support for employees with caring responsibilities.
- 7.2 Carers Leeds facilitates an active Employer Forum for organisations across Leeds including Blacks solicitors, Channel 4 and Northern Gas. The forum has 50 members and meets quarterly to share ideas and best practice around identifying, engaging, supporting, and retaining working carers in the workplace. Carers Leeds provides bespoke consultancy support to employers, helping them to identify and support carers in their workforce and develop and promote carer-friendly employment opportunities. This includes workforce analysis, designing carer policies, training for managers, and implementing best practice. Carers Leeds have achieved the highest-level Carers UK Carer Confident Level 3 Award (Ambassador) for its gold standard policies and practice in

relation to working carers. Leeds City Council and the NHS Trusts in Leeds are members of the Carers UK Employers for Carers network.

- 7.3 An increasing number of employers now use Carer Passport schemes to identify and support carers and help retain valuable staff. The passport facilitates conversations about the flexibility needed to balance work and caring responsibilities within existing policies. Both LTHT and the council use the scheme to support their employees.





2026 – 2027 Work Plan

In response to the recent CQC assessment, diagnostic assessment and the councils own review—and in alignment with the Health and Wellbeing Strategy and the wider Leeds Ambitions—the following plan sets out a programme of delivery.

Our mission is to tackle the inequalities experienced by unpaid carers and strengthen the information, advice and support that enables them to sustain their caring roles.

The following proposals are underpinned by the city’s four ambitions—Healthy, Growing, Thriving and Resilient—and focus on improving early identification, access to information, mental health support, inclusive community provision, and system-wide workforce confidence.

Leeds Ambitions	Drivers	Proposal	Successes	Owner
Healthy <i>Leeds will be a healthy and caring city for everyone: where together we create the conditions for healthier lives so people who are the poorest improve their health the</i>	Strengthen Early Identification and Information Pathways for Unpaid Carers in Leeds	Implement a coordinated early-identification and information pathway across ASC, NHS partners, and the third sector that: <ul style="list-style-type: none"> Ensures all frontline staff have the opportunity complete updated carer-awareness and identification training. Introduce a “Carers Information Offer” for professionals to use at first contact (ASC, primary care, VCS partners). – Information resource 	75% of frontline workforce trained by March 2027. 25% increase in the number of carers identified at first contact. 15% reduction in carers reporting that they “did not know where to go for help”. Quarterly Care Champion network meetings held, with attendance	Carers Partnership

<p><i>fastest, and everyone is supported to thrive from early years to later life</i></p>	<p>Strengthen Mental Health Support & Suicide Prevention for Unpaid Carers</p>	<ul style="list-style-type: none"> Expand the Care Champion model (currently in place across ASC teams and GP surgeries) –To primary care, secondary/community healthcare and VCS Reduce barriers to accessing support by providing culturally relevant, accessible resources - continuing to offer information, advice through many different contact methods - telephone, digital, face to face, community presence. <p>Rolling out the newly developed carer-specific suicide prevention training and resources (created by Carers Leeds with unpaid carers and academic collaborator <i>Siobhan O’Dwyer</i>) across the Leeds Health and Care System.</p>	<p>from all sectors and logged actions showing continuous improvement.</p> <p>Annual survey shows improvement in carers’ understanding of available support by 20%.</p> <p>250 professionals trained in carer-specific suicide prevention.</p>	<p>Carers Leeds</p>
<p>Growing</p> <p><i>Leeds will be a place where we reduce poverty and inequality by creating growth in our economy that works for all</i></p>	<p>Improve Employment Support & Financial Resilience for Unpaid Carers</p>	<p>Using the existing Carers Leeds Employer Forum (50 employer members) as the primary vehicle to drive best practice, shared learning and innovation across the city.</p> <p>Supporting more organisations to access bespoke consultancy from Carers Leeds (workforce analysis, policy design, manager training, carer-friendly practice).</p> <p>Raising employer standards by promoting uptake of the Carers UK Carer Confident Award and</p>	<p>Increase reach and participation in the Carers Leeds Employer Forum</p> <p>10 employers achieving Carer Confident Level 1 or higher.</p> <p>Leeds City Council accredited at Carer Confident Level 2</p>	<p>Carers Leeds</p> <p>LCC</p>

		<p>showcasing Carers Leeds' own Ambassador-Level achievement as the benchmark.</p> <p>Progressing Leeds City Council from Carer Confident Level 1 (Active) to Level 2 (Accomplished) by strengthening internal support for staff with caring responsibilities.</p>	<p>15% increase in self-identification of carers within the council workforce.</p> <p>15% improvement in employed carers reporting they feel supported at work (Carer Passports)</p>	
<p>Thriving</p> <p><i>Leeds will be a welcoming, safe and clean city where people have the power to make the changes that are important to them, with cohesive and united neighbourhoods where people are living healthier lives</i></p>	<p>Strengthen Community-Based Support & Connection for all Carers including those from Diverse Communities.</p>	<p>Implement a targeted community engagement programme to strengthen support for underrepresented and ethnically diverse carers, including:</p> <ul style="list-style-type: none"> - A carers' self-assessment rolled out through VCS partners (Touchstone, Leeds Black Elders, Association of Blind Asians). <p>Grow The Caring Kind Project to increase the number of carer breaks which appeal to a diverse carer population and ensure that these are matched with carers who need them.</p> <p>Adult Social Care– Audit Participation group – Practitioner review of social work practice. Carers Assessments</p>	<p>25% increase in engagement from global majority carers.</p> <p>500 breaks per year available for carers in Leeds, with take up from carers who reflect the diverse carer population.</p> <p>A review of 30 referrals for a carers assessment – deep dive into assessment outcomes for learning and development.</p> <p>Review findings and implement action plan</p>	<p>ASC VCS</p> <p>Carers Leeds – Caring Kind Project.</p> <p>ASC</p> <p>Commissioning</p>

Meeting name:	Leeds Committee of the West Yorkshire Integrated Care Board
Agenda item no.	15
Meeting date:	11 February 2025
Report title:	Work, Skills and Health Programme Update – Healthy Working Life
Report presented by:	
Report approved by:	
Report prepared by:	David Edeson

Purpose and Action			
Assurance <input type="checkbox"/>	Decision <input checked="" type="checkbox"/> (approve/recommend/ support/ratify)	Action <input type="checkbox"/> (review/consider/comment/ discuss/escalate)	Information <input type="checkbox"/>
Previous considerations:			
<p>Over 2025/26, the Healthy Working Life accelerator funding has supported a range of local schemes aimed at improving work, health and skills outcomes across West Yorkshire. This has included activity across fit note utilisation, community-based prevention, long-term conditions, weight management, and neurodevelopmental pathways, aligning with wider ICB and WYCA work and the commitments set out in the Work, Health and Skills Plan.</p>			
Executive summary and points for discussion:			
<p>Financial Position (as of January 2026)</p> <p>To date, there is no confirmation of recurrent or extension funding for the accelerator element of Healthy Working Life for 2026/27.</p> <p>There may be other future funding routes but these are also unconfirmed and wouldn't be expected to start until November 2026 at the earliest and will be significantly less than received for the accelerator.</p> <p>Given this position, no bridging funding is expected in the first half of 2026/27, and the ICB matrix team has advised planning on the basis of minimal confirmed resource.</p>			
<p>Proposed Approach to Current Schemes</p> <p>In light of the funding gap, it is proposed that all current fixed-term Healthy Working Life schemes will come an end at the end of their contracts, as was always signalled in the original contract discussions, with the following exceptions or transition arrangements:</p> <ul style="list-style-type: none"> • Fit Note Project – continues into 2026 under existing funding; may be extendable using WorkWell monies once allocations are confirmed. • Community Hypertension Project – efforts will be made to secure funding via Trailblazer or ICB allocation routes. • William Merritt – efforts will be made to secure funding via Trailblazer 			

- MLTC Programme – to be rolled into HomeFirst 2, aligning with wider long-term conditions transformation.
- Weight Management Programme – funded through the new model from July 2026 (independent of HWL accelerator).
- ADHD / Neurodevelopmental Work – to be absorbed into existing ND workstreams.
- Other Activities – most were extensions of existing services and will continue through their core programmes.

The proposal is to review learnings from the Accelerator with evaluation delivery in April 2026 to determine priority activities for future schemes should any future funding become available.

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

- Improve healthcare outcomes for residents in their system
- Tackle inequalities in access, experience and outcomes
- Enhance productivity and value for money
- Support broader social and economic development

Recommendation(s)

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

1. Consider and endorse the recommendation of the ICB matrix team that, subject to absence of confirmation of recurrent 2026/27 resources, all fixed-term Healthy Working Life schemes come to an end at the end of their contract periods, with the transition arrangements noted above.

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:

Appendices

- 1.

Acronyms and Abbreviations explained

- 1.

What are the implications for?

Residents and Communities	
Quality and Safety	
Equality, Diversity and Inclusion	
Finances and Use of Resources	
Regulation and Legal Requirements	

Conflicts of Interest	
Data Protection	
Transformation and Innovation	
Environmental and Climate Change	
Future Decisions and Policy Making	
Citizen and Stakeholder Engagement	

Meeting name:	Leeds Committee of the West Yorkshire Integrated Care Board
Agenda item no.	16
Meeting date:	11 February 2026
Report title:	Merger Application – Manston Surgery and Ashfield Medical Centre
Report presented by:	Kirsty Turner, Associate Director of Primary Care
Report approved by:	Kirsty Turner, Associate Director of Primary Care
Report prepared by:	Lisa Kundi, Senior Pathway Integration manager

Purpose and Action			
Assurance <input type="checkbox"/>	Decision <input checked="" type="checkbox"/> (approve/recommend/ support/ratify)	Action <input type="checkbox"/> (review/consider/comment/ discuss/escalate)	Information <input type="checkbox"/>
Previous considerations:			
<p>In December 2025 the Primary Care Operational Group (PCOG) recommended approval of the merger request from Ashfield Medical Centre and Manston Surgery following a previous request to commence patient engagement in August 2025.</p> <p>PCOG recognised this was a complex scenario but ultimately supported the request for merger to continue to build capacity in the local area and focus on improving services for patients.</p>			
Executive summary and points for discussion:			
<p>Ashfield Medical Centre (AMC) currently serves a list of 6,308 patients and Manston Surgery (MS) a list of 8003 patients (October 2025). The practice currently operates across 4 sites and is led by the same partnership of Dr Walling and Dr Nathan.</p> <p>There are several aspects to this change:</p> <ul style="list-style-type: none"> • The merging of the contracts (April 2026) - requires approval from ICB • The closure of the dispensary at Scholes (November 2025) – 3 months’ notice was served by the practice and the dispensary has closed. • The closure of the Manston branch site at Scholes (April 2026) – Landlord has given notice and therefore the site will close • A change of clinical system at Manston to EMIS through GP system of choice. (December 2025) Impact on patients requiring action to reestablish access • A change in name to reflect the move to 1 practice with 3 sites (TBC) <p>A robust engagement exercise was undertaken over a period of 9 weeks. This paper will summarise the key outcomes from the feedback gathered, the practice responses and the impact the merger of the two practices will have. It sets out the recommendations for the Leeds Committee of the ICB to consider who are required to approve the proposed merger.</p>			

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

- Improve healthcare outcomes for residents in their system
- Tackle inequalities in access, experience and outcomes
- Enhance productivity and value for money
- Support broader social and economic development

Recommendation(s)

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

1. **Note** the feedback from patients and local stakeholders around the impact of the merger and other changes
2. **Note** and agree the recommendations for the future provision for the Scholes population
3. **Approve** merger of Ashfield Medical Centre and Manston Surgery

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:

Appendices

1. Business Case
2. Engagement Report
3. Equality and Impact Assessment (EIA)
4. Quality and Equality Impact Assessment (QEIA)

Acronyms and Abbreviations explained

1. AMC – Ashfield Medical Centre
2. MS – Manston Surgery
3. ICB – Integrated Care Board
4. EIA – Equality Impact Assessment
5. QEIA – Quality and Equality Impact Assessment
6. PCOG – Primary Care Operational Group
7. PPG – Patient Participation Group
8. DDA – Disability Discrimination Act
9. CQC – Care Quality Commission

What are the implications for?

Residents and Communities	<p>The proposal submitted for approval is for the merger of the two practices however, as demonstrated by the engagement report the more significant aspect of the change relates to the closure of the Scholes site and dispensary.</p> <p>The pharmaceutical regulations require 3 months' notice to terminate a dispensary service and the ICB is obliged to accept this.</p> <p>The landlord of the Scholes site has given notice to the practice as tenants to vacate the site at the end of March 2025. As the landlord has given the practice notice, as an ICB we do not have the ability to reject this closure.</p> <p>The engagement exercise clearly reflects that it is this closure that will have the greatest impact on residents in the Scholes and neighbouring community.</p> <p>The merger and the closure of a site cannot be separated despite different decision-making processes. Residents have concerns that they will see an overall reduction in the service offer and level of personalisation they receive in particular those that use the Scholes site.</p>
Quality and Safety	<p>The aim of the merger is to improve access and the range of services on offer for all patients as well as streamline the back-office functions across all sites to enable the business to run more efficiently and effectively through a reduction in administration.</p> <p>Quality will be improved by providing a more resilient and stable workforce across a larger footprint with the ability to share expertise and reduce administration.</p> <p>Whilst it is important to recognise the strong feedback regarding the closure of Scholes as part of the engagement there are opportunities to improve the service offer to patients.</p> <p>Currently, capacity at Scholes is not fully utilised, moving this capacity to other sites will enable the practice to ensure that appointments are better filled, the merger will create further opportunities to offer wider appointment options and increase appointment fill rate across a wider patient population.</p> <p>The site at Scholes is not (Disability Discrimination Act (DDA) compliant and does not have the facilities to offer appointments beyond GPs such as nurses,</p>

	<p>HCA or PCN services. The provision of a service at alternative sites, whilst further, will offer a better patient experience in terms of modern estate facilities, a one stop shop and accessibility.</p>
<p>Equality, Diversity and Inclusion</p>	<p>In recognition of the breadth of changes a Quality Equality Impact Assessment (QEIA) and Equality Impact Assessment (EIA) have been completed and has been included as appendices. Both the EIA and QEIA have now been to panel who are fully assured that the changes have been fully considered and a that robust action plan has been put in place.</p> <p>The reports clearly outline a greater impact on older patients within the Scholes community. This section of the patient population is more likely to suffer from long term conditions and need to access health services more frequently.</p> <p>Due consideration must be given to ensuring that this population continue to receive the healthcare they need.</p>
<p>Finances and Use of Resources</p>	<p>There will be a small reduction in estate costs following the closure of the Scholes branch. Due to the size and condition of the building this does not deliver a significant saving.</p> <p>There may be a reduction in dispensing costs as patients move from receiving their medications from the practice dispensary to community pharmacy due to how dispensing practices are incentivised under their contract.</p> <p>Discussions regarding future estate arrangements of the practices are ongoing. The partnership has been open as part of the engagement that they are pursuing opportunities to obtain an additional/replacement site that is closer to Scholes village than the current locations.</p> <p>The ICB is working with Leeds City Council to plan for a new site along the East Leeds Orbital Route (ELOR) on land that has been identified by the council. An expression of interest exercise closed at the end of December 2025.</p> <p>Whilst the practice has expressed an interest, the ICB must follow due process in line with procurement guidance and there is no guarantee that the partnership will be successful in securing these premises. If the partnership were successful, the site would align well to the location of Scholes and their registered population.</p> <p>Regardless of who is successful in securing the site, patients will have the choice to register here.</p>
<p>Regulation and Legal Requirements</p>	<p>The application to merge the practices has been enacted in line with section 8.11.25 of the Policy and Guidance Manual</p>

Conflicts of Interest	None identified.
Data Protection	None identified.
Transformation and Innovation	This request will enable the practices to have greater opportunity to innovate and transform across a larger footprint.
Environmental and Climate Change	The closure of the Scholes site will mean that more patients will need to travel by car to access GP services.
Future Decisions and Policy Making	This proposal has been submitted independently of future developments as part of the ELOR and GP Surgery site identified however, there is a clear link between the two and consideration should be given to the longer-term potential to find a permanent solution for this population of Scholes.
Citizen and Stakeholder Engagement	The engagement report in Appendix 2 gives a detailed account of the engagement process undertaken and a full breakdown of the feedback.

1. BACKGROUND / SUMMARY OF PROPOSAL

- 1.1 This paper outlines an application from Ashfield Medical Centre (AMC) and Manston Surgery (MS) to merge their practices from 1 April 2026. The paper also outlines some further changes the practices are implementing that do not require approval but will have a significant impact on the population. The practices have engaged with their population on all of these changes.
- 1.2 Ashfield Medical Centre and Manston Surgery are operated by the same partnership, Dr Walling and Dr Nathan. The partnership currently holds a separate PMS contract for each practice, operating across 4 sites with each practice having a main and branch site. Both practices are part of the Crossgates Primary Care Network (PCN).
- 1.3 By way of background, in January 2024, the Care Quality Commission (CQC) rated Manston Surgery as inadequate following inspection. One of the areas of improvement identified as part of the review was around leadership capacity and during this time Ashfield extended mutual support to help streamline processes and to provide leadership which led to the development of a new partnership between all partners (across the two practices).
- 1.4 It is recognised that following a period of significant work, Manston Surgery has now been rated as Good by CQC however during this period the partners at Manston expressed a desire to step down from the partnership and move to a salaried position, leaving the Ashfield partnership on the PMS contract (in addition to their existing Ashfield contract).
- 1.5 The partnership now wish to merge both contracts so that they can further improve services and streamline their own operations with more opportunities to do this across one footprint to ensure robust and effective leadership.
- 1.6 The landlord for Scholes Surgery has also given notice to the partnership as they intend to sell the building. This site also operates a dispensary and so as part of the changes, the dispensary has now closed following the required notice period being served. The Scholes site is still operational until the end of March 2026 when the landlord will move forward with the sale of the building.
- 1.7 In preparation for the merger of the two practices (subject to approval), Manston Surgery migrated to the EMIS clinical system with effect from December 2025. The change to clinical system was included as part of the engagement to inform patients of this change and the system change over appears to have been well received.

- 1.8 The partnership intends to rename the practice following approval to merge so that it better reflects the geography that the practice serves. The practice will need to submit a request to the ICB for this change in due course for formal approval.
- 1.9 The partnership anticipates that the merger will provide stability for registered patients, economies of scale with the opportunity to invest and develop services, increase patient choice, and improve patient experience whilst operating over a larger footprint to create a sustainable business model.
- 1.10 A robust engagement exercise has taken place over a period of 9 weeks. This paper summarises the key outcomes from the feedback, the practices response and the impact the merger and other changes will have. It should be noted that the decision for consideration by the Leeds Committee is on the formal approval to merge, it is important to note the concerns regarding the other changes and be assured by the practices plans to mitigate some of the concerns identified by residents.

2. PRACTICE INFORMATION

- 2.1 AMC currently serves a list of 6,308 patients and MS a list size of 8003 (October 2025).
- 2.2 The practice currently operates over 4 sites, a map of these is available in the engagement report. The partnership has no plans to amend the boundaries and intend to merge the existing geographies.
- 2.3 There is a distance of 0.4 miles between the main sites. Scholes Surgery which will close at the end of March 2026 is a distance of 2.8 miles from Manston, 3.4 miles from Ashfield and 2.3 miles from the branch site The Grange at Seacroft. (All distances reflect the fastest driving distance on google maps).
- 2.4 There is public transport available however, Scholes residents have reported long standing issues with the frequency and reliability of this service; particularly for those that are less physically able to use this service or in periods of bad weather. Residents and councillors have been seeking changes for many years with no success to date.
- 2.5 The practices' premises meet all current DDA and infection control standards with the exception of the site at Scholes. The Scholes site offers GP appointments only as it does not have the facilities nor the clinical room space to support nurse or HCA led appointments. The site at Ashfield Medical Centre needs modernisation and had previously been due to move to a new site at Crossgates Library however, the move did not go ahead.
- 2.6 The Scholes site was a dispensing location until November 2025 when the dispensary ceased to operate. The new partnership upon taking on the contract

quickly identified that the service was not financially viable. Three months' notice was submitted to the ICB and the dispensary has now closed.

- 2.7 Accessible car parking is available at all sites except Scholes Surgery where there is on street parking only. Whilst there is a car park at Manston Surgery it does not have the capacity to deal with demand (there is another practice also co-located in the building) and on street parking is difficult around this site if a patient is unable to walk short distances.

3. **STRATEGIC CONTEXT**

- 3.1 The ICB has previously determined the need for a new practice to support the increased population expected with the East Leeds Extension which covers areas bordering the practice catchment area including Red Hall, Swarcliffe, Whinmoor and Crossgates, with the East Leeds Orbital Route (ELOR) connecting communities. Around 5,000 new homes are expected as part of the East Leeds Extension.

- 3.2 Land has been identified at Pendas Beck to support the development of a local centre including a healthcare facility and the ICB has recently undertaken an Expression of Interest with local practices to identify the preferred provider of this newly identified branch site.

- 3.3 The new development at Pendas Beck provides a longer term opportunity to mitigate the impact of the changes at Scholes by providing a modern fit for purpose facility for this growing population.

4. **PATIENT ENGAGEMENT**

- 4.1 The engagement process began on 12 September 2025 and closed on the 12 November 2025 (9.5 weeks). The engagement was extended so that an additional meeting could be held in Scholes.

- 4.2 The practices led on the engagement, and a variety of activities and methods were used to seek the views of as many registered patients as possible across all practice sites.

- 4.3 A link to a letter outlining the proposed changes was sent through PATCHS (the practices online consultation tool) to all patients registered with a mobile number on their record. The practice was able to identify those patients who did not open the message and send a paper version of the letter. In addition, those that live in Scholes Village were written to directly given the scale of the changes affecting residents of the village. The letter included an outline of the merger plans, the other planned changes and an invitation to take part in the engagement activities.

- 4.4 A survey was developed that was available to patients online with a link in the letter, or as a hard copy available in the practices to ensure those unable to

access the survey online were still able to provide feedback. Surveys in alternative formats or different languages were available on request.

- 4.5 The proposed changes were outlined on both practice websites with a link to the online survey.
- 4.6 The partnership organised and held four face to face public Q&A events at Scholes, Manston and The Grange Surgery. The first meeting at Scholes was oversubscribed due to the room capacity limitation of 60, so 2 meetings were run back to back on this date. There was still a cohort of patients that attended but were unable to access the first meeting and could not wait until the second meeting. Members of the parish council kindly collected contact details, and a further meeting was arranged whereby patients from this list were personally invited.
- 4.7 A message was sent to all patients to inform them that an additional meeting would be held in Scholes. Dr Walling personally led all meetings supported by his management team.
- 4.8 The practices responded to informal queries raised by patients in person and over the phone.
- 4.9 A total of 401 people formally participated in the engagement process through either attending a meeting or submitting a survey.
 - 167 attended the public meetings - of these 145 (87%) were attendees of the Scholes meetings
 - 234 people completed the survey, including paper copies. 136 (58.7%) said they used or were a carer/friend/relative of someone who used the Scholes Surgery site.
- 4.10 An FAQ document was created with responses to patients' queries and concerns. This was updated throughout the engagement process in response to survey feedback and questions raised at the public events. A breakdown of the responses and assurances given to the concerns raised can be found in the full engagement report in Appendix 1.
- 4.11 The engagement identified some key themes, including:
 - Accessibility and travel / transport including parking concerns
 - Uncertainty about service quality and continuity of care
 - Quality of care and funding – potential for a merger to degrade quality and access over time.
 - Booking systems including access by telephone and online and risk of digital exclusion
 - Appointment availability by location and patient preference
 - Loss of a local service and the community impact.
 - Concerns for more vulnerable residents and continued ease of access

- Concerns regarding maintaining medication supply and new arrangements particularly understanding the offer of an online pharmacy
 - Cautious optimism about the benefits outlined by the practice and a willingness to await the delivery of benefits post-merger
- 4.12 The Engagement Report details the engagement process and outcomes and the practice response to the feedback received (see Appendix 2).
- 4.13 Prior to the commencement of the engagement exercise both practices sought to engage the Practice Participation Group (PPG) to understand their views on the engagement plan and approach. Unfortunately, MS did not have an active PPG and so the plan was only shared with AMC PPG who did not have any comments. As a result of the survey 35 patients have since expressed an interest in the PPG and so the practice are confident that they will be able to build an effective PPG building on this interest.

5. COMMUNICATIONS AND INVOLVEMENT

- 5.1 Plans for the merger were shared with local councillors, parish councillors and MPs. The Councillors for the outer wards have been involved in the engagement and attended all meetings in Scholes. The initial meeting in Scholes was attended by Sir Alec Shelbrooke (MP). Mr Shelbrooke has written to the Secretary of State for Health and Social Care Rt Hon Wes Streeting to express his concerns about the planned closure of Scholes.
- 5.2 The councillors for Crossgates and Whinmoor also contacted the ICB for further information. They were concerned about the overall impact on local services of the significant new housing developments in the area more so than the changes proposed by the practices.
- 5.3 Plans for the merger were shared with local practices within the PCN and local pharmacies. There were no concerns received however, one pharmacy extended an offer to work closely together through the transition should patients choose this pharmacy provider.
- 5.4 Garforth Medical Centre have observed an increase in registrations from Scholes Village registering with their Barwick Site (around 20+). They have building alterations planned to expand capacity and do not feel at this point that the increase in demand is a concern. This site also acts as a dispensary so may be a preferred option for some patients who wish to retain access to this type of pharmacy.
- 5.5 The ICB have met several times with the local councillors who are keen to work with us to identify a temporary option for Scholes until the new site at Penda Beck is in place. The ICB and the practice have agreed to work through any options that the councillors have identified and understand the costs/benefits

and viability. The ICB have confirmed that as in other similar scenarios an interim taxi budget will be made available for patients who require this support to access services.

6. PRACTICE RESPONSE AND CONSIDERATIONS

- 6.1 The patient engagement process conducted by the practices was a robust and thorough exercise which allowed patients to access various engagement methods to provide feedback. As stated above, at least 401 registered patients contributed to the engagement (a number of surveys appeared to be a collation of several residents' comments).
- 6.2 The practice made arrangements to extend the engagement and hold a further meeting in Scholes village as the initial meeting was oversubscribed, despite two sessions being accommodated on the day. They wanted to ensure that all residents had the opportunity to hear from the partnership, ask questions and raise their concerns about the proposals.
- 6.3 The feedback was very much focused on the proposed changes affecting residents of Scholes. There is a high level of concern amongst residents that more vulnerable groups will be disproportionately affected. The practice understands this concern and have set out measures they intend to put in place to ensure that patients continue to receive the care they need (Appendix 2 Engagement Report).
- 6.4 The remainder of the practice population, not directly affected by the site closure had more general concerns of what the changes meant for their ability to get an appointment. Their focus was on current challenges and seeking assurance that these were being addressed and that the changes would have no impact on their access or care that they receive.

7. PROPOSAL

Option	Benefits	Risks
Reject the application to merge Ashfield Medical Centre and Manston Surgery.	Patients may feel reassured with less change taking place alongside the other changes already happening at the same time.	<p>The practice would continue to have an increased administrative burden which would mean that their ambition to channel more resource into direct patient care would not be realised.</p> <p>Rejecting the proposal would not impact the implementation of the wider changes planned and Scholes patients who choose to remain registered would only be able to attend the</p>

		<p>Manston site which may not be their closest option.</p> <p>Without the merger, there is a risk to the financial viability and limited scale of the practice to invest in a new site which they are keen to take forward to update their estate.</p>
<p>Approve the application to merge Ashfield Medical Centre and Manston Surgery.</p>	<p>Supports the practice plans for long term viability, improved service offering and reduced administrative burden.</p> <p>Will support access improvements by combining the best of both practices, improving resilience and business continuity and offering choice of site and clinician to patients.</p>	<p>There a number of aspects to the changes outlined in the engagement which have proved contentious. The ICB is unable to influence some of these changes but can make a decision on the merger.</p> <p>There is a risk that approving the merger means that patients feel that the ICB has not given due consideration to their concerns raised in the engagement.</p>

8. FINANCIAL IMPLICATIONS AND RISK

- 8.1 There is a small saving to the ICB in rent reimbursement for the Scholes site. Local councillors are keen to work in partnership and identify a temporary site in Scholes until the Pendas Beck site is mobilised. Should there be an affordable, viable option there may be some cost consideration to this and we will continue to explore this option with councillors and Leeds City Council.
- 8.2 As with previous changes of this nature, a site closure in a village location, the ICB will make available an interim taxi budget based on set criteria to ensure those that may not be otherwise able can continue to access the care they need.

9. STATUTORY / LEGAL / REGULATORY / CONTRACTUAL

- 9.1 The merger application has been considered in the context of The Primary Medical Services Policy Guidance Manual (Section 8.11) which clearly sets out what should be considered by the commissioner when deciding on practice

mergers and PCOG were assured that these factors have been assessed throughout the application, engagement and final report.

- 9.2 An Equality Impact Assessment (EIA) and a Quality and Equality Impact Assessment (QEIA) has been completed to ensure due consideration has been given to the impact on patients as a whole and identifying any adverse impact for cohorts of patients identified with protected characteristics or vulnerable communities. See Appendix 3 & 4.

10. WORKFORCE

- 10.1 The practice does not plan to reduce their staffing levels. There will be some changes to staff roles who were aligned to the dispensary site at Scholes. The practice has offered alternative roles to these staff at other sites.

11. NEXT STEPS

- 11.1 The practice dispensary has now closed and the practice has worked with all patients to ensure that a new nominated pharmacy that meets the patients needs has been identified.
- 11.2 Manston Surgery moved over to the EMIS clinical system on 10 December 2025 and will be working intensively with staff and the system to ensure that access to services to maintained. There will be some disruption in access to records, prescriptions and patient online record access. The practice are working closely with EMIS and the GP IT team to make the transition as smooth as possible.
- 11.3 The Scholes site will close fully at the end of March 2026, the practice will need to put in place a full close down plan ensuring that anything on the site is cleared and retained / disposed of appropriately. The closure of a branch site will require a contract variation to be issued.
- 11.4 The Engagement Report has now been finalised and can be uploaded to the practice website for patients and the public to view.
- 11.5 The practice and ICB will continue to work with local councillors to explore the viability of a temporary site in Scholes.
- 11.6 Subject to the merger being approved, the practice will work alongside the ICB to implement the mobilisation plan.

12. RECOMMENDATIONS

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

- a) **Note** the feedback from patients and local stakeholders around the impact of the merger and other changes

- b) **Note** the continued focus on identifying options for the future provision for the Scholes population
- c) **Approve** merger of Ashfield Medical Centre and Manston Surgery

Proposal for a practice merger

Applications to merge practices must be submitted at least 4 months before the intended effective date.

Proposed date of merger	1st April 2026
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1. Details of the contractual agreements you are proposing to merge:

Practice Name and Address Practice A	Practice Name and Address Practice B	Practice Name and Address Practice C	Practice Name and Address Practice D
Ashfield Medical Centre	Grange Medical Centre	Manston Surgery	Scholes Surgery
Practice Code	Practice Code	Practice Code	Practice Code
B86055	B86055	B86009	B86009
Main/Branch	Main/Branch	Main/Branch	Main/Branch
Main	Branch	Main	Branch
GMS/PMS	GMS/PMS	GMS/PMS	GMS/PMS
PMS	PMS	PMS	PMS
Number of GPs	Number of GPs	Number of GPs	Number of GPs
5		6	
Number of WTE GPs	Number of WTE GPs	Number of WTE GPs	Number of WTE GPs
3.25		3.5	
Number of Nurses and Grade	Number of Nurses and Grade	Number of Nurses and Grade	Number of Nurses and Grade
1 x ACP 1 x Nurse Manager 2 x Practice Nurses Band 5		2 x Practice Nurses Band 6	
Number of WTE Nurses	Number of WTE Nurses	Number of WTE Nurses	Number of WTE Nurses
Premises Owned/Leased/NHS PS	Premises Owned/Leased/NHS PS	Premises Owned/Leased/NHS PS	Premises Owned/Leased/NHS PS
Owned	Owned	Leased	Leased
Patient List Size	Patient List Size	Patient List Size	Patient List Size

6408		8163	
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2. Proposed Merger

Reasons for proposed merger
<p>This proposal to merge include the following elements:</p> <ol style="list-style-type: none"> 1. The merger of the two practice contracts 2. The closure of the Scholes site including the dispensary 3. A change of name for the practice which is yet to be proposed and will form part of the engagement <p>On 1st May 2025, Dr A Walling and Dr S Nathan assumed the PMS contract for Manston Surgery. Both practices have been collaborating within their PCN. Following a recent CQC report that placed Manston Surgery into special measures one of the areas identified was leadership deficiencies, Ashfield extended mutual support to streamline processes and to provide leadership structure. During discussions, Manston's current partners expressed a desire to step down, leading to an agreement for Ashfield's partners to take over the PMS contract as well as Ashfield. Implementing a streamlined management structure to ensure robust and effective leadership is in place.</p> <p>The merger of the practices will enhance efficiency, provide staff depth for resilience, and address estate capacity issues, enabling recruitment and improved patient access. Additionally, it will reduce administrative burdens by eliminating the need to duplicate tasks such as claims, CQC documentation, and required submissions to NHSE and ICB.</p> <p>The Scholes site, which also hosts the dispensary is owned by the previous partnership of the practice who have expressed intent to sell the building. The premises, a converted house, offers limited facilities with only one consultation room, thereby restricting the provision of nurse, midwifery, and enhanced services. The site is not suitable for modern healthcare services and so the partnership do not propose to buy the building.</p> <p>Additionally, the dispensary service is not financially viable. The new partnership's long term plan is to not continue with the service in order to ensure the future financial viability of the practice and offer a consistent service to all patients. The merger would lead to one practice operating across 3 sites and so a new name to reflect this new configuration would help patients to better understand the geographical boundary and service offer.</p>
Benefits of Proposed Merger for Patients

1. **Expanded Services:** Merging two practices can lead to a broader range of medical services and specialties being available to patients. This means patients can access a more comprehensive set of healthcare offerings without having to visit multiple locations.
 2. **Improved Access to Care:** With a larger combined practice, there is the potential for patients to attend at either site which may be more convenient and also will give more capacity for additional sessions. Through greater efficiency a larger proportion of our staffing budget can be spent on clinical staff, therefore increasing patient access.
 3. **Enhanced Technology and Resources:** Merging practices can pool resources and also find new ways of working that are more beneficial to patients.
 4. **Continuity of Care:** Merging practices can create a more stable and resilient healthcare environment, ensuring that patients receive continuous care even if one of the practices faces challenges.
 5. **Increased Collaboration:** A larger practice has a larger group of healthcare professionals, enabling better collaboration between healthcare professionals to deliver integrated and coordinated care.
 6. **Reduced Waiting Times:** By combining resources and staff, the merged practice can potentially reduce waiting times for appointments and procedures, leading to quicker access to medical care.
 7. **Better Staffing Levels:** The merger can address workforce shortages by combining the staff from both practices, allowing for a more efficient allocation of healthcare professionals and support staff.
 8. **Streamlined Administrative Processes:** Merged practices can achieve economies of scale and simplify administrative tasks, leading to a more efficient patient experience and reducing paperwork and bureaucracy.
 9. **Enhanced Patient Education and Support:** A larger practice may be better equipped to offer health education programs, support groups, and other resources to help patients manage their health more effectively.
- Financial Sustainability:** Merging practices may improve financial stability, allowing for the longer term viability of the practice for the patients benefit.

Benefits of the Proposed Merger for the Practices

1. Enhanced Patient Care and Services:

Combining our resources and expertise would lead to improved patient care and services. With a larger team of healthcare professionals, we can potentially offer reduced waiting times, and a more comprehensive range of medical services. This will significantly enhance the overall patient experience, ultimately leading to increased patient satisfaction and loyalty.

2. Increased Efficiency and Resource Utilisation:

By pooling our resources, we can eliminate redundant processes and streamline administrative tasks. Shared facilities and staff would result in optimised resource utilisation and cost savings.

3. Expanded Specialisation and Expertise:

Both practices likely have clinicians with varying areas of specialisation, such as joint injections, coil fitting & implants. Merging would allow us to combine these specialties and offer a broader range of medical expertise under one practice. This means that patients will have access to a more diverse and knowledgeable team of doctors, ensuring comprehensive care for all their health needs.

4. Improved Financial Stability:

Healthcare systems, especially small independent practices, often face financial challenges due to increasing costs and reduced reimbursements. A merger would create a stronger financial base, enabling us to negotiate better contracts with insurers and suppliers. This

increased financial stability would safeguard the future of our practices and allow for further investment in quality improvement initiatives.

5. Enhanced Collaboration and Learning:

Merging two practices would encourage increased collaboration among healthcare professionals. This sharing of knowledge and best practices would lead to a positive learning environment, fostering professional growth and continued education among our team members. As a result, our doctors and staff would remain updated with the latest information.

6. Effective Population Health Management:

A combined patient database would provide a more comprehensive view of the local population's health status. This data-driven approach will aid in effective population health management, enabling us to identify prevalent health issues and design targeted interventions to improve community health outcomes.

7. Greater Influence in Local Health Policy:

As a larger and more influential entity, our merged practice would have a stronger voice in local health policy decisions. This would enable us to advocate for our patients' needs and contribute to shaping healthcare policies that benefit the community we serve.

8. Better Placed to deal with a Growing Population There is a large amount of house-building approved for the Crossgate's Area and a larger more resilient practice will be better placed to provide a comprehensive general practice service to this population.

9. Financial

Details of the current practice boundaries (inner and outer if agreed)

Please attach maps / descriptions

Please indicate the practice boundary for the proposed merged practice

The area will be the two areas overlaid and maintaining the existing boundaries

3. Practice opening hours

Please provide details of current core opening hours

Premises	Current Opening Hours	Current Surgery Hours
Practice A	8am – 6pm Mon-Fri	8am – 6pm Mon-Fri
Practice B	8am – 6pm Mon-Fri	8am – 6pm Mon-Fri
Practice C	8am – 6pm Mon-Fri	8am – 6pm Mon-Fri
Practice D	Monday 8.00am – 12noon Tuesday 8.00am – 12noon Wednesday 8.00am – 12noon – 2.30pm – 5.00pm Thursday 8.00am – 12noon Friday 8.00am – 12noon – 2.30pm – 5.00pm	Monday 8.00am – 12noon Tuesday 8.00am – 12noon Wednesday 8.00am – 12noon – 2.30pm – 5.00pm Thursday 8.00am – 12noon Friday 8.00am – 12noon – 2.30pm – 5.00pm

Please provide details of current extended opening hours

Premises	Current extended opening hours	Proposed extended opening hours
Practice A	N/A	N/A
Practice B	N/A	N/A
Practice C	N/A	N/A
Practice D	N/A	N/A

Are any changes planned to opening hours; if so please give details for each site affected. Please provide the rationale behind the changes and any patient consultation around the changes.
No change.

4. Services provided

Enhanced Services currently provided at:
Practice A QOF NHS Healthchecks QIS Implants Hospital Phlebotomy Minor Surgery Injections Frailty Scheme DMARD blood monitoring
Practice B QOF NHS Healthchecks QIS Implants Hospital Phlebotomy Minor Surgery Frailty Scheme DMARD blood monitoring
Practice C QOF NHS Healthchecks QIS Implants Hospital Phlebotomy Minor Surgery Frailty Scheme DMARD blood monitoring
Practice D QOF QIS Frailty Scheme

Enhanced services to be provided at merged practice: QOF NHS Healthchecks QIS Implants Hospital Phlebotomy Minor Surgery Frailty Scheme DMARD blood monitoring We would review any other services available and offer if at all possible .
--

5. Practice Premises

Please indicate whether you intend to operate from all practice premises: YES

a. If YES, which premises will be considered the main and which is to be considered the branch (if applicable)
Neither would be a branch site, The Grange and Scholes would continue to be branch sites
b. If NO, which practice do you intend to practice from
c. Do the proposed premises have the capacity and infrastructure to accommodate the additional patients and services
Yes
d. Details of the distances between the practices
e. Details of the distances between the practices
f. Details of car parking arrangements currently in place at all practices
Ashfield has a small patient parking space to the front of the building, with staff parking to the rear of around 8 cars double parked and has an ambulance Bay. The Grange has a large patient and staff car park with designated disabled parking and ambulance bays. Manston has a large staff and patient parking with spaces specifically for on call GP. Scholes site has on street parking only, with a limited driveway for staff parking.
g. Details of public transport to proposed sites
All sites are on major bus routes

Are any changes to the existing premises planned? – If so please give details
Yes the proposal includes the closure of the branch site at Scholes.

6. Technology

Please indicate which IT Clinical systems are currently in use at each practice i.e. EMIS, SystemOne

Practice A	Practice B	Practice C	Practice D
EMIS	EMIS	S1	S1
Has IT been consulted to assess if the systems are compatible to be merged?			Yes
Has IT been consulted to confirm the costs of the IT systems merger?			Yes
If YES, what are the costs?			TBC
Has IT confirmed the timescales of merging the databases?			No
Have the costs been approved by the CCG? Or are the practices self-funding?			No
Additional comments:			
We will conduct a thorough review and develop a business case to determine the most suitable clinical system for serving our population. Following our decision, all staff will receive comprehensive training and support to ensure a smooth transition and effective utilisation of the new system.			

Please give details of any changes to the Telephone Systems in use and any proposed changes.
Manston Currently use Smart IT and Ashfield use Redcentric, we will choose one system for both after discussion with both companies and review of other providers should they be a better provision available which will better support modern general practice processes. Both are on the Better Purchasing Framework so are CBT approved by NHSE.

7. Consultation and engagement

Details of Consultation already undertaken with patients (It is expected that a degree of consultation has taken place prior to a merger application being submitted.)
No activities have yet taken place, the engagement plan will be drafted shortly in conjunction with the ICB Comms and engagement team
Details of any patient feedback received
.
Details of future plans for patient consultation should the merger be approved including communicating the actual change and ensuring patient choice throughout.
Initial meeting with PPG to share the proposal and engagement plan to be scheduled in the next few weeks. A comprehensive engagement plan is being drafted working with the ICB primary care and communications and engagement team.
Details of Consultation with the CCG
The primary care team are supporting the practice through this process and have had several meeting to discuss the proposal and process.

9. TO BE COMPLETED BY THE COMMISSIONER

Please indicate if any of the following exist:

	Any remedial breach notices	Any performer issues
Practice A		
Practice B		
Practice C		
Practice D		

Three years QOF performance for each practice:

	22/23	21/22	20/21
Practice A			
Practice B			
Practice C			
Practice D			

Any other practice issues:

Please note the commissioner advises each party to seek their own financial advice in respect of areas such as superannuable earnings under each contract and a recommendation for the parties to have a formal partnership deed prepared to underpin the arrangements.

Any changes to any partnership will require a new registration with the CQC.

Note: this application does not impose any obligation on the commissioner to agree to this request.

Ashfield Medical Centre and Manston Surgery



(Proposed practice merger of Ashfield Medical Centre and Manston Surgery and closure of branch site Scholes Surgery)

Report on the patient / public engagement - Friday 12th September to 12th November 2025

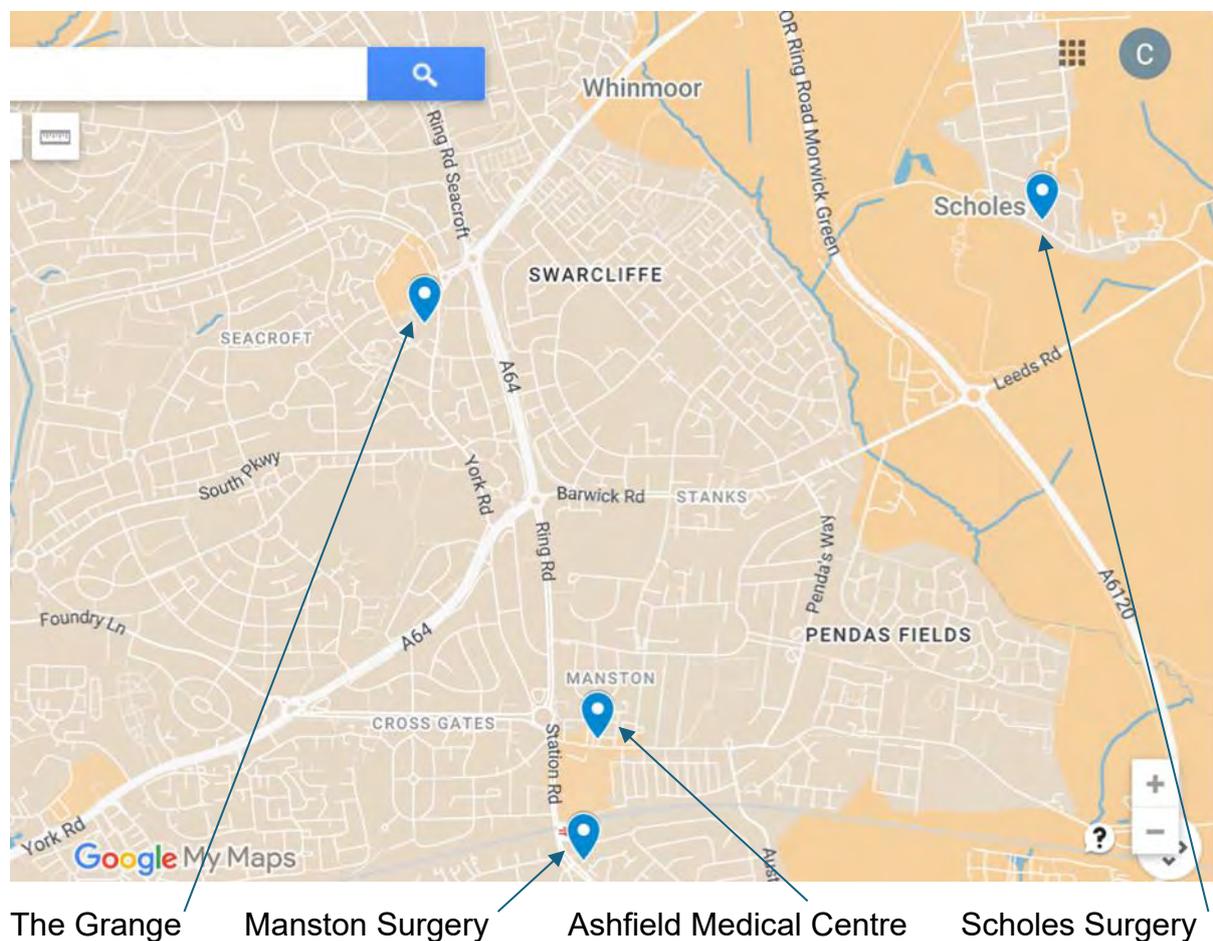
Publication date: December 2025

Executive Summary

Ashfield Medical Centre and Manston Surgery are located approximately 0.4 miles apart (around an eight-minute walk) in Cross Gates, Leeds, and are situated roughly 4.1 miles from Leeds city centre. Scholes surgery is around 3.4 miles by car from Ashfield Medical Centre, and around 2.8 miles to Manston Surgery.

Manston Surgery has more than 8,000 patients on its books, including those using its branch practice, the Scholes Surgery. Ashfield Medical Centre, along with its branch practice, Grange Medical Centre, has around 6,300 patients. They are all part of the Cross Gates Primary Care Network or PCN.

The map below shows the locations of both practices and their branch sites. The village of Scholes is situated just outside the East Leeds Orbital Road and recorded a population of 2,269 in the 2021 Census.



Following a Care Quality Commission (CQC) inspection in early 2024, Manston Surgery was placed into special measures, with leadership identified as a key area of concern. In response, Ashfield Medical Centre extended mutual support to Manston Surgery to streamline processes and strengthen leadership arrangements.

During these discussions, the current partners at Manston Surgery expressed a wish to move to a salaried position. This led to an agreement that the partners at Ashfield

Medical Centre would assume responsibility for the PMS (Personal Medical Services) contract at Manston Surgery, alongside their existing contract at Ashfield, and implement a unified, streamlined management structure to ensure robust and effective leadership across both sites.

On 1 May 2025, Dr A Walling and Dr S Nathan assumed the PMS contract for Manston Surgery. Both practices have an established history of collaboration within their Primary Care Network (PCN).

The proposed merger of Ashfield Medical Centre and Manston Surgery builds on these developments, and is intended to:

- improve operational efficiency,
- increase resilience through a larger and more flexible staff team, and
- address estate capacity constraints that currently limit recruitment and service development.

By operating as a single, larger practice, we expect to improve patient access, support safer and more sustainable workloads, and reduce duplication of administrative tasks such as claims, CQC documentation, and mandatory submissions to NHS England and the Integrated Care Board (ICB) in Leeds.

This report sets out the background to the merger proposal and describes how we have engaged with patients and stakeholders about these plans. It summarises the feedback received during the engagement process and explains how we are responding to what people have told us, as well as outlining the next steps.

The engagement period ran from 12 September to 12 November 2025 and aimed to:

- Inform people about the proposed changes; and
- Provide an opportunity for people to share their views, raise any concerns, and tell us what matters most to them about GP services.

In total, over 14,000 people were made aware of the engagement activity. A total of 234 people completed our survey, and over 150 people attended face-to-face and online events to learn more and share their views.

This report will be shared with all those involved in the engagement and will be published on both practice websites. The feedback gathered will not only inform decisions about the merger but will also contribute to the wider development of local health and care services in Leeds.

Background	5
Involving stakeholders	7
Hearing from patients	8
The Survey	9
0Who did we hear from?	10
What did people tell us?	11
Section One – Feedback about the proposed practice merger	11
Section Two – Feedback about the closure of Scholes dispensary	16
Section Three – General feedback about accessing your practice	20
Practice response to feedback received	23
Next steps	25
Appendix A – Additional Equality Monitoring detail	26

Background

Ashfield Medical Centre and Manston Surgery together provide primary care services to around 15,000 people in the East Leeds area.

Along with many GP practices across the country, our services are under a great deal of pressure. We need to find ways to work differently so that we can continue to provide high quality and safe care for our patients into the future.

Ashfield Medical Centre and Manston Surgery are now operated by the same partnership of Dr A Walling and Dr S Nathan, supported by the existing practice teams that patients are already familiar with. In May 2025, Dr Walling and Dr Nathan joined the Manston Surgery partnership and took on responsibility for running the practice. The existing GPs at Manston have remained in clinical roles but no longer hold leadership responsibilities.

Patients can access a wider range of services, a broader mix of clinicians and multiple sites. By working as a single organisation, the practices aim to reduce duplication and time spent on administration, increase the time available for direct patient care, and create a sustainable GP service capable of meeting the health and care needs of the local population.

As part of this wider change, the landlord of the Scholes Surgery site has indicated their intention to sell the building. Following a review, the partners have decided not to purchase the premises, as it is not suitable for the delivery of modern healthcare services. Consequently, Scholes Surgery will permanently close from 1 April 2026.

Scholes dispensary closure

As part of the wider changes to the practice estate and service model, the dispensary at the Scholes Surgery site will close with effect from 14 November 2025. This decision has been taken in the context of the planned closure of the Scholes Surgery premises and the need to consolidate services to ensure long term sustainability and compliance with modern healthcare standards.

The partners recognise that the closure of the dispensary will be disappointing and potentially disruptive for patients who currently rely on this service. The practice is committed to supporting affected patients through this transition, including providing clear information and practical assistance to help them select and update their nominated community pharmacy. This will include proactive communication, staff support for changing nominations on the clinical system, and signposting to suitable local pharmacy options to minimise any interruption to medicines supply.

The proposed merger

The proposed merger would be expected to deliver a number of benefits for patients and staff, including:

- Greater stability and continuity of care by bringing all staff together under one organisation.
- Increased availability of appointments with a range of clinicians.

- More efficient administration and improved coordination of care through one combined team and streamlined processes.

To realise the full benefits of the merger, both practices will move onto a single clinical computer system. This will require patients to reset their online access accounts. This change will take place in December 2025, and patients will receive further information and step by step instructions. Patients will continue to be able to access services in person and by telephone.

In parallel, the partners are exploring the possibility of establishing a new site in the local area to further enhance service provision. While any new site will not be in place by the time of the proposed merger, it would be chosen to improve accessibility and convenience for patients and to support the delivery of high quality, modern primary care.

Involving patients

All the feedback we have received from our registered patients is being considered and where there are clear themes or concerns about any of our plans, we would work to address and reduce any potential negative impacts (mitigations).

Ashfield Medical Centre have an established Patient Participation Group (PPG) with both in person and virtual participants. Manston did not have an established PPG, but through the engagement over 30 patients have expressed an interest in becoming a PPG member so we look forward to establishing a PPG that is representation of all the sites. The engagement plan was shared with Ashfield Medical Centre PPG prior to the commencement of the exercise.

Involving stakeholders

Following agreement from the ICB in Leeds to carry out an engagement with our registered patients, we identified a number of key stakeholders that we needed to hear from through this engagement and developed a range of ways to involve everyone in conversations about this proposed change. These are outlined below:

- Involving patients
- Patient Participation Groups

- Staff engagement
- Contacting patient households (by letter / text message)
- Local councillors / MP
- Other stakeholders in the community such as pharmacies and other practices
- Local Parish Council in Scholes

As part of our engagement, we identified and engaged with key stakeholders across our locality to provide a range of opportunities to communicate our plans and hear people's thoughts and feedback. These stakeholders include:

- **Staff working at all sites**
All practice staff across the different sites have been kept informed and involved throughout the process. Regular updates, team meetings and opportunities for feedback have been provided to ensure staff are aware of the proposed changes, understand the rationale, and can raise any concerns or suggestions. This has been essential in maintaining morale, supporting continuity of care, and aligning teams around a shared vision for the proposed merged practice.
- **Patient Participation Groups**
Members of the practice's Patient Participation Group (PPG) were informed and involved from the outset as part of the initial communication and engagement process to ensure transparency and to gather representative feedback. This included Ashfield only and work is underway ensure Manston patients are represented moving forward.
- **Local councillors**
Local councillors and MP have been informed of the plans given the potential impact on local services and the wider community. Their awareness and support are important in terms of representing residents' interests, understanding local population growth and housing developments, and helping to facilitate constructive dialogue with other local agencies where appropriate.

As part of the engagement, the Senior Partner and Practice Manager had separate communications with local councillors and Members of Parliament to outline the rationale for the closure of the Scholes site and to consider any potential mitigations.

- **Local pharmacies**
Community pharmacies in the area have been engaged to ensure they are aware of our plans for the proposed merger, closure of the Scholes dispensary, any changes to prescribing or repeat prescription processes, and to support ongoing collaborative working. Maintaining strong relationships with local pharmacies is vital for safe medicines management, effective repeat prescribing, and the delivery of integrated neighbourhood services.

These stakeholder relationships will continue to be developed through and beyond this process to support stability, responsiveness to local needs, and opportunities for future service development at scale.

Hearing from patients

A paper from the practices, requesting to go out to engage with their patients, was submitted to the ICB in Leeds in summer 2025. The Primary Care Operational Group (PCOG) agreed the request on 21 August, and an Involvement plan was developed to run a patient / public engagement from 12 September to 12 November 2025, including the following activities:

- Patient / public survey (online / paper copies) open throughout the engagement period.
- Four face-to-face public events:
 - o 24 September – 5 – 7pm at the Church Hall, Scholes
 - o 1 October – 2 - 3pm – Manston Surgery
 - o 14 October – 2 – 3pm – The Grange Medical Centre
 - o 7 November 10am – 11noon - Village Hall, Scholes (An additional meeting added due to the large attendance at the first engagement in Scholes)
- Online public Microsoft Teams meeting - 15 October – 6 – 7pm

Representatives from the practice's management team and representatives from the ICB in Leeds attended each of the public sessions, with local councillors, MP and a local residents' committee represented at the meetings in Scholes.

The initial meeting in Scholes was attended by around 120 people, with some not able to access the hall due to capacity issues. A second Scholes meeting was organised to ensure everyone had the opportunity to get involved, and around 25 people attended the second session in Scholes in November.

Around 10 people attended a face-to-face meeting at Manston Surgery, and 8 people attended a similar event at The Grange Medical Centre.

4 people joined an online Microsoft Teams evening meeting.

The main themes emerging from the face-to-face events included:

- Concerns around the potential impact on the aging population at Scholes,
- Concern for those who are not digitally engaged,
- A belief the surgery was used more than it was for Scholes patients,
- How patients would obtain prescriptions,
- Home visits for patients unable to leave their home / place of residence,

- Concerns about a potential reduction in appointments,
- Concerns re continuity of care,
- Patients not being able to attend their preferred site,
- Concerns about parking, and about transport links with Scholes,
- Concerns about the Patches system and how appointments are allocated,
- Concerns about the growing population within Scholes and surrounding area and the need for estates, and
- Concerns about changes to the clinical system.

The Survey

The survey opened on **12 September 2025** and was extended to **12 November 2025**. This extension followed the first Scholes meeting, attendance for which exceeded the capacity of the hall, and a later, additional event was scheduled to ensure everyone had a chance to take part. The survey was extended to enable attendees at the later event to provide their feedback.

All patients registered at Ashfield Medical Centre and Manston Surgery were sent a Patches message containing information about the proposal and a link to the online survey. For Scholes patients, an additional letter was sent by post to ensure they received the information, recognising the greater impact for this group. Any patients who did not open the message were always followed up and sent a paper copy of the letter by post.

Information about the proposals and details of all the engagement activities, including the link to the survey, were published on the Manston and Ashfield practice websites.

Paper copies of the survey were also made available at the practice reception desks or handed out at the engagement meetings, and 40 patients completed the survey using this method. Surveys in alternative formats or different languages were provided upon request.

By the end of the engagement period, **234 survey responses** had been received.

This report will first summarise who we heard from, including answers provided in the survey responses and from the equality monitoring section at the end of the survey. The report will then outline the overarching headlines from all the survey responses, followed by the main themes from the responses to each of the survey questions.

Who did we hear from?

69.7% of respondents (154) told us they were registered with Manston Surgery, and 23.5% with Ashfield Medical Centre (52). 6.8% of respondents (15) told us they were

a carer or family member of someone registered with these practices. (Not all respondents answered all of the questions).

The table below shows which site respondents told us they use:

I use Ashfield Medical Centre.	37	15.9%
I am a relative, friend or carer of someone who uses Ashfield Medical Centre.	2	0.9%
I use Manston Surgery.	36	15.5%
I am a relative, friend or carer of someone who uses Manston Surgery.	2	0.9%
I use The Grange Medical Centre.	13	5.6%
I am a relative, friend or carer of someone who uses The Grange Medical Centre.	0	0%
I use the Scholes Surgery.	124	53.5%
I am a relative, friend or carer of someone who uses the Scholes Surgery.	12	5.2%

Equality monitoring data

The survey included a standard section with equality monitoring questions. This section is optional, and some people (14% of all respondents) chose not to provide any information in this section. However, most respondents (201) did, although several provided answers to some questions and not others. A summary of responses is provided below, with further detail provided in Appendix A.

Almost three quarters of respondents stated they were female (71%). Three quarters of respondents stated they were age 56 or over, with 57% of respondents (115) stating they were retired.

Nearly half of all respondents who completed the equality monitoring section stated they were disabled (45%), with 33 (16% of respondents) reporting living with at least one long-term condition, 28 (14%) living with a physical or mobility impairment and eight reporting a mental health condition.

17% of respondents (34) stated that they provide unpaid care or support for someone who is older, disabled or has a long-term condition. 11% reported caring for a child, or children, between 0 and 19 years old.

What did people tell us?

The survey was divided into three sections:

- The first section asked for feedback on the proposals to merge Ashfield Medical Centre and Manston Surgery, along with the closure of the Scholes Surgery,

- The second section included questions about the closure of the dispensary at Scholes Surgery, and
- The third section asked more general questions about people’s experiences of using their local practice.

Section 1 - Feedback about the proposed practice merger

Headlines:

Accessibility and Transport Concerns Dominate Patient Feedback on Practice Merger

Responses in this section highlight widespread anxiety about increased travel distances, poor public transport, and the impact on vulnerable groups - especially with the closure of Scholes Surgery. Accessibility is repeatedly highlighted as a critical issue for patient well-being.

Fears Over Loss of Personal Care and Community Connection Amidst Service Changes

Many respondents worry that merging practices will reduce continuity of care, make services feel impersonal, and erode the sense of community - particularly for elderly and disabled patients who rely on local, familiar staff.

Survey questions:

How would you feel about Manston Surgery and Ashfield Medical Centre merging?

Option	Total	% of responses
Positive	61	26.8%
Negative	83	36.4%
I don't know	84	36.8%
Answered	228	97.5%
Not Answered	6	2.5%

We asked people to tell us more about their answer. We asked Microsoft Copilot Artificial Intelligence (AI) software to generate the top three themes from all the answers to this question:

1. Concerns About Accessibility and Travel

Many respondents express significant worries about increased travel distances, especially for elderly patients, those with disabilities, and families with young children. The closure of Scholes Surgery is a particular concern, as it would force

patients to rely on infrequent public transport or expensive taxis, potentially leading to missed appointments and difficulties in collecting prescriptions. Accessibility and the location of services are repeatedly highlighted as critical factors for patient well-being and satisfaction.

2. Uncertainty About Service Quality and Continuity of Care

There is widespread apprehension that the merger may lead to reduced continuity of care, longer wait times for appointments, and less personalised service. Some respondents fear that larger practices may become less efficient, lose their identity, and treat patients as numbers rather than individuals. Others are concerned about the lack of clear communication regarding the merger and its impact on patient care, with some expressing scepticism about whether promised improvements will materialise.

3. Potential Benefits and Openness to Improvement

Despite the concerns, a number of respondents acknowledge possible advantages of the merger, such as access to a wider range of medical staff and facilities, improved venues, and the potential for better services if managed well. Some are willing to keep an open mind and support the merger if it leads to tangible improvements in appointment availability and overall patient experience. However, this optimism is often tempered by a “wait and see” attitude, with many reserving judgement until the outcomes are clear.

What more do you think we need to consider when we’re thinking about merging the Manston and Ashfield practices?

We asked Microsoft Copilot AI software to generate the top three themes from all the answers to this question:

1. Accessibility and Transport Challenges

A significant number of responses highlight concerns about how patients (especially those from Scholes) will physically access healthcare services after the merger. Key points include:

- Poor public transport links, infrequent buses, and expensive taxis make it difficult for elderly and mobility-impaired residents to reach Manston or Ashfield surgeries.
- The closure of Scholes surgery would force vulnerable groups to travel further, increasing anxiety and potentially deterring them from seeking care.
- Suggestions for solutions include maintaining a local surgery in Scholes, improving transport options, and ensuring adequate parking at the remaining sites.

2. Continuity and Quality of Patient Care

Many respondents express worries about the impact of the merger on the consistency and quality of care:

- Concerns that merging will disrupt relationships with familiar doctors and staff, leading to a loss of continuity and personalised care.
- Fears that a larger, merged practice may become impersonal, with patients feeling like “just a number” and staff stretched too thin.
- The importance of retaining the ability to see the same GP, building trust, and ensuring that patient voices are heard in decision-making.

3. Booking Systems and Appointment Availability

The responses repeatedly mention frustrations with current booking systems and worries about future appointment access:

- The online booking system (PATCHS) is seen as difficult to use, especially for elderly patients and those without internet access.
- Long wait times on the phone, insufficient appointment slots, and uncertainty about when appointments will be available are major pain points.
- There is a strong call for a more straightforward, accessible, and responsive booking process, with options for both online and telephone bookings.

What impact might the closure of the Scholes surgery have on you, or the person you care for?

Option	Total	%
No impact	66	28.7%
Some impact	48	20.9%
A big impact	104	45.2%
I don't know	12	5.2%
Answered	230	98.3%
Not Answered	4	1.7%

We asked people to tell us more about their answer. We asked Microsoft Copilot AI software to generate the top three themes from all the answers to this question:

1. Loss of Local Accessibility and Convenience

Many respondents emphasised how Scholes surgery’s proximity makes healthcare accessible, especially for those living in the village, elderly residents, and people with mobility issues. The closure would mean longer journeys, reliance on infrequent or unreliable public transport, and increased difficulty in accessing appointments and prescriptions. Walking to the surgery is a key benefit that would be lost, and parking at alternative sites is a major concern.

2. Impact on Vulnerable Groups and Health Inequalities

There is strong concern that closure will disproportionately affect elderly, disabled, and vulnerable patients who depend on local services. Respondents highlighted the risk of increased health inequalities, as those less able to travel or without access to private transport would struggle most. The surgery is described as a “vital lifeline” for these groups.

3. Concerns About Service Quality, Continuity, and Community Impact

Respondents expressed anxiety about losing the personal, friendly, and efficient service provided by Scholes surgery. There is worry that merging with larger practices will lead to longer wait times, less continuity of care, and a loss of community connection. The surgery is seen as an integral part of village life, and its closure is viewed as a business decision rather than one prioritising patient care.

How do you normally travel to your GP practice?

Option	Total	%
I walk	150	64.4%
I drive	65	27.9%
Someone else drives me	7	3%
By taxi	3	1.3%
By bus	5	2.1%
By bike	3	1.3%
Answered	233	99.44%
Not Answered	1	0.56%

If you currently use the Scholes surgery, will you need to change how you travel to your GP when the surgery closes?

Option	Total	%
Yes	106	48%
No	29	13.1%
I don't know	6	2.7%
Not applicable	80	36.2%
Answered	221	94.4%
Not Answered	13	5.6%

We asked people to tell us more about their answer. We asked Microsoft Copilot AI software to generate the top three themes from all the answers to this question:

1. Transport Challenges and Accessibility

Many respondents highlight significant difficulties with public transport, describing it as infrequent, unreliable, and poorly synchronized with appointment times. For those who do not drive—especially elderly or disabled individuals—this creates a major barrier to accessing healthcare. The need to rely on lifts from others or expensive

taxi is frequently mentioned, and walking is often not feasible due to distance or health limitations.

2. Parking Problems and Increased Car Dependency

A large number of answers mention the necessity to drive to alternative surgeries (such as Manston or Ashfield) if Scholes surgery closes. However, parking at these locations is described as limited, difficult, or costly. Respondents express concern about the environmental impact of increased car use and the financial burden of petrol, parking fees, and taxi fares. For some, driving is currently possible, but they worry about future loss of mobility.

3. Impact on Vulnerable Groups and Community Wellbeing

There is a strong sense of concern for elderly, disabled, and less mobile residents. Respondents note that closure of the local surgery would disproportionately affect these groups, making access to essential healthcare much harder and potentially leading to missed appointments or reduced care. The stress and inconvenience for both patients and those who assist them (family, friends, carers) are recurring themes, with some stating they might forgo appointments due to these challenges.

Section 2 - Feedback about the closure of Scholes dispensary

Headlines:

Impact on Vulnerable Residents and Accessibility Challenges

Respondents fed back significant concerns for elderly, disabled, and vulnerable residents, who face increased difficulty accessing healthcare and prescriptions due to limited mobility, unreliable public transport, and high travel costs. The closure is seen as risking isolation and unmet healthcare needs for those most dependent on local services.

Loss of Local, Personalised Healthcare and Digital Exclusion Risks

There is a strong desire to retain local healthcare services, with many expressing frustrations over losing personal, face-to-face care and the supportive community aspect. The shift towards online pharmacy options raises concerns about digital exclusion, especially for older patients and those lacking internet access or digital skills.

Survey questions:

Do you currently collect prescribed medicines from the dispensary at Scholes surgery?

Option	Total	%
Yes, I currently collect my prescribed medicines from Scholes Surgery.	104	44.4%
Yes, I currently collect prescribed medicines from Scholes Surgery for a relative or friend.	6	2.6%

No, but a relative, friend or carer collects them on my behalf.	3	1.3%
No, I don't collect prescribed medicines from Scholes Surgery.	121	51.7%
Answered	234	100%
Not Answered	0	0%

What more do you think we need to consider in relation to the closure of the Scholes surgery and dispensary?

We asked Microsoft Copilot AI software to generate the top three themes from all the answers to this question:

1. Impact on Elderly and Vulnerable Residents

A dominant theme is the significant concern for elderly, disabled, and vulnerable residents in Scholes. Many responses highlight that these groups will face increased difficulty accessing healthcare and prescriptions if the local surgery and dispensary close. Issues include:

- Limited mobility and inability to drive.
- Reliance on local, walkable services.
- The risk of isolation and unmet healthcare needs.
- Anxiety about coping with travel, especially for those with health or mobility challenges.

2. Transport and Accessibility Challenges

Another major theme is the challenge of transport and accessibility. Respondents repeatedly mention:

- Poor and unreliable public transport (especially the hourly bus service).
- High taxi costs, which are prohibitive for pensioners.
- The impracticality of traveling several miles to alternative surgeries or pharmacies, especially for those without cars.
- The need for solutions such as home delivery of medication, improved bus services, or a local collection point.

3. Need for Local Healthcare Services and Delivery Options

The third key theme is the strong desire to retain local healthcare services in Scholes, or at least ensure robust alternatives if closure proceeds. This includes:

- Calls for a new or alternative surgery within the village.
- Suggestions for home delivery of prescriptions and better communication about which pharmacies offer delivery.

- Concerns that closure will increase pressure on other practices and reduce the quality of care.
- Emphasis on the importance of local, accessible, and inclusive healthcare provision.

Would you / your relative, friend or carer be able to collect the prescribed medications from one of the alternative locations on the list above?

In the survey we included details of eleven pharmacies within a two mile radius of the Scholes dispensary which could be used as alternative sites when the dispensary at the Scholes surgery closed on 14 November 2025.

Option	Total	%
Yes	70	67.3%
No	16	15.4%
Don't know	18	17.3%
Answered	104	44.4%
Not Answered	130	55.6%

We asked people to tell us more about their answer. We asked Microsoft Copilot AI software to generate the top three themes from all the answers to this question:

1. Increased Inconvenience and Travel Burden

Many respondents highlighted that collecting prescriptions from alternative locations would require significantly more effort. This includes needing to drive or use unreliable / infrequent public transport, resulting in longer journeys, more time spent, and increased costs. Several mentioned that what was once a simple walk would now become a car or bus trip, sometimes taking hours, especially for those without direct bus routes or with mobility issues.

2. Impact on Vulnerable Groups (Elderly, Disabled, and Carers)

A strong theme was concern for elderly patients, people with disabilities, and those who care for others. Respondents worried that these groups would struggle the most with the closure, as they may not drive, have limited mobility, or lack local family support. Some noted that increased reliance on friends, family, or carers would add to their responsibilities and reduce independence for those currently managing on their own.

3. Loss of Local, Accessible Service and Community Frustration

There was a clear sense of frustration and disappointment about losing a local, easily accessible dispensary. Many felt that the change puts patient needs second to organisational convenience, with comments expressing that “the NHS is supposed to be for everyone” and that “there should be a service within the village.” Some respondents mentioned that while they can currently manage, the situation would become problematic if their circumstances change (e.g. if they stop driving).

Would you consider using an online pharmacy instead?

Option	Total	%
Yes	30	28.8%
No	50	48.1%
Don't know	24	23.1%
Answered	104	44.4%
Not Answered	130	55.6%

We asked Microsoft Copilot AI software to generate the top three themes from all the answers to this question:

1. Digital Exclusion and Technology Barriers

Many respondents express concerns about their ability to use online pharmacies due to lack of internet access, limited computer skills, or discomfort with technology. There is a clear sense that older patients and those without digital skills would be disadvantaged, with several noting reliance on others or the need for family help. This theme highlights a significant risk of digital exclusion if online pharmacy services become the primary or only option.

2. Preference for Personal, Face-to-Face Service

A strong preference emerges for traditional, in-person pharmacy services. Respondents value the ability to speak directly with pharmacy staff, resolve issues quickly, and maintain relationships with people who know their medical history. There is concern that moving services online could erode the quality of care and personal connection currently experienced.

3. Need for More Information, Trust, and Flexibility

Many responses indicate uncertainty or lack of knowledge about online pharmacies. People ask about the availability, cost, reliability, and safety of these services. There are also worries about delivery logistics, data protection, and the flexibility of the service (e.g., needing to be at home for deliveries, concerns about delays, and the ability to get prescriptions quickly). Trust in the authenticity of online pharmacies is also questioned, with references to negative stories and fears of fake websites.

Do you have any other comments about getting your medicines, which you would like us to consider?

We asked Microsoft Copilot AI software to generate the top three themes from all the answers to this question:

1. Access and Convenience of Local Pharmacy and Surgery

Many respondents expressed strong concerns about the closure of Scholes Surgery and the local dispensary. They highlighted the importance of having a pharmacy and

GP practice within the village, emphasising that local access is crucial, especially for elderly patients, those with mobility issues, and individuals who rely on friends or neighbours for help. The loss of these facilities is seen as creating logistical challenges, increasing travel time, and potentially leading to missed medications or increased pressure on A&E services.

2. Challenges with Online and Remote Services

There is significant apprehension about shifting to online pharmacy services. Respondents noted that many elderly or less tech-savvy patients may struggle with online ordering. Concerns were raised about losing the supportive community aspect and about the accessibility and reliability of online systems.

3. Medication Supply, Synchronization, and Service Quality

Respondents frequently mentioned issues with the current prescription system, such as only receiving one month's supply at a time, which they find inconvenient and time-consuming. There were also concerns about medication synchronisation (aligning all repeat prescriptions to the same date), the risk of being given generic alternatives, and the need for better communication if prescriptions are delayed or unavailable.

These themes reflect a strong desire for local, accessible, and reliable pharmacy services, with particular attention to the needs of vulnerable groups and the challenges posed by digital solutions.

Section 3 - General feedback about accessing your practice

Headlines:

Convenience and Speed in Accessing Care Are Top Priorities for Patients

Survey respondents most value getting appointments quickly, receiving high-quality care, and having good communication with their GP practice. These factors are consistently highlighted as the most important when making appointments.

2. Mixed Experiences with the NHS App: Prescription Management Praised, Appointment Booking and Digital Inclusion Need Improvement

While many users appreciate the NHS App for managing prescriptions and accessing test results, there are notable frustrations with booking appointments, limited two-way communication, and usability challenges—especially for older or less tech-savvy individuals. Calls for more inclusive, user-friendly digital solutions are prominent.

Survey questions:

Which three things are most important to you when you make an appointment at your GP practice? (please only pick three)

Option	Total	%
Getting an appointment quickly	152	24.3%
Same day appointments	71	11.4%
Seeing a specific person at the practice	45	7.2%
The quality of care I receive	158	25.3%
Feeling that it is a safe environment	27	4.3%
Good communication	77	12.3%
The opening times of the practice	39	6.3%
Being able to access a range of different services locally	52	8.3%
Other	4	0.6%
Answered	192	82%
Not Answered	42	18%

Have you heard of, or are you signed up to use, the NHS App?

Option	Total	%
I haven't heard of it	3	1.6%
I have heard of it, but I haven't signed up to it	13	6.8%
I have signed up to it but don't really use it	66	34.6%
I have signed up to it and find it helpful	109	57%
Answered	191	81.6%
Not Answered	43	18.4%

We asked people to tell us more about their answer. We asked Microsoft Copilot AI software to generate the top three themes from all the answers to this question:

1. Prescription Management and Test Results Access

Many respondents highlighted that the NHS app is primarily used for ordering repeat prescriptions and checking test results. This functionality is valued for its convenience and speed, with users appreciating the ability to manage medications and view results without waiting for direct contact from their GP. However, some noted inconsistencies, such as not all results being available or certain prescriptions missing from the app.

Key points:

- Quick access to test results and prescriptions.
- Dependence on timely medication collection.
- Frustration when expected information or prescriptions are missing.

2. Challenges with Booking Appointments and Communication

A significant number of users expressed difficulty booking appointments through the app, often being redirected to phone lines or other systems like Patchs. The inability to reply to messages or interact directly with the practice via the app was a common frustration. Many users still prefer telephone or face-to-face interactions, especially when technology feels daunting or when urgent care is needed.

Key points:

- Appointment booking often not available or redirects to phone.
- Lack of two-way communication within the app.
- Preference for human contact, especially among older users.

3. Digital Inclusion and Usability Concerns

Feedback revealed concerns about the app's accessibility and ease of use, particularly for elderly or less tech-savvy individuals. Some users find the app confusing, not user-friendly, or too complicated compared to previous online systems. There's a clear call for more inclusive solutions that consider both younger and older demographics, as well as those without internet access or smartphones.

Key points:

- App is not intuitive for all users; some rely on others for help.
- Digital exclusion for elderly and those without devices.
- Desire for simpler, more inclusive systems.

Additional Observations

- Some users appreciate the app for accessing hospital appointments and consultant letters, but wish for more comprehensive integration.
- There are concerns about data privacy, especially regarding third-party data sharing.

Did you know that every GP practice has a Patient Participation Group (PPG)?

Option	Total	%
Yes	70	33.7%
No	138	66.3%
Answered	208	88.9%
Not Answered	26	11.1%

We asked respondents if you would like to find out more about getting involved with the PPG at your practice.

35 people said they would like to find out more.

Practice Response to Feedback

Theme	Detail	Practice Response
Digital Access	Patients have raised that they may not be aware how to use the various systems available that support access.	<p>Develop a communication plan to tell patients about the NHS App.</p> <p>To ask patients if they need any support with the NHS App and managing their medications so that they can be guided through what is available.</p> <p>Run face to face sessions whereby patients can attend and have hands on support to set up access and use digital systems.</p>
Travel from Scholes	There was feedback from the Scholes population and others that patients may find it difficult to attend appointments.	<p>The Lead Nurse is commencing the annual review process and will assess issues on an individual basis.</p> <p>The ICB will make available an interim taxi budget to support patients that meet a defined criterion.</p>
Getting an appointment	Concerns were raised that it may be more difficult to obtain an appointment	There will be no deduction in appointments offered. All sessions currently delivered in Scholes will be delivered across the other practice sites. The practice has recently recruited a new GP and so patients should be an

		increase in the number of appointments available.
Telephone access	Concerns were raised that it can take too long to get through on the telephone.	We know that patients are waiting longer than we would like. We have two telephone systems in place across the practices at present and will review the best available options for one unified system.
Continuity of Care	There was concern that over a larger footprint, patients would not have the ability to see the same clinician consistently who was familiar with their medical record.	We do not intend to change the practice you intend unless it is more convenient for you. We may be able to offer you an appointment quicker at another site but if your request is not urgent you can still choose to attend your usual site.
Accessibility Concerns	There was concern about difficulty accessing sites further away, particularly whereby parking was limited.	We are aware that parking is better at some of our sites than others. We will consider this and your circumstances when offering an appointment. For example, parking is limited at Manston but there is good availability at The Grange site. All our sites (with the exception of Scholes) are accessible for patients in a wheelchair or with mobility issues.

Next Steps

We have now submitted our report to the West Yorkshire ICB who will make a decision on our request to merge practices. The ICB will also need to be assured that the partnership has given due consideration to the needs of patients in relation to the other changes taking place.

The final decision on the merger of the two practices will be made at the Leeds Committee of the ICB meeting scheduled for 11 February 2026. We will contact all patients after this date to inform you of the decision and what will happen next.

Appendix A - Additional Equality Monitoring detail

Gender

53 respondents (27% of those who responded to this question) stated they were Male

141 respondents (71% of those who responded to this question) stated they were Female

Three people preferred not to answer, and one person stated they were 'Other'.

Age range

0 people stated they were between 16 – 25 years old
12 people stated they were between 26 – 35 years old
15 people stated they were between 36 – 45 years old
21 people stated they were between 46 – 55 years old
51 people stated they were between 56 – 65 years old
54 people stated they were between 66 – 75 years old
36 people stated they were between 76 – 85 years old
7 people stated they were 86 or over

Disability

91 respondents said Yes, they were disabled. Further detail was provided as follows:
28 people said they had a physical disability (14% of responses provided)
16 people said they had a hearing impairment (8% of responses provided)
8 people said they had a mental health condition (4% of responses provided)
33 people said they had a long-term condition (16% of responses provided)
Some respondents ticked more than one type of disability, indicating they had multiple conditions.

Caring responsibilities

Several respondents stated that they have caring responsibilities, with 23 (11%) people saying they care for a child or children, and 34 (17%) saying they provide unpaid care or support for someone who is older, disabled or has a long-term condition.

Ethnic group

Arab	0
Asian or Asian British - Chinese	1
Asian or Asian British - Indian	0
Asian or Asian British - Pakistani	0
Black or Black British - African	0
Black or Black British – Caribbean	0
	25

Mixed - White and Black Caribbean	2	
Mixed – White and Asian	1	
Mixed - White and Black African	0	
White - English, Welsh, Scottish, Northern Irish		166 (83%)
White – Irish	1	
White - Other White	9 (4%)	

Employment

47 people stated they were in full-time employment

15 people stated they were employed part-time

3 people stated they were in receipt of state benefits

1 person stated they were not in employment

115 people stated they were retired

0 people stated they were students

Equality Impact Assessment (EIA)

1. Project/Programme Summary Information

Project name	Transfer of services (and closure of branch site) of Scholes Surgery of Manston Surgery. Merger of Manston surgery with Ashfield Medical Centre
Organisation/s	Ashfield Medical Centre Manston Surgery NHS West Yorkshire Integrated Care Board (ICB) In Leeds
Date	Start Date: 01/06/2025
Project/Programme Lead	Michaela Guilfoyle – Practice Manager Ashfield Medical Centre Manston Surgery
Clinical Lead	Dr Alistair Walling Ashfield Medical Centre Manston Surgery
Equality, Diversity and Inclusion Lead	Senior Equality, Diversity and Inclusion Manager NHS Integrated Care Board in Leeds
Senior Responsible Owner (SRO)	Kirsty Turner, Associate Director for Primary Care West Yorkshire Integrated Care Board (Leeds place)

Project/Programme proposal / objectives

This proposal to merge include the following elements:

1. The merger of the two practice contracts
2. The closure of the Scholes site including the dispensary
3. A change of name for the practice which is yet to be proposed and will form part of the engagement

On 1st May 2025, Dr A Walling and Dr S Nathan assumed the Personal Medical Services (PMS) contract for Manston Surgery. Both practices have been collaborating within their Primary Care Network (PCN). Following a recent Care Quality Commission (CQC) report that placed Manston Surgery into special measures one of the areas identified was leadership deficiencies, Ashfield extended mutual support to streamline processes and to provide leadership structure which led to the development of a new partnership. During discussions, Manston's current partners expressed a desire to step down from the partnership, leaving the Ashfield partnership on the the PMS contract in addition to the existing Ashfield contract and implemented a streamlined management structure to ensure robust and effective leadership.

The merger of the practices will enhance efficiency, provide staff depth for resilience, and address estate capacity issues, enabling recruitment and improved patient access. Additionally, it will reduce administrative burdens by eliminating the need to duplicate tasks such as claims, CQC documentation, and required submissions to NHS England (NHSE) and the NHS Integrated Care Board in Leeds (ICB.)

The Scholes site, which also hosts the dispensary, is owned by the previous partnership of the practice who has expressed intent to sell the building. The premises, a converted house, which offers limited facilities with only one consultation room, thereby restricting the provision of nurse, midwifery, and enhanced services. The site is not suitable for modern healthcare services, and so the partnership does not propose to buy the building.

Additionally, the dispensary service is not financially viable. The new partnership's long-term plan is to not continue with the dispensary service in order to ensure the future financial viability of the practice, and offer a consistent service to all patients. The merger would lead to one practice operating across 3 sites and so a new name to reflect this new configuration would help patients to better understand the geographical boundary and service offer.

1. **Expanded Services:** Merging two practices can lead to a broader range of medical services and specialties being available to patients. This means patients can access a more comprehensive set of healthcare offerings without having to visit multiple locations.
2. **Improved Access to Care:** With a larger combined practice, there is the potential for patients to attend either an alternative site which may be more convenient or also will give more capacity for additional sessions. Through greater efficiency a larger proportion of our staffing budget can be spent on clinical staff, therefore increasing patient access.
3. **Enhanced Technology and Resources:** Merging practices can pool resources and also find new ways of working that are more beneficial to patients.
4. **Continuity of Care:** Merging practices can create a more stable and resilient healthcare environment, ensuring that patients receive continuous care even if one of the practices faces challenges.
5. **Increased Collaboration:** A larger practice has a larger group of healthcare professionals, enabling better collaboration between healthcare professionals to deliver integrated and coordinated care.
6. **Reduced Waiting Times:** By combining resources and staff, the merged practice can potentially reduce waiting times for appointments and procedures, leading to quicker

Project/Programme proposal / objectives

access to medical care.

7. **Better Staffing Levels:** The merger can address workforce shortages by combining the staff from both practices, allowing for a more efficient allocation of healthcare professionals and support staff.
8. **Streamlined Administrative Processes:** Merged practices can achieve economies of scale and simplify administrative tasks, leading to a more efficient patient experience and reducing paperwork and bureaucracy.
9. **Enhanced Patient Education and Support:** A larger practice may be better equipped to offer health education programs, support groups, and other resources to help patients manage their health more effectively.
10. **Financial Sustainability:** Merging practices may improve financial stability, allowing for the longer-term viability of the practice for the patients benefit.
11. **Expanded Services:** Merging two practices can lead to a broader range of medical services and specialties being available to patients. This means patients can access a more comprehensive set of healthcare offerings without having to visit multiple locations.
12. **Improved Access to Care:** With a larger combined practice, there is the potential for patients to attend either site which may be more convenient or also will give more capacity for additional sessions. Through greater efficiency a larger proportion of our staffing budget can be spent on clinical staff, therefore increasing patient access.
13. **Enhanced Technology and Resources:** Merging practices can pool resources and also find new ways of working that are more beneficial to patients.
14. **Continuity of Care:** Merging practices can create a more stable and resilient healthcare environment, ensuring that patients receive continuous care even if one of the practices faces challenges.
15. **Increased Collaboration:** A larger practice has a larger group of healthcare professionals, enabling better collaboration between healthcare professionals to deliver integrated and coordinated care.
16. **Reduced Waiting Times:** By combining resources and staff, the merged practice can potentially reduce waiting times for appointments and procedures, leading to quicker access to medical care.
17. **Better Staffing Levels:** The merger can address workforce shortages by combining with the staff from both practices, allowing for a more efficient allocation of healthcare professionals and support staff.
18. **Streamlined Administrative Processes:** Merged practices can achieve economies of scale and simplify administrative tasks, leading to a more efficient patient experience and reducing paperwork and bureaucracy.
19. **Enhanced Patient Education and Support:** A larger practice may be better equipped to offer health education programs, support groups, and other resources to help patients manage their health more effectively.

2. Evidence Base

What evidence has been used to inform this assessment?

In the table below please provide details of all the evidence that has been used to inform this assessment, e.g., service user equality monitoring data, patient experience intelligence, national and local research, engagement and consultation with patients, service users and the wider community, information from partner agencies, staff and any other interested groups

Local demographics / Census data

Provide in this section local demographic and or Census data

Scholes Village has a population of 2266 (2021 Census)

Gender Ratio (local area): The specific 2021 census data for the statistical area of Scarcroft, Shadwell & Scholes shows a slight female majority (50.11% females in 2021, and 50.22% in 2022).

Age Groups:

0-15 years:

19.9%

16-64 years:

63.3%

65+ years:

16.8%

Ethnicity

- White: 76.6%
- Asian: 15.8%
- Black: 3.1%
- Mixed: 2.8%
- Other: 1.7%

Religion or belief:

- Christian: 40.6%
- No religion: 36.7%
- Muslim: 14.5%
- Hindu: 0.8%
- Other: 0.8%
- Buddhist: 0.3%
- Jewish: 0.3%
- Sikh: 0.4%

Crossgates: The 2021 Census data for the Cross Gates and Whinmoor ward in Leeds reports a population of **23,827**.

The ward has a male population of 11,685 and a female population of 12,142.

Age Groups:

0-17 years, 5,460. 18-64 years, 14,524. 65+ years, 4,859. 65+ years. Age Groups (C 2021). 0-17 years, 5,460. 18-64 years, 14,524. 65+ years 4859

Ethnicity

- White: 89.78%
- Asian, Asian British or Asian Welsh: 4.65%
- Mixed or Multiple ethnic groups: 2.93%

Local demographics / Census data

Provide in this section local demographic and or Census data

Religion or belief:

- Christian: 46.2% (down from 59.3% in 2011)
- No religion: 37.2% (up from 25.2% in 2011)
- Islam: 6.5% (up from 4.9% in 2011)
- Hindu: 1.7% (up from 1.5% in 2011)
- Sikh: 0.9%
- Buddhist: 0.5%
- Jewish: 0.5%

Killingbeck & Seacroft. 26,679 Population [2021] – Census.

Female population:

52.6%

Male population:

47.4%

Age Groups:

0-17 years, 6,776. 18-64 years, 16,375. 65+ years, 3,532. 65+ years.

Religion or belief:

- Christian: 43.7%
- No religion: 42.6%
- Muslim: 5.2%
- Other religion: 2.3%
- Not answered: 5.5%

Ethnicity

- White: 80.1%
- Asian, Asian British or Asian Welsh: 7.44%
- Black, Black British, Black Welsh, Caribbean or African: 6.75%
- Mixed/Other: The percentage for this group is around 5.69%

Service user equality monitoring data:

Provide in this section analysis of

Total Patients including split:

Scholes/Manston

Female 4035

Unknown 1

Male 3909

Ashfield/Grange

Female 3210
 Unknown 1
 Male 3115

Breakdown of age of population Scholes/Manston

0-15	1361
16-18	234
19-65	4664
66-75	817
76 +	869

Breakdown of age of population Ashfield/Grange

0-15	974
16-18	219
19-65	3615
66-75	538
76-108	568

Ethnicities within the practice Scholes/Manston

Other Asian	183
Indian or British Indian	170
Chinese	86
Other Mixed	84
Irish	101
British or Mixed British	6836
Other Black	87
Other White	510
African	170
Other	191

Ethnicities within the practice Ashfield/Grange

African	265
Other	68
British or mixed British	2712
Caribbean	37
Chinese	40
Other Asian	117
Other White	217
Pakistani or British Pakistani	35
White and Black Caribbean	47
White British	2254

Top 10 first Languages within the practice:

Scholes/Manston

Main spoken language English	7102
Main spoken language Polish	75
Main spoken language Russian	21
Main spoken language Spanish	22
Main spoken language Urdu	23
Main spoken language Farsi	17

Main spoken language Kurdish	27
Main spoken language Greek	19
Main spoken language Main	
Main spoken language Lithuanian	16
Main spoken language Romanian	18

Ashfield/Grange

Main spoken language Arabic	21
Main spoken language English	5518
Main spoken language Kurdish	21
Main spoken language Persian	11
Main spoken language Polish	57
Main spoken language Portuguese	23
Main spoken language Romanian	21
Main spoken language Russian	22
Main spoken language Spanish	23
Main spoken language Urdu	20

Mental Health SMI (Severe Mental Illness)

Ashfield/Grange

62 patients Male x 30, Female x 32

Scholes/Manston

37patients Male x 20, Female x 17

Learning Disability

Ashfield/Grange

36 patients Male x 19, Female x 17

Scholes/Manston

41 patient Male x 25, Female x 16

Accessible Information Standard Recorded information

Ashfield/Grange 1

112 patients Male x 44, Female 68

Scholes/Manston

142 patients Male x 74, Female 68

Reasonable Adjustment

Ashfield/Grange

107 patients Male x 47, Female x 60

Scholes/Manston

228 patients Male x 103, Female x 125

Other demographic information:

People with long term conditions:

Diabetes

Ashfield/Grange

519 patients

Male x 285

Female X 234

Scholes/Manston

560 patients

Male x 326, Female x 234

Asthma

Ashfield/Grange

527 patients,

Male x 152, Female x 254

Scholes/Manston

528 patients

Male x 246, Female x 285

COPD (Chronic obstructive pulmonary disease)

Ashfield/Grange

216 patients

Male x 95, Female x 121

Scholes/Manston

159 patients

Male x 71, Female x 88

Heart Failure

Ashfield/Grange

97 patients Male x 49, Female x 48

Scholes/Manston

119 patients

Male x 66, Female x 53

Coronary heart Disease

Ashfield/Grange

229 patients

Male x 143, Female x 86

Scholes/Manston

303 patients

Male x 198, Female x 105

People over the age of 65

Ashfield/Grange 1216

Scholes/Manston 1576

Patient experience data:

Information about the people who live in the areas served by the practice can be found on the Leeds observatory website here:

- Manston Surgery: [Overview - Ward | Cross Gates & Whinmoor | Report Builder for ArcGIS](#)
- [Crossgates Infographic Final](#)
- The ward tends to have an older demographic than that of the rest of Leeds.
- The population tends to be less deprived than the rest of Leeds on average however there are pockets of deprivation.

Friends and family Test:

- **Manston Surgery**
 - Not had any issues or complaints with Manston Surgery
 - Always find the staff on reception very helpful, and the nurses and doctors I see and speak to extremely helpful professional and friendly thank you
 - The surgery has always been there for me in my time of need; everyone has always been amazing to me!
 - They are so helpful and cannot do enough
 - Manston surgery has been my surgery for the last 28 yrs always been good to me
- **Ashfield Medical Centre**
 - Access to the surgery has improved since using PATCHS (an online consultation service that helps you communicate with your GP more quickly). the actual medical care has always been good.
 - I was given good help with my enquiry
 - Up to now they have really helped while I am trying to find out why I am getting the symptoms that I have
 - I have been at this practise for over 40 years I have seen a lot of changes and overall, it a good practice. As everywhere you get good staff and bad staff but overall, most as good
 - Called back really promptly to offer an appointment in about an hour's time, which was really helpful and convenient. The GP we saw was great too. Overall, fantastic service.
 - Recently I have had the need to contact reception over a fault with my 'patient access' app, the lady in reception could not have been more caring and helpful, even though it has not been sorted I feel that there is a genuine assistant being offered, thank you.
 - My wife had to have a follow up blood test, first of thanks to the doctor for requesting it, but when the second blood test had been seen by the doctor she very kindly sent a message via Patches, informing it was 'normal' we felt this was excellent communication, thank you doctor and staff
- **Care opinion**
- **Manston Surgery**

Completed patches consult, got an appointment the same day with a female GP as requested. The GP was running late, however when I got to see her, she didn't rush my

Patient experience data:

appointment quite the opposite, she went above & beyond even though she had other patients to see & probably meant she wouldn't get lunch. She made me feel so much better, she was kind, caring & empathetic. Gave me comprehensive follow up advice also.

- I have had two great experiences at Surgery over the last couple of weeks. The first was using the Patches system for the first time to book an appointment for my daughter, which worked very well, I received an appointment within an hour and the care and attention given to my daughter during her appointment was amazing.
- Secondly, I went for my smear test, which I've had poor experiences of in the past. However, the nurse was incredible. Reassuring, calming and helpful throughout the appointment, she listened to my concerns, provided practical solutions and I didn't even realise the procedure had taken place. She was also incredibly supportive afterwards and made what is an invasive experience pleasant as it could have been.
- Ashfield Medical Centre – 1 story in the last 12 months with a response. This is on our website:
- What can I say but THANK YOU to a locum Doctor who saw me this morning 15.1.25 @ 10.40am in the Ashfield Medical Centre. I made the appointment through Patient Access via NHS APP as my doctors Patient Access App was kept working got an appointment 3 hours later, sat only for 5 minutes when the lady called me in to her treatment room where

Dr.Nayak patiently listen to me and with great communication / Empathy examined me, comforted me, reassured me in a way that made me feel reassured and less anxious, she had depth and compassion in her voice which may I say I have not had in a lot of years and I have been at this practice for over 40 years.

Now I am not saying other Doctors and other professionals at this practice or any other practice are doing a bad job no not at all they are all coping best they can under the extreme circumstances they and we are facing in this day and age..

Dr. Nayak if you do read this, I thank you. Your " bedside manner " as it were is outstanding the way you spoke to me the way you reassured me and the way you explained the way forward was simply outstanding.

Take Care & God Bless You.

- I have been registered at this practice since 1993 and have never had any issues. I have seen patients been aggressive to reception staff who shouldn't have to put up with such abuse. I've never had an issue getting an appointment. With the patches system it might not be a GP. The last time I went was to see nurse for annual check-up. I mentioned to her a nasal issue I had hoping she could deal with it rather than waste the Drs time. She referred me to GP appointment, and I saw a Dr that same afternoon. Previously I turned up unannounced peeing blood I was seen within the hour. I can understand why patients are not seen immediately with a runny nose but when your triaged with an emergency you will be seen ASAP. Keep up the good work. Some of us appreciate your overworked and short staffed and are doing your best.

National GP survey

- **Manston Surgery:**
 - 31% find it easy to get through on the phone (53% NATIONAL)

Patient experience data:

- 70% find receptionist helpful (83% NATIONAL)
- 74% are satisfied with GP appointment times
- 29% usually get to see or speak to their preferred GP (40% NATIONAL)
- 64% described their overall experience as good (75% NATIONAL)

• Ashfield Medical Centre

- 31% find it easy to get through on the phone (53% NATIONAL)
- 75% find receptionist helpful (83% NATIONAL)
- 77% are satisfied with GP appointment times
- 26% usually get to see or speak to their preferred GP (40% NATIONAL)
- 79% described their overall experience as good (75% NATIONAL)

Engagement and Consultation activity

A paper requesting to go out to engage was presented to the Primary Care Operational Group (PCOG) on the 21st August 2025 and was agreed.

A draft Involvement plan was developed outlining the proposed activities:

- Survey (online and paper copies) open from 12th September 2025
- Four face-to-face public events:
 - 24th September 2025 5.00pm – 7.00pm at Church Hall, Scholes (two back-to-back hour-long sessions)
 - 1st October 2025 – 2.00-4.00pm – Manston Surgery
 - 14th October 2025 – 2.00pm – 4.00pm – Grange Surgery
 - Additional meeting added due to volume of attendance at the first engagement held in Scholes – 7th November 2025 10.00am – 12.00 noon, Village Hall, Scholes
- Online public Microsoft Teams meeting on 15th October 2025 – 6.00pm – 7.00pm
- By the end of the engagement period, **234 survey responses** had been received. The Engagement report has been completed by the practice.

In addition to the public engagement activity, the Senior Partner and Practice Manager have held separate discussions with local councillors and Members of Parliament to outline the rationale for the proposed closure of the Scholes site and to consider potential mitigations. This includes exploring the feasibility of a short-term, interim primary care presence within the village while longer-term solutions, such as a potential new-build facility, are being investigated. These exploratory discussions are ongoing and will continue as part of the wider decision-making process.

Manston Surgery, at the outset of the engagement, did not have an active Patient Participation Group (PPG). Ashfield Medical Centre had an established group who were given the opportunity to comment on the plan. There were no responses from Ashfield Medical Centre's PPG. As part of the engagement exercise over 30 patients across both practices have expressed an interest in joining the PPG and the practices has contact details to take this forward.

Information from other agencies

Provide in this section relevant information from other agencies that would add value to the assessment for example Healthwatch, Community Groups, Local authority, third sector organisations.

As part of the engagement, the local Parish Council have been an active participant. They have contacted and met with the ICB, completed the survey and uploaded a report on their website following these discussions.

Any other evidence

Provide in this section any additional information that would add value to the assessment

No other evidence

3. Equality Impact Assessment

Describe the actual or potential impact (positive, neutral and negative) of any proposed changes on **the groups listed in the table below**. Include the impact and evidence used to make this decision and any actions / mitigations that should be put in place. **Please put n/a in any blank cells you are not putting text into.**

Group	Impact and evidence used	Actions / Mitigation
General Issues	Public Transport in the village of Scholes was raised as an issue due to reduced bus times Continuity of care for Long Term Conditions	Buses from the village into Crossgates or Seacroft appear to be every hour. Residents have been raising this with the local councillors. Patients with Long term conditions of any age raised concerns that they will lose continuity of care by attending different sites. This will continue to be monitored. Currently all Long-Term Condition reviews are provided at Manston by our experienced Health Care Assistants and Practice Nurses. Our new nurse manager is an Independent Prescriber, and we feel this will add to the service

Group	Impact and evidence used	Actions / Mitigation
	<p>By the end of the engagement period, 234 survey responses had been received.</p> <p>Almost three quarters of respondents to the survey were age 56 or over, with 57% of respondents (115) stating they were retired.</p> <p>The outcome from the engagement activity indicates there is a strong sense of concern for elderly, disabled, and less mobile residents. Respondents note that closure of the local surgery would disproportionately affect these groups, making access to essential healthcare much harder and potentially leading to missed appointments or reduced care.</p> <p>The stress and inconvenience for both patients and those who assist them (family, friends, carers) are recurring themes, with some stating they might forgo appointments due to these challenges.</p>	<p>We have been reviewing our all patients who are unable to get out of their homes to ensure all are coded correctly and our Nurse Manager has planned that this group of patients will be receiving their annual reviews shortly and we hope to create proactive care for these patients.</p> <p>The ICB has agreed that as in previous scenarios, a budget will be made available for taxis for those that would not meet the criteria associated with patients who are unable to get out of their homes (defined on the clinical system as housebound) but would struggle to travel to the current alternative sites by public transport.</p>
Disability	<p>Availability of accessible parking and access to buildings.</p> <p>Patients raised that there is limited parking at Manston Surgery. The site is also difficult to access currently, due to works at the train station.</p>	<p>As above – please see general issues</p> <p>Patients who are physically disabled and unable to get out of their homes/ places of residence will continue to receive home visits.</p> <p>Ashfield, Manston and The Grange all have accessible parking. (Scholes does</p>

Group	Impact and evidence used	Actions / Mitigation
	<p data-bbox="312 1234 887 1375">Patients with impairments, or sensory loss specifically in respect of information and communication</p> <p data-bbox="312 1839 842 1980">The practices maintain a learning disability and serious mental illness register to ensure that patients in this</p>	<p data-bbox="922 136 1501 226">not currently meet the required standards).</p> <p data-bbox="922 241 1497 331">Ashfield has ramps at the entrance, with touch pad door openings.</p> <p data-bbox="922 347 1406 383">Manston has a lift to the first floor.</p> <p data-bbox="922 405 1493 546">Grange has the best accessibility parking and has no stairs throughout for patients.</p> <p data-bbox="922 568 1501 882">For those unable to use public transport there are several taxi companies in the local area that can accommodate a wheelchair. (See above comment regarding an interim budget to cover this where necessary).</p> <p data-bbox="922 954 1497 1099">The practice will consider individual patient needs in relation to access when offering appointments at each site.</p> <p data-bbox="922 1173 1497 1653">Ashfield, Manston and The Grange all adhere to the requirements of the Accessible Information Standard in relation to ensuring that patients get information in a format they can understand, for example large print, Easy Read and are supported by communication professionals, such as a British Sign Language (BSL) interpreter.</p> <p data-bbox="922 1727 1469 1980">Continue to deliver proactive annual health checks for patients on learning disability and serious mental illness registers, having due consideration for accessibility needs.</p>

Group	Impact and evidence used	Actions / Mitigation
	<p>higher risk group receive their annual health checks in a timely manner.</p> <p>By the end of the engagement period, 234 survey responses had been received.</p> <p>The outcome from the engagement activity indicates there is a strong sense of concern for elderly, disabled, and less mobile residents. Respondents note that closure of the local surgery would disproportionately affect these groups, making access to essential healthcare much harder and potentially leading to missed appointments or reduced care.</p> <p>The stress and inconvenience for both patients and those who assist them (family, friends, carers) are recurring themes, with some stating they might forgo appointments due to these challenges.</p>	<p>The annual review process led by the Lead Nurse will offer an opportunity to discuss with residents of Scholes their concerns and accessibility needs.</p> <p>The practice will consider if any residents should be added to the 'housebound' list which would define those that should be visited at home as opposed to attending the surgery.</p> <p>In addition, for those where there are challenges there will be the option to offer patients a taxi service if needed. The practice will define the criteria and assess patients for this offer.</p>
Gender reassignment	No impacts have been identified in relation to gender reassignment	No actions/ mitigation required
Marriage and civil partnership (employment only)	Marriage and civil partnership are relevant to employment only	No actions/ mitigation required

Group	Impact and evidence used	Actions / Mitigation
Pregnancy and maternity	Scholes currently doesn't offer any midwife services	Patients all attend Manston currently and will be able to attend Ashfield or the Grange moving forward.
Ethnicity	No impacts have been identified in relation to ethnicity	No actions/ mitigation required
Religion or belief	No impacts have been identified in relation to religion or belief	No actions/ mitigation required
Sex	<p>By the end of the engagement period, 234 survey responses had been received</p> <p>Almost three quarters of respondents to the survey stated they were female (71%), which suggests a disproportionate response or potential that there could be a greater impact on females</p>	Please see actions/ mitigations in the General Section above
Sexual orientation	No impacts have been identified in relation to sexual orientation	No actions/ mitigation required
Carers	<p>Carers Health Checks will continue from both our other sites.</p> <p>By the end of the engagement period, 234 survey responses had been received</p> <p>Carers: increased travel time impacts responsibilities. 17% of respondents (34) stated that they provide unpaid care or support for someone who is older, disabled or has a long-term condition.</p>	<p>Carers health Checks will be offered at all our sites.</p> <p>As part of our review of patients who are unable to get out of their homes /vulnerable patients, we will also ensure carers are reviewed and supported</p>

Group	Impact and evidence used	Actions / Mitigation
	11% reported caring for a child, or children, between 0 and 19 years old.	
Any other groups e.g., people from low-income backgrounds, rural communities, homeless people, asylum seekers and refugees	<p>Dispensary closure in Scholes</p> <p>The dispensary closure and patients needing to change pharmacy provision was a concern.</p> <p>The outcome from the engagement activity indicates significant concerns for elderly, disabled, and vulnerable residents, who face increased difficulty accessing healthcare and prescriptions due to limited mobility, unreliable public transport, and high travel costs. The closure is seen as risking isolation and unmet healthcare needs for those most dependent on local services.</p>	<p>The team are actively contacting patients to change their nominations in relation to alternative pharmacy provision; patients have been given the details of the closest pharmacies and what they offer in relation to delivering medication, for example</p> <p>We are looking at supporting patients/carers with online access/NHS app so they can use these methods to request medication without the need to come to surgery.</p> <p>Some patients are only receiving prescriptions monthly; we will review and move where suitable and safe to two monthly prescriptions to help reduce the need to attend surgery for those who prefer to bring in their requests.</p> <p>Please also refer to taxi initiative above.</p>
Human Rights	No impacts have been identified in relation to Human Rights	No actions/ mitigation required
Health Inequalities Refer to Public Health Information such as	<p>Impact on continuity, particularly affecting patients with complex needs</p> <p>The outcome from the engagement activity indicates there is strong concern that closure of the Scholes branch will disproportionately affect elderly,</p>	<p>This is a clear concern arising from the engagement exercise.</p> <p>The actions described throughout this impact assessment will be implemented and held under review.</p>

Group	Impact and evidence used	Actions / Mitigation
Joint Strategic Needs Assessment (JSNA)	disabled, and vulnerable patients who depend on local services. Respondents highlighted the risk of increased health inequalities, as those less able to travel or without access to private transport would struggle most. The surgery is described as a “vital lifeline” for these groups	Following the implementation of any changes the ICB and the practice/s will review the ongoing impact and effectiveness of the measures in place to support ongoing service improvement, particularly of vulnerable patients.

4. Action Plan

In the table below describe the actual or potential impact (positive and negative) of any proposed changes on the following groups and the actions that will be undertaken to address the impact. Please put n/a in any blank cells you are not putting text into or delete rows with no information in.

Impact	Action	Timescale	Lead
Patients who are unable to access public transport, due to them being unable to get out of their home/ place of residence	The practice will continue to provide home visits for patients unable to get out of their home/ place of residence (defined on the clinical system as housebound) and will always consider new patients for this service on a case-by-case basis. The ICB have agreed to an interim taxi budget and a policy to ensure appropriate use of funds.	Ongoing	Manston Surgery
Patients with impairments, or sensory loss specifically in respect of information and communication	Continue to adhere to the requirements of the Accessible Information Standard in relation to ensuring that patients get information in a format they can understand, for example large print, Easy Read and are supported by communication	Ongoing	Ashfield, Manston and The Grange

Impact	Action	Timescale	Lead
	professionals, such as a BSL interpreter.		
Patients who find the bus services unreliable, meaning they may not be able to make their appointments on time.	The practice responded to these queries through the public engagement and will continue to encourage patients to feedback about their experience with, for example, the buses. The practice, and the ICB, will continue to flag and raise this as a concern with local councillors where necessary including seeking clarification if the local ACCESS buses could support patients	Ongoing	Manston Surgery
Change of Pharmacy provision	<p>The team are actively contacting patients to change their nominations; patients have been given the details of the closest pharmacies and what they offer.</p> <p>We are looking at supporting patients/carers with online access/NHS app so they can use these methods to request medication without the need to come to surgery.</p> <p>Some patients are only receiving prescriptions monthly; we will review and move where suitable and safe to two monthly scripts to help reduce the need to attend</p>	Ongoing but plan to have all patients' nominations changed before the 31 March 2026	Manston Surgery

Impact	Action	Timescale	Lead
	surgery for those who prefer to bring in their requests.		
Feedback from the engagement highlights strong concern from residents and local representatives about the loss of accessible healthcare facilities in Scholes, particularly during any transition period.	Continue proactive engagement with local councillors to identify and assess potential temporary sites within Scholes that could support ongoing patient access. Ensuring that any interim solution is evaluated against overall patient need, service practicality, and financial implications.	Ongoing	Manston Surgery
Carers	Continue with Carers Health Checks from all alternative sites As part of our review of patients who are unable to get out of their homes (defined on the clinical system as housebound) /vulnerable patients, we will also ensure carers are reviewed and supported	Ongoing	Manston Surgery
Learning Disability and Serious Mental Illness	Continue to deliver proactive annual health checks for patients on learning disability and serious mental illness registers, having due consideration for accessibility needs	Ongoing	Manston Surgery
65+, disabled residents, and less mobile residents	The practice will consider if any residents should be added to the 'housebound' list which would	Ongoing	Manston Surgery

Impact	Action	Timescale	Lead
	define those that should be visited at home as opposed to attending the surgery.		
Accessibility Needs	The annual review process led by the Lead Nurse will offer an opportunity to discuss with residents of Scholes their concerns and accessibility needs.	Ongoing	Manston Surgery
All identified impacts	Following the implementation of any changes the ICB and the practice/s will review the ongoing impact and effectiveness of the measures in place to support ongoing service improvement, particularly of vulnerable patients.	Quarterly	ICB/ Practice/s

5. Implementation

Detail in the table below how the actions will be embedded into mainstream activity, impact and effectiveness monitoring process for actions, and who will be responsible for reviewing the outcome of proposed changes. **Please put n/a in any blank cells you are not putting text into**

Action Implementation	Name of individual, group or committee	Role	Frequency
How will the impact and effectiveness of the actions be monitored and reviewed?	The practice leadership team, meet weekly. We will continue to review patient feedback.	Review	Monthly
How will these actions be embedded into mainstream activity?	The practice leadership team, meet weekly. We will continue to review patient feedback.	Review	Monthly
Who will review the outcome of the proposed changes and when?	The practice leadership team, meet weekly. We will continue to review patient feedback.	Review	Monthly

6. For Equality, Diversity and Inclusion Lead Only

Equality, Diversity and Inclusion Lead to sign off in table below

Equality, Diversity and Inclusion Lead	Sharon Moore
Recommendations	The mitigating actions and activities identified in this impact assessment should be robustly monitored on a regular basis, particularly, but not limited to, age (65+), disability and carers.
Sign off date	Initial Review: 31 st March 2025 (comments/ suggestions) Second Review: 24 th November 2025 (comments/ suggestions) Third Review: 2 nd December 2025 (comments/ suggestions) Fourth Review: 4 th December 2025 (comments/ suggestions) Fifth Review 8 th December 2025 (comments/ suggestions) Sixth Review 9 th December 2025

7. For SRO Only

SRO to sign off in table below

SRO	Kirsty Turner Associate Director Primary Care
Recommendations	The ICB will continue to work with the practice team to monitor patient experience post implementation and to inform future arrangements in respect of accessible primary medical services locations in and around East Leeds.
Sign off date	16 January 2026

Quality and Equality Impact Assessment (QEIA)

To be completed with support from Quality, Equality and Engagement leads; email for all correspondence: wycb-leeds.qualityteam@nhs.net

Complete all sections (see instructions/comments and consider) Impact Matrix on page 10

Assessment Completion	Name	Role	Date	Email
Scheme Lead	Michaella Guilfoyle	Practice Manager Ashfield Medical Centre / The Grange Medical Centre Manston and Scholes Surgery	20 November 2025	Michaella.Guilyfoyle@nhs.net
Programme Lead sign off	Lisa Kundi	Senior Manager Delegated Primary Medical Services Primary Care and Same Day Response NHS West Yorkshire ICB (Leeds) (ICB)	20 November 2025	lisa.kundi1@nhs.net

A. Scheme Name	PMO Number: PMO-060 Transfer of services (and closure of branch site) of Scholes Surgery to Manston Surgery. Merger of Manston surgery with Ashfield Medical Centre
Type of change	Adjust existing
ICB	Leeds

B: Summary of change

This proposal to merge includes the following elements:

1. The merger of the two practice contracts (ICB must approve)
2. The closure of the Scholes site including the dispensary (ICB unable to decline / approve)
3. A change of name for the practice which is yet to be proposed and will form part of the engagement (ICB must approve)

On 1st May 2025, Dr A Walling and Dr S Nathan assumed the PMS contract for Manston Surgery. Both practices have been collaborating within their PCN. Following a recent CQC report that placed Manston Surgery into special measures one of the areas identified was leadership deficiencies, Ashfield extended mutual support to streamline processes and to provide leadership structure. During discussions, Manston's current partners expressed a desire to step down, leading to an agreement for Ashfield's partners to take over the PMS contract as well as Ashfield. Implementing a streamlined management structure to ensure robust and effective leadership is in place.

The merger of the practices will enhance efficiency, provide staff depth for resilience, and address estate capacity issues, enabling recruitment and improved patient access. Additionally, it will reduce administrative burdens by eliminating the need to duplicate tasks such as claims, CQC documentation, and required submissions to NHSE and ICB.

The Scholes site, which also hosts the dispensary, is owned by the previous partnership of the practice who has expressed intent to sell the building. The premises, a converted house, offer limited facilities with only one consultation room, thereby restricting the provision of nurse, midwifery, and enhanced services. The site is not suitable for modern healthcare services, and so the partnership does not propose to buy the building.

Additionally, the dispensary service is not financially viable. The new partnership's long-term plan is to not continue with the service in order to ensure the future financial viability of the practice and offer a consistent service to all patients. The merger would lead to one practice operating across 3 sites and so a new name to reflect this new configuration would help patients to better understand the geographical boundary and service offer.

C. Service Change Details – (Engagement and Equality Checklist) - please describe the impact in each section To be completed in conjunction with Equality Lead; Sharon Moore sharon.moore12@nhs.net and Engagement Lead; Caroline Mackay caroline.mackay2@nhs.net	Yes/No
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<p>1. Could the project change the way a service is currently provided or delivered?</p> <p>From 14 November 2025, patients who currently use the Scholes site for dispensary services will no longer be able to collect their medication from this location. GP appointments will continue to be provided at the Scholes site until 1 April 2026. If the proposed change is approved, from this date all patients will access general practice appointments and services at the remaining three sites.</p> <p>This change represents a key component of the practice’s wider service reconfiguration programme. Clear communication, targeted support, and planned transition arrangements will be implemented to ensure that affected patients—particularly those with additional needs or who may be disproportionately impacted—are appropriately informed and supported throughout the transition.</p>	yes
<p>2. Could the project directly affect the services received by patients, carers, and families?</p> <p>Impact on older people (65+), and on who are unable to leave their homes, may be disproportionately affected by changes to local service provision. To mitigate this impact, home visits for clinical care will continue to be provided for all patients who are unable to attend a practice site.</p> <p>The practice is currently reviewing its list of patients who are unable to leave their homes (housebound) to ensure accurate coding and identification of those requiring enhanced support. The Nurse Manager has scheduled annual reviews for all these patients, and the practice aims to strengthen proactive care planning for this cohort to maintain continuity and minimise inequalities in access.</p> <p>Impact on people with disabilities - patients with physical disabilities, including those unable to leave their place of residence, will continue to receive home visits to ensure equitable access to clinical care.</p> <p>Accessibility across the remaining practice sites has been assessed:</p> <ul style="list-style-type: none"> • Ashfield Medical Centre- Accessible parking, entrance ramps, and touch-pad automated doors. The site has two pharmacies in the vicinity. • Manston Surgery: Accessible parking and a lift providing access to the first floor. The site does have a pharmacy on site, not attached to the practices within the building. • The Grange: The highest level of physical accessibility, including accessible parking and a fully step-free environment throughout. The site does have a pharmacy on site, not attached to the practices within the building. • Scholes: The existing building does not meet current accessibility standards, contributing to the need for service reconfiguration. <p>For patients unable to use public transport, several local taxi providers offer wheelchair-accessible vehicles, and a budget has been agreed with the ICB to support eligible patients where appropriate.</p>	yes

<p>3. Could the project directly affect staff</p> <p>The proposed changes may directly affect staff currently based at the Scholes site. Two dispensing staff will require relocation to alternative roles within the wider practice. A formal staff consultation process will be undertaken in line with organisational policy, and initial exploratory discussions with affected staff have already begun. The intention is to support all staff through the transition and ensure roles are aligned with service needs.</p> <p>The service reconfiguration is also expected to deliver broader workforce benefits. By operating from fewer sites, the practice will be able to improve staffing levels through the consolidation of teams, enabling more efficient allocation of clinical and administrative staff. This may help to address existing workforce pressures and support more sustainable service delivery.</p> <p>In addition, the merger of operational functions is anticipated to streamline administrative processes, reduce duplication, and create economies of scale. These efficiencies aim to enhance the experience for both staff and patients by simplifying workflows and reducing unnecessary bureaucracy.</p>	<p>yes</p>
<p>4. Does the project build on feedback received from patients, carers and families, including patient experience?</p> <p>A comprehensive patient engagement process was undertaken to ensure that all affected groups, including those with protected characteristics, had the opportunity to contribute their views on the proposed changes.</p> <ul style="list-style-type: none"> • Patient Survey: <p>An online and paper survey opened on 12 September 2025. The closing date was extended to 12 November 2025 to allow for an additional engagement meeting in Scholes following high attendance at the initial event.</p> <ul style="list-style-type: none"> • Face-to-Face Public Events: <p>Four in-person engagement sessions were held across the practice area to maximise accessibility for different patient groups:</p> <ul style="list-style-type: none"> ○ 24 September 2025, 5.00pm–7.00pm, Church Hall, Scholes (two back-to-back hour-long sessions) ○ 1 October 2025, 2.00pm–4.00pm, Manston Surgery ○ 14 October 2025, 2.00pm–4.00pm, Grange Surgery ○ 7 November 2025, 10.00am–12.00 noon, Village Hall, Scholes (added due to demand) 	<p>yes</p>

<ul style="list-style-type: none"> Online Engagement Session: A Microsoft Teams public meeting took place on 15 October 2025, 6.00pm–7.00pm, to provide an accessible option for patients unable to attend in person. Engagement Report: A full engagement report is scheduled for completion by 4 December 2025. In addition to the public engagement activity, the Senior Partner and Practice Manager have held separate discussions with local councillors and Members of Parliament to outline the rationale for the proposed closure of the Scholes site and to consider potential mitigations. This includes exploring the feasibility of a short-term, interim primary care presence within the village while longer-term solutions, such as a potential new-build facility, are being investigated. These exploratory discussions are ongoing and will continue as part of the wider decision-making process. 	
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D: To be completed in conjunction with the Engagement and Equality lead: Insert comments in each section as required.	Yes/No
Engagement activity required Patients will be provided with multiple opportunities to attend engagement sessions or to submit questions and concerns through a range of accessible channels. Following the close of the engagement period, all feedback received will be reviewed by the practice. Responses will be issued to address any queries not already covered within the initial Frequently Asked Questions (FAQ) document, ensuring that patients receive clear, comprehensive, and timely information. Manston Surgery do not have an active Patient Participation Group (PPG). Ashfield Medical Centre have an established group who will be given the opportunity to comment on the plan. We will capture in the survey any patients who wish to join the patient participation group (PPG). The practice will engage proactively with local MPs, Councillors and Parish Council to ensure they are fully informed and involved throughout the process. Their participation will help support both patients and the practice during the transition, strengthen community confidence, and enhance transparency in the decision-making and communication processes.	Yes
Formal consultation activity required?	No

<p>Although the proposed change would have the greatest impact on the existing patient population of the Scholes site, it would not be considered a major change that requires formal consultation following NHS England guidance. A two-month public engagement with clear communications and a wide range of opportunity for all interested parties to get involved and have their say is proportionate to the proposed change.</p>	
<p>Full Equality Impact Assessment (EIA) required?</p> <p>Yes, a full EIA has been completed.</p>	Yes
<p>Communication activity required ?</p> <p>Staff will be included in regular, structured updates throughout the change process to ensure transparency, maintain confidence, and support operational readiness. Engagement will be delivered through routine briefings, written communications, and opportunities for feedback, allowing staff to contribute to the development and implementation of the change.</p> <p>Patients will be provided with a clear roadmap outlining the key stages of the change, expected timelines, and what they can anticipate at each phase. This will ensure that patients remain informed, reassured, and supported. Engagement with local councillors and community representatives will be incorporated as appropriate to strengthen public communication, enhance local understanding, and maintain trust in the process.</p>	Yes

<p>E. Data Protection Impact Assessment (DPIA) is carried out to identify and minimise data protection risks when personal data is going to be used and processed as part of new processes, systems or technologies.</p>	Yes / No
<p>Does this project/decision involve a new use of personal data, a change of process or significant change in the way in which personal data is handled? If yes, please email the IG Team at; wycb-leeds.dpo@nhs.net for Leeds ICB or wycb-wak.informationgovernance@nhs.net for the wider WY ICB, to complete the screening form.</p>	No

F. Evidence used in this assessment

List any evidence which has been used to inform the development of this proposal for example, any national guidance (e.g. NICE, CQC, DoH, Royal Colleges), regional or local strategies, data analysis (e.g. performance data), engagement / consultation with partner agencies, interest groups or patients. Where applicable, state 'N/A' in boxes where no evidence exists, 'Not yet collected' where information has not yet been collected or delete where appropriate

Evidence Source	Details
Research and Guidance (local, regional, national)	<p>The concept of general practice at scale is not new. The 10-year NHS plan very much encouraging GP practices to work together across neighbourhoods.</p> <p>The principles of working at a greater scale make practices more resilient by creating workload efficiencies and being able to adapt easier to change. A merger is one way to achieve this whilst also creating the opportunity to improve the quality and variety of services available to registered patients.</p>
Service delivery data such as who receives services	<p>What does the service offer at each site:</p> <ul style="list-style-type: none"> • Scholes site: The branch practice at Scholes cannot offer bloods/Nurse/Midwifery appointments and all registered patients living near the Scholes site are accessing these services at Manston Surgery. Most patients access the main practice sites and will see limited change. • Manston Site – Offer all of the following All long-term condition reviews, NHS Health checks, Enhanced services, Contraceptive services, Phlebotomy, Minor Surgery Injections, Frailty Scheme, DMARD blood monitoring, home visits • Ashfield and Grange Sites – Offer all of the following All long-term condition reviews, NHS Health checks, Enhanced services, Contraceptive services, Phlebotomy, Minor Surgery Injections, Frailty Scheme, DMARD blood monitoring, home visits <p>For more detailed information please see the full Equality Impact Assessment</p>
Consultation / engagement	<ul style="list-style-type: none"> • The Patient Participation Group (PPG) (Ashfield only, no established at Manston) will be invited to shape the involvement plan • Face to face engagement meetings covering all practices, 1 virtual meeting • Survey made available in paper form, online via a text/Face Book and website. This will include the patient survey which will outline the proposal, including the risks and benefits

	<ul style="list-style-type: none"> • All registered households will receive a link to a letter outlining the proposal, with details of how to give their views via patches the online consultation tool, a message via text and for Scholes patients a letter was sent. • Use of social media and practice website • Posters displayed in all waiting rooms • Report and feedback shared with patients and stakeholders once all feedback has been gathered and collated.
Experience of care intelligence, knowledge and insight (Complaints, Compliments, PALS, National and Local Surveys, Friends and Family Test, consultation outcomes)	<ul style="list-style-type: none"> • Friends and family Test • Care opinion • National GP survey • Complaints received can be reviewed to spot themes of complaints and could the proposed changes help with this. <p>Further detail relating to each of the bullet points above can be found in the Full Equality Impact Assessment</p>
Other	Not applicable

G. Impact Assessment: Quality, Equality, Health Inequalities, Safeguarding etc

What is the potential impact on quality of the proposed change? Outline the expected outcomes and who is intended to benefit. Include all potential impacts (positive, negative or neutral).

For negative impacts, list the action that will be taken in mitigation.

See [guidance notes on p. 10-11](#)

Quality Domain	Quality elements/ Description of impact:	Impact: Positive / Negative / Neutral & score	What action will you take to mitigate any negative impact?
<i>The list in each domain is not exhaustive; it is illustrative of the type of impact that should be considered. When describing impacts; use words that you consider are meaningful)</i>	<i>Where appropriate provide information about the proposed or current service that contextualises the impact. (Quantify where possible, e.g. number of patients affected) (List & number if more than one in each domain)</i>	<i>(Assess each impact using the Impact Matrix; colour cell RAG)</i>	<i>How could the impacts and/or mitigating actions be monitored? Are there any communications or engagement considerations or requirements?</i>

<p>1. Patient Safety</p>	<ul style="list-style-type: none"> • Patients will need to travel further for medication adding an extra burden to patients, carers and family to collect the prescriptions. • Reduced access for patients who currently walk to the village site; longer travel for appointments. The Scholes site also has a high proportion of older patients with long term conditions (LTC) who could be disproportionately affected by the closure of the site and the pharmacy. • Increased travel / transport costs • Poor public transport links <p>A local GP practice may be perceived by patients as a community hub where vulnerable people get comfort and company not just appointments from nurses and staff – this could impact patients mental health and mood if this is then closed</p> <p>Temporary disruption during migration of services and records may mean delays in actioning urgent clinical/diagnostic results to patients or other clinicians</p>	<p>Negative High risk</p> <p>$(L \times 4) \times (C \times -3) = -12$ (robust mitigation may reduce risk to moderate)</p>	<ul style="list-style-type: none"> • Clear communication of new processes • Support for vulnerable patients (e.g., delivery services) • Transition period with enhanced staffing • ICB to fund interim taxi service • Village has public transport (hourly), that residents feel this is inadequate raised with councillors • Patients currently travel to Manston for non-GP appointments <p>Working with councillors to scope out the viability of a temporary offering within the village. The long-term strategy is that a new build will be located nearby as part of the East Leeds extension.</p> <p>A significant period of planning will be undertaken with system providers and local system specialists who will be located in practice at the time of migration. The local team have a wealth of experience and will support the practice to ensure that the migration is managed safely.</p>
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	Improved access to wider clinical services is available at the other sites	Positive $(L \times 3) \times (O \times +2) = +6$	
2. Experience of Care	<ul style="list-style-type: none"> • Reduced convenience / local access • Distress due to change and loss of familiar local practice • Patients need to re-register for online access 	Negative Moderate risk $(L \times 4) \times (C \times -2) = -8$	<ul style="list-style-type: none"> • Travel support, medication delivery • Communications plan to highlight benefits <p>Continuity of care with same staff available at Manston that residents in Scholes know.</p> <ul style="list-style-type: none"> • Patient engagement sessions, Q&A, PPG (Patient Participation Group) support • Heavily staff main site to support online registration • Encourage NHS App sign-up to reduce registration burden
	Improved range of services at consolidated site Improved access to wider clinical services	Positive $(L \times 3) \times (O \times +2) = +6$	
3. Clinical Effectiveness	<ul style="list-style-type: none"> • Better continuity of care • Improved access to multidisciplinary teams if centralised <p>Improved access to wider clinical services is available at the other sites</p>	Positive $(L \times 3) \times (O \times +3) = +9$	<ul style="list-style-type: none"> • One unified system reduces fragmentation • Proactive allocation of GP/nurse continuity for vulnerable patients • Greater joined-up care and streamlined pathways

	<ul style="list-style-type: none">• Temporary disruption during migration of services and records may mean delays in actioning urgent clinical/diagnostic results to patients or other clinicians	<p>Negative Low risk $(L \times 3) \times (C \times -2) = -6$</p>	<p>Reduced capacity for 2 days during migration; provide urgent care only</p> <ul style="list-style-type: none">• Roadmap of support for patients during migration <p>See above also in patient safety section for actions</p>
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<p>4. Equality</p>	<p>By the end of the engagement period, 234 survey responses had been received</p> <p>Gender/ Sex - Almost three quarters of respondents to the survey stated they were female (71%)</p> <p>Older adults (65+): potential difficulty travelling. Almost three quarters of respondents to the survey they were age 56 or over, with 57% of respondents (115) stating they were retired.</p> <p>People with disabilities / mobility issues: travel and accessibility challenges. Nearly half of all respondents who completed the equality monitoring section in the survey stated they were disabled (45%), with 33 (16% of respondents) reporting living with at least one long-term condition, 28 (14%) living with a physical or mobility impairment and eight reporting a mental health condition.</p> <p>Carers: increased travel time impacts responsibilities. 17% of respondents (34) stated that they provide unpaid care or support for someone who is older, disabled or has a long-term condition. 11% reported caring for a child, or children, between 0 and 19 years old.</p>	<p>Negative High risk $(L \times 4) \times (C \times -4) = -16$</p>	<p>Transport support, medication delivery, maintain telephone/non-digital access</p> <p>Flag vulnerable patients on phone system</p> <p>Nursing team proactive care for patients unable to leave home</p> <p>Carers coded correctly and aware of available support</p> <p>Ashfield, Manston and The Grange continue to adhere to the requirements of the Accessible Information Standard in relation to ensuring that patients get information in a format they can understand, for example large print, Easy Read and are supported by communication professionals, such as a BSL interpreter.</p> <p>Part of our review will include patients who are unable to get out of their homes /vulnerable</p>
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Patients with impairments, or sensory loss specifically in respect of information and communication

The outcome from the engagement activity indicates there is a strong sense of concern for elderly, disabled, and less mobile residents. Respondents note that closure of the local surgery would disproportionately affect these groups, making access to essential healthcare much harder and potentially leading to missed appointments or reduced care.

The stress and inconvenience for both patients and those who assist them (family, friends, carers) are recurring themes, with some stating they might forgo appointments due to these challenges.

Dispensary closure in Scholes - The dispensary closure and patients needing



patients, we will also ensure carers are reviewed and supported.

The practice is working closely with local pharmacies (10 within 2 miles) to support patients to move across to a community pharmacy of their choice. Patients who prefer a traditional dispensary may choose to register with Barwick Surgery, a local practice that have this service. Local pharmacies have shared if they offer a delivery service.

	<p>to change pharmacy provision was a concern.</p> <p>The outcome from the engagement activity indicates significant concerns for elderly, disabled, and vulnerable residents, who face increased difficulty accessing healthcare and prescriptions due to limited mobility, unreliable public transport, and high travel costs. The closure is seen as risking isolation and unmet healthcare needs for those most dependent on local services.</p> <p>Please see the Full Equality Impact Assessment for more detail</p>		
<p>5. Safeguarding</p>	<ul style="list-style-type: none"> • Potential loss of safeguarding alerts during system migration • Delayed referrals 	<p>Moderate risk Negative (L x 2) x (C x -4) = -8</p>	<ul style="list-style-type: none"> • Pre- and post-migration safeguarding audits • Ensure alerts and flags transferred accurately • Safety-netting for high-risk patients <p>Close working with local system specialists with experience of migrations</p>

<p>6. Workforce</p>	<ul style="list-style-type: none"> • Staff morale and uncertainty; anxiety and instability • Staff unfamiliar with new systems / processes; potential errors or reduced efficiency 	<p>Moderate Negative (L x 4) x (C x -2) = -8</p>	<ul style="list-style-type: none"> • Clear communication; engagement sessions; HR support • Training, shadowing, induction packages • Regular communications / FAQs
<p>7. Health Inequalities</p>	<p>Impact on continuity, particularly affecting patients with complex needs</p> <p>The outcome from the engagement activity indicates there is strong concern that closure will disproportionately affect people 65+, women, disabled people, and vulnerable patients who depend on local services.</p> <p>Respondents to the survey highlighted the risk of increased health inequalities, as those less able to travel or without access to private transport would struggle most.</p> <p>The surgery is described as a “vital lifeline” for these groups</p> <p>Please see equality section above for more detail (section 4) and the full Equality Impact Assessment.</p>	<p>Negative High risk (L x 4) x (C x -4) = -16</p>	<ul style="list-style-type: none"> • Enhanced long-term condition and frailty reviews • More proactive care plans
<p>8. Sustainability</p>	<ul style="list-style-type: none"> • Building energy use: Scholes is an old, inefficient building • Supply chain & procurement will improve • Financial savings from consolidation 	<p>Positive (L x 3) x (O x +2) = +6</p>	<ul style="list-style-type: none"> • Consolidation into larger modern site reduces footprint • Streamline ordering and procurement processes

	Patients who would have walked to Scholes site may now have to use transport to travel to another site or rely on friends or family members to take them to it.	<p style="text-align: center;">Negative Low risk $(L \times 1) \times (C \times -1) = -2$</p>	<ul style="list-style-type: none"> • Reinvest savings into frontline care
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H. Action Plan
Describe the action that will be taken to mitigate negative impacts

Identified impact	What action will you take to mitigate the impact?	How will you measure impact / monitor progress (Include all identified positive and negative impacts. Measurement may be an existing or new quality indicator / KPI)	Timescale (When will mitigating action be completed?)	Lead (Person responsible for implementing mitigating action.)
Staff morale and uncertainty; anxiety and instability Staff unfamiliar with new systems/processes; potential errors or reduced efficiency	Clear communication; engagement sessions; HR support Training, shadowing, induction packages Regular communications / FAQs	Ensure staff have time to feedback on a regular basis Utilise TARGET sessions for team meetings	Ongoing	Practice Manager
Reduced access for patients who currently walk to the village site; longer travel for appointments	ICB to fund interim taxi service Support to nominate pharmacy Nomination for medication delivery Communications plan	Friends and Family test Patient feedback Usage of Taxi service via ICB agreement	Ongoing	Practice Manager

Identified impact	What action will you take to mitigate the impact?	How will you measure impact / monitor progress (Include all identified positive and negative impacts. Measurement may be an existing or new quality indicator / KPI)	Timescale (When will mitigating action be completed?)	Lead (Person responsible for implementing mitigating action.)
	Scope out viability of a temporary site in Scholes whilst a permanent more local site is procured as part of East Leeds Extension	If cancelled appointments document reasons for i.e. travel		ICB and Practice liaise with council
Older adults (65+): difficulty travelling and People with disabilities / mobility issues: travel and accessibility challenges along with continuity of care	Transport support Medication delivery Maintain telephone / non-digital access Flag vulnerable patients on phone system Nursing team proactive care for patients unable to leave home Carers coded correctly and aware of available support	Track appointment logs – DNA (Dis Not Attend) rate Compare baseline data Monitor patient feedback on how hard it is to reach services. Track proactive care plans in place Confidence in accessing care	Ongoing	Practice Manager Nurse manager
Impacts on Learning Disability and Severe Mental Illness annual health checks	Offer communication support such as interpreters, carers or advocates if needed to reduce anxiety and support patients to fully engage and understand the process of these checks. Establish clear communication pathways between GPs, mental health teams, learning disability teams, social care	Collect feedback, review incidents and complaints and adjust training and processes if required. Identify recurring issues early and reduce likelihood of future occurrences.	Ongoing	Management Team

Identified impact	What action will you take to mitigate the impact?	How will you measure impact / monitor progress (Include all identified positive and negative impacts. Measurement may be an existing or new quality indicator / KPI)	Timescale (When will mitigating action be completed?)	Lead (Person responsible for implementing mitigating action.)
	and carers to avoid gaps in care and take a holistic approach	Track through monitoring outcomes, patient experience and incident reporting.		
Patients with impairments, or sensory loss specifically in respect of information and communication	Ashfield, Manston and The Grange continue to adhere to the requirements of the Accessible Information Standard in relation to ensuring that patients get information in a format they can understand, for example large print, Easy Read and are supported by communication professionals, such as a BSL interpreter	Track number and type of accessible information requests to understand if people communication needs are being identified and met. Review instances of translator cancellation/unavailability. Review compliments, complaints and PALS enquiries relating to communication and access to information. Include as part of annual staff appraisals to assess knowledge and capability.	Ongoing	Practice Manager supported by Operations Manager and secretaries
Migration of patient information to new system at Manston	Work closely with provider of systems and follow mobilisation / migration check lists Focus on urgent consults for the period of 2 days when access to records is limited to	Work with local specialists who are experienced in migration of systems Audits and manual systems to ensure safety netting	Ongoing	Practice Manager

Identified impact	What action will you take to mitigate the impact?	How will you measure impact / monitor progress (Include all identified positive and negative impacts. Measurement may be an existing or new quality indicator / KPI)	Timescale (When will mitigating action be completed?)	Lead (Person responsible for implementing mitigating action.)
	minimise risk of tasks not being actioned Pre and post audits for safeguarding flags Safety netting processes for migration window	Review of incident reported on patient safety system		

I. Monitoring & review; Implementation of action plan and proposal

The action plan should be monitored regularly to ensure a) actions required to mitigate negative impacts are undertaken and b) KPIs / quality indicators are measured in a timely manner so positive and negative impacts can be evaluated during implementation / the period of service delivery.

Outcome: Once the proposal has been implemented, the actual impacts will need to be evaluated and a judgement made as to whether the intended outcomes of the proposal were achieved (Section H To be completed as agreed following implementation)

Implementation: State who will monitor / review:	Name of individual, group or committee	Role	Frequency
a) that actions to mitigate negative impacts have been taken	Management team	Practice	Ongoing, to be reviewed after each stage is progressed
b) the quality indicators during the period of service delivery	Management team	Practice	Ongoing, to be reviewed after each stage is progressed
Outcome	Name of individual, group or committee	Role	Date

Who will review the proposal once the change has been implemented to determine what the actual impacts were?	Management team	Practice	30 September 2026 – 6 months post-merger and site closure
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J. Summary of the QEIA

Provide a brief summary of the results of the QEIA, e.g. highlight positive and negative potential impacts; indicate if any impacts can be mitigated; taking this into account, state what the overall expected impact will be of the proposed change.

The QEIA and summary statement must be reviewed by a member of the Quality Team and include next steps

QEIA Summary – Proposed Practice Merger

The proposal includes merging two practice contracts, closing the Scholes site (including its dispensary), and adopting a new practice name following engagement. The proposal follows a much-improved CQC inspection report and rating and a change in leadership. To be clear, the aspects of change that the ICB can influence is the merger (decision pending February 2026) and a name change. The landlord has given notice on the Scholes site beyond the control of the current partners and ICB. Practices are obliged to give 3 months-notice to close a dispensary and the ICB are required to accept this.

Positive Impacts

- **Improved leadership and governance:** A single, streamlined management structure will address previous CQC concerns and strengthen clinical and organisational oversight.
- **Enhanced patient access and service quality:** Increased staff resilience, improved estate utilisation, and recruitment potential will support more reliable and accessible services.
- **Operational efficiency:** Merging administrative functions will reduce duplication (e.g., claims, CQC processes, NHSE/ICB submissions), improving productivity and freeing capacity for patient care.
- **Clearer identity for patients:** A new practice name reflecting three operational sites will support patient understanding of service geography and access points.

Negative Impacts

- **Loss of local provision at Scholes:** Closure of the site will increase travel requirements for some patients, including those with mobility or transport challenges.
- **Closure of the dispensary:** Patients currently reliant on the dispensary service will need to transition to community pharmacies, which may be inconvenient for some.
- **Potential patient concerns about continuity:** Changes to sites, leadership, and practice identity may create uncertainty among patients, particularly vulnerable groups.

Mitigations

- **Targeted patient support:** Provide personalised guidance for patients affected by the dispensary closure, including help identifying local pharmacies, delivery options and arranging Electronic Prescribing nominations (EPS).
- **Transport and access considerations:** Communication will highlight alternative sites, their accessibility, and any available support for patients with mobility issues. Work with ICB to embed an interim taxi option for those that require support.
- **Clear, proactive engagement:** Early and ongoing communication—especially with groups potentially impacted—will minimise anxiety and maintain trust.
- **Continuity of care measures:** Clinical pathways and staff roles will be aligned across sites to provide a consistent experience irrespective of location.

Overall Expected Impact

The overall impact of the proposal is positive for most patients, with significant improvements anticipated in leadership, organisational resilience, operational efficiency, and patient access. The merger will create a stronger, more sustainable practice able to deliver high-quality, modern primary care across its locations.

While the closure of the Scholes site and dispensary presents challenges—particularly for patients who currently rely on local access—these impacts can be mitigated through targeted support, clear communication, and assistance in transitioning to alternative services. It is important to note that there is a strong sense of loss for residents within Scholes and that both the engagement and data show that those over 65 are disproportionately affected. It is this group that likely use services most and so the impact must be closely monitored to ensure patients are still accessing the care they need.

Importantly, the proposal also creates the **potential to explore a new, fit-for-purpose site** in the future. This would allow the practice to address long-term estate limitations, improve accessibility, and expand clinical capacity, offering a more suitable environment for delivering enhanced services and joined up working with other services. The location of this potential site is close to the village of Scholes.

Taken together, the changes are expected to strengthen clinical governance, secure long-term financial viability, and position the practice to develop a more modern, resilient, and patient-centred service for the whole population however, the impact of Scholes residents must continue to be monitored and reviewed.

K: For Team use only		
1. Reference	XX /	
2. Form completed by (names and roles)	Lisa Kundi – Senior Pathway Integration manager Amanda Sykes – Quality Manager Sharon Moore – Senior Equality Diversity and Inclusion Manager Caroline MacKay – Involvement Manager Michaela Guilfoyle – Practice Manager Manston Surgery and Ashfield Medical Centre	
3. Quality Review completed by:	Name: Amanda Sykes Second review: Amanda Sykes	Date: 09/01/2026 Date: 13/01/2026
4. Equality review completed by:	Initial Review: Sharon Moore Second Review: Sharon Moore Third Review: Sharon Moore Fourth Review: Sharon Moore	Date: 02 December 2025 Date: 04 December 2025 Date: 08 December 2025 Date: 13 January 2026
5. Date form/scheme agreed for governance		
6. Proposed review date (6 months post implementation date)	30 September 2026	
7. Notes		

Involvement review completed by: Caroline Mackay 28/11/2025
 Second Review: Caroline Mackay 13/01/2026

L: Likely financial impact of the change (and/or level of risk to the ICB)
 (as advised by finance lead)

Low		Medium		High	
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M: Approval to proceed	Name/ Role	Y/N	Date
PMO/PI/Director			
Proposed 6-month review date (post implementation)	To be agreed with Pathway Integration/Programme or scheme lead		

N: Review (to be completed following implementation only).

1.Review completed by	
2.Date of Review	
3.Scheme start date	

4. Were the proposed mitigations effective? (If not why not, and what further actions have been taken to mitigate?) Put details in box below

--

5. Is there any intelligence/service user feedback following the change of the service? If yes, where is this being shared and have any necessary actions been taken because of this feedback? Put details in box below

--

6. Overall conclusion

Please provide brief feedback of scheme in box below i.e. its function, what went well and what didn't.

--

7. What are the next steps following the completion of the review?

Provide next steps in box below i.e. Future plans, further involvement/consultation required?

--

Appendix A: Impact Matrix

This matrix is included to help your thinking and determine the level of impact on each area.

Likelihood		
0	Not applicable	
1	Rare	Not expected to occur for years. Will occur in exceptional
2	Unlikely	Expected to occur at least annually. Unlikely to occur.
3	Possible	Expected to occur at least monthly. Reasonable chance of
4	Likely	Expected to occur at least weekly. Likely to occur.
5	Almost Certain	Expected to occur at least daily. More likely to occur than not.

		Opportunity						Consequence				
Likelihood		5	4	3	2	1	0	-1	-2	-3	-4	-5
	5	25	20	15	10	5	0	-5	-10	-15	-20	-25
	4	20	16	12	8	4	0	-4	-8	-12	-16	-20
	3	15	12	9	6	3	0	-3	-6	-9	-12	-15
	2	10	8	6	4	2	0	-2	-4	-6	-8	-10
	1	5	4	3	2	1	0	-1	-2	-3	-4	-5

Category	
	Opportunity
	Low - Moderate Risk
	High Risk

Opportunity and Consequence			
Impact	Score		The proposed change is anticipated to lead to the following level of opportunity and/or consequence:
Positive	5	Excellence	Multiple enhanced benefits including excellent improvement in access, experience and/or outcomes for all patients, families and carers. Outstanding reduction in health inequalities by narrowing the gap in access, experience and/or outcomes between people with protected characteristics and the general population. Leading to consistently improved standards of experience and an enhancement of public confidence, significant improvements to performance and an improved and sustainable workforce.
	4	Major	Major benefit leading to long term improvements and access, experience and /or outcomes for people with this protected characteristic. Major reduction in health inequalities by narrowing the gap in access, experience and /or outcomes between people with this protected characteristic and the general population. Benefits include improvements in management of patients with long term effects and compliance with national standards.
	3	Moderate	Moderate benefits requiring professional intervention with moderate improvement in access, experience and /or outcomes for people with this protected characteristic. Moderate reduction in health inequalities by narrowing the gap in access, experience and /or outcomes between people with this protected characteristic and the general population.
	2	Minor	Minor improvement in access, experience and /or outcomes for people with this protected characteristic. Minor reduction in health inequalities by narrowing the gap in access, experience and /or outcomes between people with this protected characteristic and the general population.
	1	Negligible	Minimal benefit requiring no/minimal intervention or treatment. Negligible improvement in access, experience and /or outcomes for people with this protected characteristic. Negligible reduction in health inequalities by narrowing the gap in access, experience and /or outcomes between people with this protected characteristic and the general population.
Neutral	0	Neutral	No effect either positive or negative
Negative	-1	Negligible	Negligible negative impact on access, experience and /or outcomes for people with this protected characteristic. Negligible increase in health inequalities by widening the gap in access, experience and /or outcomes between people with this protected characteristic and the general population. Potential to result in minimal injury requiring no/minimal intervention or treatment, peripheral element of treatment suboptimal and/or informal complaint/inquiry
	-2	Minor	Minor negative impact on access, experience and /or outcomes for people with this protected characteristic. Minor increase in health inequalities by widening the gap in access, experience and /or outcomes between people with this protected characteristic and the general population. Potential to result in minor injury or illness, requiring minor intervention and overall treatment suboptimal
	-3	Moderate	Moderate negative impact on access, experience and /or outcomes for people with this protected characteristic. Moderate increase in health inequalities by widening the gap in access, experience and /or outcomes between people with this protected characteristic and the general population. Potential to result in moderate injury requiring professional intervention.
	-4	Major	Major negative impact on access, experience and /or outcomes for people with this protected characteristic. Major increase in health inequalities by widening the gap in access, experience and /or outcomes between people with this protected characteristic and the general population. Potential to lead to major injury leading to long-term incapacity/disability
	-5	Catastrophic	Catastrophic negative impact on access, experience and /or outcomes for people with this protected characteristic. Catastrophic increase in health inequalities by widening the gap in access, experience and /or outcomes between people with this protected characteristic and the general population. Potential to result in incident leading to death, multiple permanent injuries or irreversible health effects, an event which impacts on a large number of patients, totally unacceptable level or effectiveness of treatment, gross failure of experience and does not meet required standards

Appendix B: Guidance notes on completing the impacts section G

Domain	Consider.....
<p>1. Patient Safety</p>	<ul style="list-style-type: none"> • Safe environment • Preventable harm • Reliability of safety systems • Systems & processes to prevent healthcare acquired infection • Clinical workforce capability and appropriate training and skills • Provider’s meeting CQC Essential Standards
<p>2. Experience of care</p>	<ul style="list-style-type: none"> • Respect for person-centred values, preferences, and expressed needs, including cultural issues; the dignity, privacy and independence of service users; quality-of-life issues; and shared decision making; • Coordination and integration of care across the health and social care system; • Information, communication, and education on clinical status, progress, prognosis, and processes of care in order to facilitate autonomy, self-care and health promotion; • Physical comfort including pain management, help with activities of daily living, and clean and comfortable surroundings; • Emotional support and alleviation of fear and anxiety about such issues as clinical status, prognosis, and the impact of illness on patients, their families and their finances; • Use co-production with the population and service users as the default position for project design. • Use what we know from insight and feedback in project design and be explicit in the expected outcomes for experience of care improvements. • Involvement of family and friends, on whom patients and service users rely, in decision-making and demonstrating awareness and accommodation of their needs as caregivers; • Transition and continuity as regards information that will help patients care for themselves away from a clinical setting, and coordination, planning, and support to ease transitions; • Access to care e.g., time spent waiting for admission, time between admission and placement in an in-patient setting, waiting time for an appointment or visit in the out-patient, primary care or social care setting. <p>[Adapted from the NHS Patient Experience Framework, DoH 2011] revised in: NHS Patient Experience Improvement Framework 2018</p>
<p>3. Clinical Effectiveness</p>	<ul style="list-style-type: none"> • Implementation of evidence based practice (NICE, pathways, royal colleges etc.) • Clinical leadership • Care delivered in most clinically and cost effective setting • Variations in care • The quality of information collected and the systems for monitoring clinical quality • Locally agreed care pathways • Clinical engagement • Elimination of inefficiency and waste

	<ul style="list-style-type: none"> • Service innovation • Reliability and responsiveness • Accelerating adoption and diffusion of innovation and care pathway improvement • Preventing people dying prematurely • Enhancing quality of life • Helping people recover from episodes of ill health or following injury
4. Equality	<ul style="list-style-type: none"> • In order to answer section C and G4 the groups that need consideration are; • Protected characteristics; age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex, sexual orientation (Use the hyperlinks for further information) • Other groups would include, but not be limited to, people who are; carers, homeless, living in poverty, asylum seekers / refugees, in stigmatised occupations (e.g. sex workers), problem substance use, geographically isolated (e.g. rural) and surviving abuse
5. Safeguarding	<ul style="list-style-type: none"> • Will this impact on the duty to safeguard children, young people and adults at risk? • Will this have an impact on Human Rights – for example any increased restrictions on their liberty?
6. Workforce	<ul style="list-style-type: none"> • Staffing levels • Morale • Workload • Sustainability of service due to workforce changes (Attach key documents where appropriate)
7. Health Inequalities	<ul style="list-style-type: none"> • health status, for example, life expectancy • access to care, for example, availability of given services • behavioural risks to health, for example, smoking rates • wider determinants of health, for example, quality of housing
8. Sustainability	<p>See Climate-change-and-sustainability-paper-october-2020.pdf Climate change poses a major threat to our health as well as our planet. The environment is changing, that change is accelerating, and this has direct and immediate consequences for our patients, the public and the NHS.</p> <p>Also consider; technology, pharmaceuticals, transport, supply/purchasing, waste, building/sites and impact of carbon emissions</p> <p>Visit; Greener NHS for more info</p>
9. Other	<ul style="list-style-type: none"> • Publicity/reputation • Percentage over/under performance against existing budget • Finance including claims

Meeting name:	Leeds ICB Committee
Agenda item number:	17
Meeting date:	11 February 2026
Report title:	Risk Register (Cycle 4 2025/26)
Report prepared by:	Asma Sacha, WY ICB – Risk Manager
Report approved by:	Sue Baxter, Head of Partnership Governance
Report presented by:	Asma Sacha, WY ICB – Risk Manager

Purpose and Action:			
Assurance <input checked="" type="checkbox"/>	Decision <input type="checkbox"/> (approve/recommend/ support/ratify)	Action <input checked="" type="checkbox"/> (review/consider/com- ment/discuss/escalate)	Information <input type="checkbox"/>
Previous considerations:			
Directors Team Meeting – Email circulated Quality and People’s Experience Sub – Committee Meeting – 21 January 2026 Finance, Performance and Value Sub – Committee Meeting – 28 January 2026			
Executive summary and points for discussion:			
<p>This report provides details of all risks on the Leeds Place Risk Register at the end of the current risk cycle (Cycle 4, 2025/26) in Appendix 1. The total number of place risks for consideration, the numbers of risks which are marked for closure, new, increasing or decreasing in score are set out in the report, along with the numbers of Critical and Serious Risks. The full Leeds Place risk register is attached at Appendix 1.</p> <p>The paper includes the final Place review of the Board Assurance Framework (BAF) which is attached at Appendix 3. 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.</p>			
With which purpose(s) of an Integrated Care System does this report align?			
<input checked="" type="checkbox"/> Improve healthcare outcomes for residents in their system <input checked="" type="checkbox"/> Tackle inequalities in access, experience and outcomes <input checked="" type="checkbox"/> Enhance productivity and value for money <input checked="" type="checkbox"/> Support broader social and economic development			
Recommendation(s):			
<p>The Leeds ICB Committee is asked to review the risks and:</p> <ol style="list-style-type: none"> RECEIVE and NOTE the High-Scoring Risk Report as a true reflection of the risk position in the ICB in Leeds following any recommendation 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, 2025/26

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 will be drawn between risks on each going forward.

Appendices:

Appendix 1: Leeds Place Risk Register, Cycle 4 2025/26

Appendix 2: Leeds Place Risks on a Page Report, Cycle 4 2025/26

Appendix 3: West Yorkshire ICB Board Assurance Framework, Cycle 4 2025/26

Acronyms and abbreviations explained:

- 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

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. Purpose of this report

- 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 current risks captured on the Leeds Place Risk Register for Cycle 4 2025/26. New risks, risks marked for closure and risks rated 15 or above and risks with changes in risk score are highlighted below.

2. Context and Background information

- 2.1 The WY 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 During each risk cycle, risk leads across the ICB review the risks on each place risk register. This supports the identification of place risks scoring 15+ and common risks on the registers. The detailed review and mapping of the risks also enables the flagging of potential anomalies in scoring or wording between different places, supporting the discussions that ensure the continued evolution of the risk register.
- 2.3 All corporate risks, place risks scoring 15 and above and common risks will be presented to the relevant WY ICB committee and to the WY ICB Board on the following dates:
 - West Yorkshire ICB Finance, Investment and Performance Committee – 3 March 2026
 - West Yorkshire ICB Quality Committee – 3 March 2026
 - West Yorkshire ICB Board – 24 March 2026

2.4 The Cycle 3, 2025/26 [Corporate Risk Register](#) the common risk mapping across the five places and the Cycle 3 [Board Assurance Framework](#) was presented to West Yorkshire Integrated Care Board on 16 December 2025.

3. Key Points

3.1 This report set out the key changes to the risk profile of the Leeds place risks during risk cycle 4 2025/26 which commenced on 17 December 2025 and will end after the WY ICB Board meeting on 24 March 2026.

3.2 The ICB is undergoing organisational change with the primary focus on becoming strategic commissioners with the governance framework transitioning from 1 April 2026 and continuing to evolve during 2026/27. The Place Committees will continue to meet on a quarterly basis through the 2026/27 transitional year, however the meetings will be streamlined with their primary focus on ensuring effective decision-making and assurance; they will be running alongside shadow collaborative governance arrangements. In line with this arrangement, the Risk Manager will be liaising with senior managers from each of the Places prior to the end of March 2026 to determine which risks remain open for transfer to the ICB corporate risk register. The complete risk report will be made available to the Place Provider Partnerships for them to determine whether any risks will inform their risk registers. Risks that are not transferred will be closed and archived. An updated risk report highlighting the status and destination of Place risks will be presented to the Q1 Place Committees.

3.3 The extract of the Risk Register (Appendix 1) provides further detail of all risks including the key controls and assurances for each risk. The 'Risk on a Page' report (Appendix 2) provides a summary of the key changes since the last review cycle.

There are 17 risks on the Leeds place risk register:

- Ten risks are aligned to the Quality and People's Experience Sub-Committee (QPEC)
- Five risks are aligned to the Finance, Performance and Value Sub-Committee
- Two risks are aligned to both the Quality and Finance Sub-Committees

The following changes have been made:

- Four high scoring risks (15+ in risk score)
- One new risk
- Four risks have decreased in risk score
- One closed risk

3.4 High scoring risks (15+ in risk score)

There are four high scoring risks in Cycle 4, 2025/26:

Risk	Sub-Committee	Cycle 4 2025/26	Update for Cycle 4 2025/26
2019 - There is a risk of harm to patients in the Leeds system due to people spending too long in Emergency Departments (ED) due to high demand for ED, the numbers, acuity and length of stay of inpatients and the time spent by people in hospital beds with no reason to reside, resulting in poor patient quality and experience, failed constitutional targets and reputational risk. 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.	QPEC	16 (14xL4)	Static – 11 cycles Although there has been no change to the risk score the risk action has been updated to include; Home First 2 Intermediate Care workstream, with particular focus on people transferred to care homes.
2301 - There is a risk of CYP being unable to access a timely diagnostic service for neurodevelopmental conditions (Autism and ADHD) due to rising demand for assessments and capacity of service to deliver this (ICAN for under 5, CAMHS for school age). In addition, with the focus on diagnosis and the associated costs of referrals, there is less opportunity to resource additional needs led provision over and above what we already locally provide to meet the escalation of needs. The delays in access to timely diagnosis may impact upon children's outcomes, access to other support services across health, education and social care,	QPEC	16 (14xL4)	Static – 12 cycles The risk score remains the same but further mitigations have been put in place: - Refreshed framework for accreditation of providers to secure face to face capacity has been published which will help with QA of providers and also aims to increase medication initiation capacity - Northpoint has taken on MindMate SPA triage model and is in process of

Risk	Sub-Committee	Cycle 4 2025/26	Update for Cycle 4 2025/26
and also compliance with NICE standards for assessment within 3 months from referral.			<p>clearing triage backlog entirely.</p> <ul style="list-style-type: none"> - LCH in process of confirming capacity in place for all complex assessments within LCH. Activity plan will be confirmed for 2026/27. - All other routine referrals to be triaged into newly accredited providers as per choice model. 5. ND cluster offer pilot in process to understand how needs of children and families can be met both before, during and after diagnosis and whether this changes the need for diagnosis or not for some children
<p>2530 - There is a risk that the needs and demands for NHS infrastructure investment in West Yorkshire is greater than the resources being made available to the ICB/ICS.</p> <p>This is due to the specific environmental and building issues prevalent in the West Yorkshire system and the finite capital resource being made available This could result in poor quality estate and equipment, with resultant risks to safety, quality, experience and outcomes.</p>	FPVC	16 (I4xL4)	<p>Static – 3 cycles</p> <p>The risk score remains the same in Cycle 4.</p>
<p>2414 - 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</p>	FPVC	16 (I4xL4)	<p>Static – 7 cycles</p> <p>The Leeds City Council position remains challenging, regular 26/27 planning meetings are taking place to review joint issues and ensure</p>

Risk	Sub-Committee	Cycle 4 2025/26	Update for Cycle 4 2025/26
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.			consistency approach where possible.

3.5 New risk

There is one new risk in Cycle 4 2025/26:

ID	Risk Description	Risk score	Update
2582	<p>There is a risk of patient harm to the population of Leeds due to ongoing operational challenges related to the LIMS system changeover, laboratory relocation, equipment validation, and supply chain disruptions have resulted in delayed test turnaround times, specimen rejections, and poor communication with clinical teams.</p> <p>These issues may lead to delayed or missed diagnoses, treatment delays, and increased risk of adverse patient outcomes.</p>	<p>9 (I3xL3)</p>	<p>There are regular updates from the primary care representatives led by Leeds Teaching Hospital Trust (LTHT).</p> <p>Recent feedback suggesting that issues are being managed.</p>

3.6 Risks marked for closure

One risk has closed in Cycle 4, 2025/26

ID	Risk Description	Reason for closure
2569	There is a risk that there will be insufficient inpatient hospice capacity in Leeds for a period, due to quality improvement in Wheatfields following a CQC inspection and changes in staffing and leadership, and some planned remedial fire door work at St Gemma's, leading to people staying longer in hospital or not being able to access	The risk has closed due to capacity reinstated following building work and the risk has reached tolerance.

ID	Risk Description	Reason for closure
	specialist palliative or end of life care when they need it from home.	

3.7 Change in Risk Score

Four risks have decreased in risk score in Cycle 4, 2025/26

Risk	Sub-Committee Alignment	Cycle 3 2025/26	Cycle 4 2025/26	Update for Cycle 4 2025/26
2494 - There is a risk that children and young people (CYP) when in crisis could be admitted to inappropriate settings including hospital, due to services inability to manage the child's complex care package and escalating needs. This could lead to further deterioration in the child's health and wellbeing, change in care placement, poor quality of care and further pressures across the health and social care system.	QPEC	16 (I4xL4)	12 (I4xL3)	The risk score has reduced from 16 to 12. Recruitment almost complete for Positive Support Team, service expected fully functioning by 01.04.26. Capital bid in process for a place of safety.
2480 - There is a risk that our current commissioned Tier 3 weight management service will not have sufficient capacity 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 obligations. 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	QPEC	16 (I4xL4)	12 (I4xL3)	The risk score has reduced from 16 to 12. Local capacity is not enough to meet demands of future cohorts but work is underway to design a model in time for cohort 2 becoming eligible. Capacity increased from 250 healthy lifestyle pathway and 108 medication pathway to 550 healthy lifestyle patients and 216 medication pathway.

Risk	Sub-Committee Alignment	Cycle 3 2025/26	Cycle 4 2025/26	Update for Cycle 4 2025/26
<p>in Leeds. There is a medium-term risk around the increasing and unsustainable cost pressure from medication and the need to ensure patients are adequately and safely supported. This could be exacerbated by increases in prices, transfer from private providers, high clinical complexity of early cohorts, poorly commissioned services, and lack of tier 2 and other non-medicine support offers.</p>				
<p>2354 - 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 leads to significant financial impact and poor value/outcomes for people.</p>	QPEC/ Finance	15 (I5xL3)	12 (I3xL4)	<p>The risk score has reduced from 15 to 12.</p> <p>There is action underway to equalise waits across available capacity and front door for ADHD now in place and working well so help and support is offered at the point of referral.</p>
<p>2529 - There is a risk that the ICB in Leeds will not deliver the 2025/26 financial requirement of break even (as submitted to NHS England on 27 March 2025). This is due to the significant level of risk contained within ICS organisational plans (including a £33.2m 'system risk' value, currently held within the ICB in WY), and the fact that delivery is predicated on delivering efficiencies of £429m of efficiencies (6.6% of allocation).</p>	FPVC	16 (I4xL4)	12 (I4xL3)	<p>The risk score has reduced from 16 to 12.</p> <p>ICB in Leeds can now see a way to achieve the financial plan position for 25/26 following extensive work around efficiencies and cost reductions.</p>

Risk	Sub-Committee Alignment	Cycle 3 2025/26	Cycle 4 2025/26	Update for Cycle 4 2025/26
Failure to deliver a break even position will result in: - reputational damage to the ICS/ICB - additional scrutiny from NHS England, - a requirement to make good deficits incurred in future year - likely implications on future access to capital (i.e. would be reduced).				

3.8 Emerging risks

None

4 Board Assurance Framework update for Cycle 4, 2025/26

- 4.1 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.
- 4.2 There will be a new ICB Governance Framework from 1 April 2025 and senior managers in Places will no longer be completing the WY ICB BAF. Their contribution to the BAF will be consolidated and archived.
- 4.3 From 1 April 2026 going forward, the BAF will only be reviewed by the ICB Executive Management Team.

5 Recommendations

The Leeds ICB Committee is asked to:

- **RECEIVE** and **NOTE** the High-Scoring Risk Report as a true reflection of the risk position in the ICB in Leeds.
- **CONSIDER** whether it is assured in respect of the effective management of the risks and the controls and assurances in place.
- **RECEIVE** and **NOTE** the Board Assurance Framework for Cycle 4, 2025/26

Risk ID	Date Created	Risk Type	Strategic Objectives	Risk Rating	Risk Score Components (I4xL4)	Target Risk Rating	Target Score Components (I3xL3)	Risk Owner	Senior Manager	Principal Risk	Key Controls	Key Control Gaps	Assurance Controls	Positive Assurance	Assurance Gaps	Risk Status
2530	14/04/2025	Finance and Best Value Committee	Enhance productivity and value for money	16	(I4xL4)	9	(I3xL3)	Matthew Turner	Alex Crickmar	There is a risk that the needs and demands for NHS Infrastructure Investment in West Yorkshire is greater than the resources being made available to the ICB/ICS. This is due to the specific environmental and building issues prevalent in the West Yorkshire system and the finite capital resource being made available. This could result in poor quality estate and equipment, with resultant risks to safety, quality, experience and outcomes.	1. Oversight at WY ICS Finance Forum, supported by Capital Working Group 2. Utilisation of organisational and place / system risk registers to generate action 3. Risk based approach to prioritisation of operational capital (within our envelope) 4. Risk based approach to lobbying for strategic capital 5. Development of an infrastructure strategy for West Yorkshire (completed July 2024) 6. Establishment of an ICS Infrastructure Strategy Oversight Group 7. Place review of capital allocation for return to constitutional standards/ left shift	1. Shared understanding / discussion of the risks arising through the prioritisation process for operational capital.	1. Individual risks flagged through place based risk registers 2. Overview of strategic capital and progress at WY ICB FIPIC and the ICS Infrastructure Strategy Oversight Group	1. Presentation of capital information through WY Capital Working Group, and reporting of capital position including forecast and risk highlighted at WY ICB FIPIC. 2. Capital position relating to both operational and other capital reported to WY ICB FIPIC and WY ICB System Oversight and Assurance Group 3. Additional allocations in 2025/26 linked to the delivery of constitutional standards may support a reduction in overall infrastructure risk	1. Robust assurance not yet fully provided through WY FIPIC. 2. Announcement to pause development of NHP at Leeds will have material impact on organisational risk	Static - 3 Archive(s)
2414	20/03/2024	Finance and Best Value Committee	Enhance productivity and value for money	16	(I4xL4)	6	(I3xL2)	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 experienced 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. Regular meetings with LCC and through ICE where financial position and risks are shared.	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 - 7 Archive(s)
2019	30/06/2022	Quality and People's Experience Committee	Improve healthcare outcomes for residents	16	(I4xL4)	9	(I3xL3)	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 LHHT) and across the system partners, supported by Decision management tool ward based transfer of care model rolled out to all in scope wards in LHHT to help early decision making and identification of need Detailed seasonal surge plans developed and overseen through Active System Leadership Structures System Escalation Actions and Processes revised continuously Ongoing communications work with Public to suggest alternatives to ED Investment in HomeFirst services and in assessment capacity through Better Care Fund Winter capacity plans for 25/26 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 productivity gains LHHT Internal improvement/efficiency plan to reduce delays in care Home First 2 Intermediate Care workstream, with particular focus on people transferred to care homes.	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 delivery plans of all partners not yet sufficient to reduce occupancy levels, and funding constraints mean that where beds are released there is financial pressure to close them rather than reduce occupancy levels	Health & Social Care Command & Control Groups: Active System Leadership, Active System Leadership Executive Group (Silver) Integrated Commissioning Executive Home First Programme Board 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 (weekly from Nov-Mar) Reviewed Silver Action cards Revised System Resilience Structure System Visibility dashboard in place and driving change Strong programme of Home First work in place and HF 2 programme being finalised Times pathways being developed to drive further pace and reduce waste 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 given funding constraints there is significantly limited 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 LHHT 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. Lack of an agreed system plan to improve flow out of Stroke wards SW capacity remains a key risk alongside groups such as therapists but retention has improved and the ICB has contributed additional funding to support resilience	Static - 11 Archive(s)
2301	16/05/2023	Quality and People's Experience Committee	Tackle inequalities in access, experience, outcome	15	(I3xL5)	6	(I3xL2)	Emily Carr	Helen Lewis	There is a risk of CYP being unable to access a timely diagnostic service for neurodevelopmental conditions (Autism and ADHD) due to rising demand for assessments and capacity of services to deliver this (ICAN for under 5, CAMHS for school age). In addition, with the focus on diagnosis and the associated costs of referrals, there is less opportunity to resource additional needs led provision over and above what we already locally provide to meet the escalation of needs. The 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.	1. Funding has moved to LCH to outsource assessments for our most vulnerable cohorts. 2. 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 3. Refreshed framework for accreditation of providers to secure face to face capacity has been published which will help with QA of providers and also aims to increase medication initiation capacity 4. Northpoint taken on MindMate SPA triage model and is in process of clearing triage backlog entirely. LCH in process of confirming capacity in place for all complex assessments within LCH. Activity plan will be confirmed for 2026/27. All other routine referrals to be triaged into newly accredited providers as per choice model. 5. ND cluster offer pilot in process to understand how needs of children and families can be met both before, during and after diagnosis and whether this changes the need for diagnosis or not for some children 6. Neighbourhood level offer mapping underway. Will be informed by outputs of pilot to develop a whole city approach in 2026/27	1. Escalating increase in choice referrals due to constrained local capacity, but long waits for other providers too and not all offer access to medication 2. Available funding and workforce will make rapid improvements difficult. 3. Staff availability with appropriate skills remains a key risk nationally and locally 4. Lack of update from national Task Force. Pace of change required to shift from diagnosis led to needs led transformation	1. Data from LCH on waiting times. Working group established this will report regularly to SEND Partnership board and CYP population board 2. Meeting in place with ICB, LCH and LCC to determine development plan and shared position statement. Engagement with Education underway. Action plan re workshop outcomes - being refreshed and relaunched. Development of WY hub provision and place provision at cluster level being developed. 3. 6/10/25 LCH and Northpoint working together to reduce the ND waiting list and to offer support to those CYP who would benefit from a needs led provided offer. Actions in place to develop a directory of services available. Developing a universal offer across Leeds place, exploring services already in place and gaps.	1. Capacity in IS confirmed for highest risk cases 2. ICB establishing a clinical reference group to support model design 3. Written to all families on the waiting list to sign post to additional resources that will offer support - need to progress work on contacting everyone on the SPA backlog. Data relating to wait times more readily available and referral numbers to Right to Choose being used to model some of the cluster offer proposals. 4. 6/10/2015 Processes agreed and being put in place to reduce the waiting list, and to offer support. Whilst initially was to develop a test and learn of provision across the cluster, now drive to develop a universal offer across all Leeds place. Links with the Adult ND collaborative work being made and explored.	Trying to balance risks to individual children and families of not receiving a diagnosis, with the costs of the diagnostic capacity and the need to provide support not just diagnosis	Static - 12 Archive(s)
2568	07/10/2025	Quality and People's Experience Committee	Improve healthcare outcomes for residents	12	(I4xL3)	6	(I3xL2)	Andrea Dobson	Jason Broth	There is a significant risk of an inability to deliver the statutory functions of the ICB concerning All Age Continuing Care (AACC) in Leeds due to challenging workforce pressures and being unable to source high-quality cost-effective care. This could result in reputational damage, financial inefficiency, complaints, challenges and appeals, and staff burnout.	1. Completion of staffing compliance and structures work 2. Work to be undertaken to understand capacity and demand across Place 3. Regular staff supervision and 1-1s in place to address any wellness/wellbeing issues 4. Support of organisation to recruit clinicians into post outside of workforce controls 5. Market Management and Sustainability activity in place in collaboration with Local Council 6. Direct conversation with Independent Sector Providers relating to gaps in local provision and areas for development 7. Cost setting activity is consideration of National Living Wage, Consumer Price Index as well as increased costs related to needs of someone eligible for NHS CHC.	1. Sickness absence due to work-related conditions 2. Inability nationally to recruit into clinical posts 3. Inability to retain all staff due to high workload patients, nature of interactions with patients/representatives as part of CHC process, or other patient representatives (external companies/legal firms) 4. Financial challenges of increasing the workforce in current operating model, even if the workforce is available. 1. Inability to block contract reduces possibility of making cost effective commissioning decisions at Place 2. Spot Purchase costs are often higher than block contract arrangements 3. Gaps in local markets and closures of care homes 4. Out of area placements required for individuals with specialist needs - no ability to influence this market where at a distance from commissioner 5. Providers will identify alternative methods for income generation (i.e. 1-1 costs).	1. Capacity and Demand modelling will identify any potential areas of efficiency/inefficiency 2. Ability to consider economies of scale with development of WY wide functions 3. Where possible, robust care management arrangements are in place to support reviews of needs. 4. Relationships have been developed with the Market to support ongoing working arrangements 5. Move to a WY ICB is supporting wider discussions regarding costs and uplifts and may support block contract arrangements in the WY area. 6. Contribution to the local Market Position Statement	1. Increased number of applicants for clinical posts when they are advertised 2. Reduction in leavers over last 12 months 3. Staff have settled into the new structures and ways of working since the organisational change programme. 4. Case Management activity 5. Knowledge of overdue review lists and potential impact 6. Developing standard specifications for AACC care contracts	1. Significant staffing gaps remain, particularly in clinical roles 2. AACC activity continues to be a consistently challenging environment for all staff, clinical and non-clinical due to the nature of the work and implications of decision making 3. Relationships at Place with Local Council can be strained at an operational and strategic level 4. Requirement for a cost setting tool to support standardised cost setting for base fees for all care home providers 5. Risk of not accessing a placement for an individual if cost 'demands' are not met. 6. Risk of paying more for weekly fee via 1-1 support or other over commissioned package if inflationary uplifts do not meet requirements of the sector.	Static - 1 Archive(s)

2550	28/07/2025	Quality and People's Experience Committee	Improve healthcare outcomes for residents	12 (13xL4)	6 (13xL2)	Angela Dillon	Jo Harding	There is a risk that initial health assessments for children in care, will not be completed within the statutory time frames. This is primarily due to ongoing capacity difficulties in children's social care and our community provider to ensure timely referrals to the health team. This could result in health needs assessments of Children in Care being delayed and the health needs of these vulnerable children not being met, which could impact upon longer term outcomes.	1. On LCH Risk Register and updates given to quarterly Safeguarding Committee. 2. Standing Operating Procedures (SOP's) across West Yorkshire to be standardised (2025/26) 3. Risk escalated to children's commissioners at Place. Regular meetings take place between commissioner provider and DN. 4. Risk communicated to Place based Corporate Parenting Board (CPB) and updates given quarterly. 5. Demand and capacity assessment undertaken and current capacity would meet demand if WNB is reduced. 6. Work with stakeholders completed to assess barriers to attendance of IHNA's reduction figures. 7. Plan in place to overcome barriers and reduce WNB. See positive assurance for reduction figures. 8. Nurse oversight of cases waiting for IHNA consent. Ensure CYP are registered with GP. 9. LCH looking to build resilience into clinic capacity to cover holiday/sickness. LCH intention is to use senior trainees in these clinics following an appropriate training and shadowing period (from 2025 until March 2026) 10. Robust weekly escalation in place between health and CSWS to speed up consent for IHNA. This has scrutiny from CPB. 11. Team is looking at producing leaflets and videos for young people and their carers explaining the value of an IHNA appointment and what the appointment entails. 12. Team is also looking at some suitable alternative venue for some of the bigger families, where multiple siblings need to be seen. 13. Workshops to take place between LCH and CSWS quarter 4 25-26 to re-design admin process across the system, to incorporate successful working practices from across WY ICB.	1. Timeliness of requests for IHNA from CSWS.	1. Monthly performance data produced by LCH business support showing IHNA delivery against KPI's. 2. DN accesses LA and Health data monthly to gain assurance of data congruence. 3. Robust systems in place that give live information of clinic availability and waiting times. Escalation process in place to notify head of service should there be CYP waiting for IHNA appointments. 4. Quarterly data is shared by LCH with NHSE and this data is collated into WYICB dashboard which is shared at the WY CIC group for oversight. 5. Ensure regular review of the WY ICB corporate risk at the bi-monthly WY CIC group meeting. 6. Ensure regular reporting into place provider Safeguarding Committees, Corporate Parenting Boards and WY ICB Safeguarding Oversight and Assurance Partnership for oversight. 7. Connecting with relevant Regional and National Groups 8. One off extra clinic capacity commissioned to reduce backlog which was completed in May 2025.	1. WNB reduced from 30% Jan 24 - Dec 24 and to 19% from Jan 25 - Dec 25. (WNB - Was Not Brought)	1. Assurance that LCH has resilience of clinic capacity to cover holiday/sickness.	Static - 2 Archive(s)
2529	14/04/2025	Finance and Best Value Committee	Enhance productivity and value for money	12 (14xL3)	12 (14xL3)	Matthew Turner	Alex Crickmar	There is a risk that the ICB in Leeds will not deliver the 2025/26 financial requirement of break even (as submitted to NHS England on 27 March 2025). This is due to the significant level of risk contained within ICS organisational plans (including a £33.2m 'system risk' value, currently held within the ICB in WY), and the fact that delivery is predicated on delivering efficiencies of £429m of efficiencies (6.6% of allocation). Failure to deliver a break even position will result in: - reputational damage to the ICS/ICB - additional scrutiny from NHS England, - a requirement to make good deficits incurred in future year - likely implications on future access to capital (i.e. would be reduced).	1. Agreement of West Yorkshire ICS Financial Framework by all NHS organisations setting out arrangements in place to manage financial risk 2. Delegation of resource to five places supported by robust budget setting at place through planning process. 3. Review of financial position via the West Yorkshire ICS Finance Forum 4. Review of system financial position at the WY System Oversight and Assurance Group 5. Implemented additional controls to manage recruitment and non pay expenditure to ensure ICB plans are delivered 6. Use of transformation and efficiency group within the ICB to focus on key strategic and system efficiency opportunities	1. Absence of a contingency in financial plans to mitigate against unplanned expenditure or efficiency delivery shortfall 2. No formal agreement at this stage on addressing the system risk (total of £33.2m in 25/26) between the ICB and providers 3. No ability to formally influence the delivery of provider efficiencies	1. Budget management at places 2. Overview of financial performance and risk in place committees 3. ICB System Oversight and Assurance Group and ICB Finance, Investment and Performance Committee oversight of financial position and risks 4. ICB Audit Committee oversight of risks and capacity to instruct a deep dive into areas of concern 5. ICB Board statutory responsibility 6. West Yorkshire System-wide management including provider target achievement 7. NHS England review of financial position on a monthly basis 8. NOF 3 framework and additional DoF led scrutiny of specific NOF3 provider organisations 9. Outputs of PwC assurance work and associated action plan	1. Submission of a system financial plan which is an aggregation of NHS provider and ICB plans which were all approved via individual organisational governance following review and challenge; 2. Financial planning assumptions have been moderated across the ICB core and 5 places, they have been subject to peer review and challenge across the WY ICS 3. All plan submissions approved via each individual organisational governance routes.	1. Further review of risks and mitigations leading to additional unmitigated risk with no formal route to address 2. No formal ability to set control totals for provider organisations (linked to approach for distribution of £33.2m system risk)	Decreasing
2511	01/04/2025	Quality and People's Experience Committee	Improve healthcare outcomes for residents	12 (14xL3)	6 (13xL2)	Andrea Dobson	Jason Broch	There is a risk that the ICB will not meet its statutory duties in the delivery of the Court of Protection Deprivation of Liberty Safeguarding for those eligible for NHS Continuing Health Care (CHC) living in the community in their own homes. This is due to a significant lack of Lead Nurses leading to reduced capacity to complete the application documentation and gain appropriate evidence. 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. In addition to the above, there is reduced capacity within the court of protection which has meant that applications may have to be redone to ensure they are completed within the timescales given by the courts. This could result in a risk of unauthorised and unlawful deprivation of liberty.	1. Monthly meetings held to review caseload, update ADASS Priority Tool, and identify any immediate risks to safety and welfare. 2. Review of care and support plans, engagement with patients and their families/representatives. 3. MCA Specialist Practitioner / Lead in place to ensure clinical team are clear on roles and responsibilities in the CHC process to support necessary CoP applications. 4. Good relationship with Local Council in CoP processes, including where joint responsibility in place. 5. Clear arrangements for local implementation for joint and fully funded individuals dependent upon residence	1. Lack of required resource at a Clinical Lead level to review and quality assure care and support plans to ensure CoP - ready 2. Lack of sufficient MCA/DoLS Lead resource at Place 3. Risk of increased legal fees due to lack of Team resource to undertake majority of workload 4. Increased costs associated with 1.2 representatives where individual resides at home with family members 5. Wrong skill mix of staff	1. Access to a full list of all individuals eligible for CHC with care arrangements amounting to a DoLS 2. ADASS tool completed it understand risk and response required 3. Care Managers / DoLS lead in close and regular contact with individuals/representatives who are kept up to date 4. Monthly update with instructed legal firm regarding ongoing representation to understand activity, costs and risks 5. Regular clinical development sessions in place delivered by MCA Lead in-house, with access to mandatory and further training as required. 6. LCH provide performance reports, highlighting the current position. 7. 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 8. The AACCC Service has agreed a joint commissioning of an advocacy service for Leeds residents which is now live.	1. Updates provided regularly at a number of senior operational meetings 2. Place lead fully involved in WY discussions and updates. 3. AACCC database able to record CoP/DoL status to support monitoring and recording 4. Specific admin support in place to ensure up to date recording and data in regard to all applications, duration and required activity. 5. Adam (CHC System) has been updated to record DoLS, enabling improved monitoring and recording of DoLS	1. Gap relates to the workforce as identified. 2. The uncertainty around ICB organisational change increases the risk of losing experienced staff or losing sight of due to the actual restructure process.	Static - 3 Archive(s)
2508	01/04/2025	Finance and Best Value Committee	Enhance productivity and value for money	12 (14xL3)	9 (13xL3)	Andrea Dobson	Jason Broch	There is a risk of overspend against the All Age Continuing Care (AACCC) budget due to increasing service demand and rising care costs which could result in Leeds place financial targets not being met.	1. Implementation of standardised Commissioning Principles via the Choice and Equity Policy 2. Working alongside local Council to align costs where appropriate.	1. Embedding Commissioning Principles is a substantial piece of work and requires a new approach to patient conversations with registered nurses 2. Implementation of Commissioning Principles has a significant impact upon operational processes and can delay commissioning decisions or lead to complaints and challenges. 3. The poor financial position of Adult Social Care Independent Sector Providers is impacting the ability to make placements for CHC-eligible individuals at standard rates due to the higher complexity and intensity of needs for this cohort. 4. Care Providers looking to increase income via requests or demands for 1-1 support. 5. Challenging financial position of Local Councils resulting in increased referrals for AACCC consideration. 6. Pressure in Acute Hospitals increases rates of individuals being Fast Tracked at full expense of ICB where Fast Track may not be appropriate.	1. Regular staff training and supervision sessions in place to discuss implementation of Policy and Principles 2. Resource Allocations processes in place aligned to Standing Financial Instructions Scheme of Delegation 3. Regular monthly budget holder and finance meetings in place to address shifts in position 4. Resource Allocation panels and processes in place with consistent completion of financial information to update AACCC database 5. Robust clinical assessment and eligibility decision - making. 6. Escalated Scheme of Delegation controls in place. 7. Embedded credit control arrangements in place to monitor invoices against AACCC financial commitment at a patient level 8. Informed and considered cost and budget setting in place to ensure correct budget in place. 9. Identified cash releasing efficiency schemes in place. 10. New PHB Payroll and Direct Payment Managed Bank Account provider in position which has enabled use of superior software supporting transparency of accounts.	1. Regular data cleansing activity in place to assure financial data held is accurate and up to date 2. All staff aware of responsibilities in regard to Scheme of Delegation 3. Decision - Makers re eligibility and commissioning decisions are fully aware of Commissioning Principles and how to implement 4. PHB Audit and 'claw-back' processes in place and in operation. 5. Packages of care to be delivered via PGH Direct Payment are carefully considered in terms of statutory duties of the ICB to deliver.	1. Spend on PHB Direct Payment budgets is subject to misuse and mis-management 2. Potential for inappropriate decisions made on PHB packages of care following historical agreements. 3. Overdue reviews lead to potential lack of up to date needs and care plan, or costs for care. 4. Local Councils responsible for agreeing uplifts and rates for non-eligible individuals, with differing level of assurance/authority to act/evidence of exceptionalty resulting in increased cost to the ICB through joint funding arrangements. 5. Lack of resource to support robust Case Management and therefore review of all fully funded packages and outcomes in a timely manner. 6. Unpredictability of the patient cohort mean significant increases in costs can occur at any time. 7. The uncertainty around ICB organisational change increases the risk of losing experienced staff or losing grip due to the actual restructure process.	Static - 1 Archive(s)
2494	25/03/2025	Quality and People's Experience Committee	Improve healthcare outcomes for residents	12 (14xL3)	9 (13xL3)	Emily Carr	Helen Lewis	There is a risk that children and young people (CYP) when in crisis could be admitted to inappropriate settings including hospital, due to services inability to manage the child's complex care package and escalating needs. This could lead to further deterioration in the child's health and wellbeing, change in care placement, poor quality of care and further pressures across the health and social care system.	1. Oversight and proactive management of individual cases via frequent multi professional/agency meetings 2. Escalation processes within each organisation in place to senior management if delays/no agreed plan 3. Escalation to the ICB to drive forward a plan and to hold providers to account (Health and LA) if required 4. Mental Health Provider Collaborative included if relevant 5. Positive support put in place by the dynamic risk register lead to identify cases earlier / reduce the number of people escalating / with a delayed discharge / requiring access to Tier 4 hospital admission 6. Recruitment almost complete for Positive Support Team, service expected fully functioning by 1/4/2026. 7. Capital bid in process for a place of safety.	1. Opportunity for greater connectivity between local controls and pressures including in Health/LA & Provider Collaborative where appropriate 2. No 'spare' capacity is available to meet the needs of all children in crisis at all times	1. Actions agreed and implemented from meetings and escalations 2. When a young person placed is placed in an inappropriate setting the CQC are informed. 3. Safeguarding colleagues are aware and additional resource and support is put in place for the young person	1. Regular supervisory/escalation meetings supporting blocks in the system 2. 1/7 Partners are now escalating cases much sooner to allow for the planning and solutions to be made and agreed. 3. Recruitment of Positive Support Service underway 4. Children with Complex Needs is now a transformation programme priority reporting into PLT. Workstreams include earlier identification of CYP with complex and escalating needs and the development of child with no onward destination protocol for all providers to work to.	1. Timely escalation - without delays 2. 1/7 Identification of placements can be a challenge if the CYP becomes looked after whilst in hospital 3. 1/7 Lack of providers that match the needs of the CYP 4. New bespoke 2/4 bedded children's home has been commissioned and estate procurement is ongoing, expected to open in 2027. 5. 6/10/2025 there will always be a risk of a CYP being presented at PED -despite the best efforts of the transformation work.	Decreasing

2480	14/01/2025	Quality and People's Experience Committee	Improve healthcare outcomes for residents	12 (14xL3)	9 (13xL3)	David Edson	Helen Lewis	There is a risk that our current commissioned Tier 3 weight management service will not have sufficient capacity 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 obligations. 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. There is a medium-term risk around the increasing and unsustainable cost pressure from medication and the need to ensure patients are adequately and safely supported. This could be exacerbated by increases in prices, transfer from private providers, high clinical complexity of early cohorts, poorly commissioned services, and lack of tier 2 and other non-medicine support offers.	1. Revised contract and specifications to help future planning facilitated by funding (ICB Leeds) 2. Recovery plans and efficiency plans in place 3. Leeds Specialist Weight Management service reopened to referrals in Apr 2025 4. Business case to start to develop new model of delivery to DTM mid October-Interface Hub in collaboration with Leeds Specialist Management service and Leeds GP confederation. Interface hub being established following approval of business case to ensure consistent application of WY criteria, reduce RTC referrals and enable discharge of patients no-longer suitable 5. NICE TA medicines policy and funding variation for agreement at Transformation Committee in July 2025 NICE TA medicines policy and funding variation agreed at Transformation Committee July 2025 dramatically reducing eligibility for the next 3 years. 6. Right to choose monitoring established and numbers reduced significantly 7. Feasibility studies for four models of primary care delivery of Tirzepatide, service specification developed at WY to enable consistency of quality, work underway to design a sustainable Leeds model in preparation for cohort 2. 8. Aligned SWMS criteria to WY Commissioning Statement eligibility criteria from 29th July 2025	1. Limited ability to mitigate referral to Right to Choose - but now limited to those in line with commissioning statement. Interface hub not yet established. Local capacity not enough to meet demands of future cohorts but work underway to design a model in time for cohort 2 becoming eligible. Capacity increased from 250 healthy lifestyle pathway and 108 medication pathway to 550 healthy lifestyle patients and 216 medication pathway. 2. Media influence and public demand 3. No local governance contract mechanisms with national right to choose provider(s) 4. Lack of Weight Management Programme leadership and governance at a West Yorkshire level 5. Lack of Tier 2 commissioned services 6. NHSE allocated funding does not match Tirzepatide cohort numbers	1. Currently discussed and reviewed via Leeds long term conditions population board with updates to Leeds Scrutiny committee and Leeds LMC 2. Local service offer in place in Leeds 3. Quality measures in place for the local offer and developing evaluation frameworks	See above	1. Not receiving quality data from right to choose (only referral numbers received though some BMI data now received) 2. Gaps in data from Leeds data model and inconsistent coding affecting accuracy 3. Gap in LCH SWMS performance data (Q1 2025/26), has been requested 4. Inconsistent coding in primary care 5. NHSE funding data does not align with local data regarding cohort numbers	Decreasing
2415	21/03/2024	Quality and Finance Sub-Committee / Leeds Committe	Tackle inequalities in access, experience, outcome	12 (14xL3)	9 (13xL3)	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 Additional workshops taking place between the ICB in Leeds and the Third Sector West Yorkshire ICB decision for a 2.15% uplift for the third sector to help mitigate some of the pressures facing the sector.	Additional workshops taking place between the ICB in Leeds and the Third Sector 08/07/2025 Recent Third Sector State of the Sector report is indicative to lower the current likelihood of the risk. The latest position statement and working with the Third Sector across the ICB in Leeds to understand the current position. Work being progressed to align future funding of Third Sector in Leeds with principles set out in position statement around joint commissioning and longer term contract arrangements. Ongoing work to build Third Sector into Neighbourhood Health Model.	Need to develop broader partnership overview in Leeds at the moment still too fragmented so assurance is limited.	Static - 2 Archive(s)
2354	14/08/2023	Quality and Finance Sub-Committee / Leeds Committe	Tackle inequalities in access, experience, outcome	12 (13xL4)	9 (13xL3)	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 leads to significant financial impact and poor valued outcomes for people.	1. Team now in place offering needed assessment of all local ADHD adult referrals on behalf of primary care. This will help us understand the volume of people who meet the threshold for a diagnosis, but also the most effective way to provide support for needs related to suspected neurodiversity. 2. Additional funding has also been secured via the Health and Work accelerator to help address some of the prescribing backlogs and test out interventions around supporting people with ADHD to access work or make reasonable adjustments with their employers 3. Leeds Autism Diagnostic Service has improved pathway efficiency and waiting times. The increased number of people diagnosed is putting strain on post-diagnostic offer. 4. The first round of WY accredited provider selection has been completed. Activity plan information and mobilisation plans for the providers are in the process of being finalised. The new capacity will be used for longest waiters to help equalise patient experience. Operational details of transfer from LYPFT are being worked through including waiting list validation. This also aims to improve patient outcomes and experience when seeking treatment and entering shared care in the local areas. 4. Indicative Activity Plans negotiated which will reduce the rate of growth by limiting activity in providers to their outturn position (10% higher for locally accredited providers) 5. A neurodiversity working group that has been established as part of the CMH Transformation programme has produced recommendations as to how to improve access to CMHT hubs and 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'. Transformation board will consider recommendations for implementation. Report is also being taken to LYPFT forum for discussion. 6. Working to reinforce data capture requirements via accreditation and other lead commissioners, but needs national push too to improve tracking and understanding 7. WY Commissioning Policy consultation is still under discussion.	1. Spend is driven by the high numbers of people already in the system and high rates of new referral. 2. There is no ring-fenced investment/funding into ADHD or autism development. 3. Data collection by all 15 providers remains patchy which makes it impossible to really track referral demand or how current needs are being met 4. The increased supply of diagnostic capacity is making it difficult to shift investment into support offers without commissioning policy difficult to require referrers to use front door offer 5. demand into ADHD pilot offer already significantly higher than anticipated, so would need more funding to cover Autism referrals too 6. No commissioning strategy yet developed for how to prioritise demand in line with available funding	1. ND Strategic Oversight Group - Provider data reporting 2. WY ND programme guidance and resources 3. Autism and ADHD diagnostic waiting list times 4. ADHD treatment waiting list times 5. ADHD annual review waiting list times. 6. ND service annual quality report. 7. Service specification reviews 8. Oversight of Right to Choose ND diagnostic pathway referrals and spend 9. Leeds Autism Strategy 10. Leeds data model including ADHD and autism data to steer priorities. 11. The "ADHD single point of access hub" is being piloted to support patients meet needs before they enter the assessment pathway. Referral and outcome data is being captured including patient experience. Early reports are that demand for the service is higher than originally thought. Investment and funding has been agreed.	1. Service annual quality board 2. ND Strategic Oversight group programme plan outlining key workstreams and work progressing	1. Lack of targeted/identified recurrent funding streams provide ongoing challenge for sustainable improvement through non-recurrence mechanisms. 2. WY Commissioning policy not yet in place and now being re thought 3. National Task Force set up, but potentially then risks local solution developments as people wait for national steer - however looking unlikely that it will be radical	Decreasing
2018	29/06/2022	Quality and People's Experience Committee	Tackle inequalities in access, experience, outcome	12 (14xL3)	9 (13xL3)	Helen Lewis	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.	1. 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. 2. 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. LYPFT has also recently realigned its crisis offers to be closer to the Area based CMHTs. Additional bed now available in reopened Oasis house 3. Mobilisation of integrated primary-community mental health new model of care is now in City-wide roll out. This should improve joint working and also enable more targeting of those most at risk of admission/deterioration by the wider team of available professionals, using a more data driven approach 4. Crisis Transformation Programme-more work to simplify and reduce duplication, and to ensure there is high quality support available via the 111 help line - have just added significant funding to increase capacity and starting to see the data on repeat callers to enable more targeted support 5. 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 6. recruited additional housing and discharge coordinators to help be more proactive in managing discharges 7. LYPFT/LTHT working group reviewing processes around supporting people waiting for assessment and admission in ED	1. Access to urgent crisis assessment within the MH trust within 4hrs whilst improved remains below target. 2. Access to housing remains significantly challenging (both for supported and general needs housing), impacting on flow - deputy director of commissioning raising this with Housing and actively supporting in this area but very significant local deficits	1. Waiting and access times to services monitored through performance metrics and Inpatient Flow Oversight Group within LYPFT 2. Integrated Commissioning Oversight Group chaired by Deputy Director of LCCS is supporting with the housing challenges, in trying to improve flow through supported housing and reducing barriers to permanent housing, through recognising big waiting lists for housing 3. daily OPEL data is flowing so visibility of key measures	1. Planned trajectory remains on track to achieve nationally mandated target to increase access to community mental health services in Leeds and more psychological support has been embedded in this model 2. Work to reduce the waiting list for access to step 3 CBT in NHS talking therapies has maintained improvement. 3. Improving MH Flow Programme -in place and governance being further refreshed, including review of membership of Discharge Workstream. 4. LYPFT reviewing configuration of community offers to help reduce barriers between teams 5. Complex rehabilitation work has seen good results in reducing inpatient stays	1. Access to urgent crisis assessment within the MH trust within 4hrs whilst improved remains below target. 2. Ongoing challenges in embedding the pathways with the provider of 111 Mental health and the data flows required to support people then accessing ongoing support in Places . 3. 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 - 6 Archive(s)
2582	19/01/2026	Quality and People's Experience Committee	Improve healthcare outcomes for residents	9 (13xL3)	6 (13xL2)	Sarah Forbes	Kirsty Turner	There is a risk of patient harm to the population of Leeds due to ongoing operational challenges related to the LIMS system changeover, laboratory relocation, equipment validation, and supply chain disruptions have resulted in delayed test turnaround times, specimen rejections, and poor communication with clinical teams. These issues may lead to delayed or missed diagnoses, treatment delays, and increased risk of adverse patient outcomes.	1. Regular updates with ICB and Primary Care representatives led by LTHT 2. Communication with affected practices regarding actions undertaken and to ascertain any potential harms 3. Regular updates provided to Place and ICB Quality and Nursing teams via AAA reporting	1. Limited real-time grip on issue resolution and service performance 2. Inadequate feedback and communication to referring clinicians 3. Absence of formally communicated risk mitigation strategies	1. Established robust oversight and incident monitoring systems through LTHT led meeting - High priority - GP concerns and steps being taken to manage held weekly 2. Develop and implement clear communication protocols for clinicians and stakeholders 3. Formulation of action plans to address specific issues and share detailed risk mitigation plans addressing patient harm at Place 4. Expedite resolution of operational bottlenecks impacting turnaround times and specimen processing	As at 12.12.25 feedback suggesting that issues are being managed and occurrences reducing. LTHT led update calls and action plans remain in place. Update meeting on 21.01.26.	None identified	New - Open

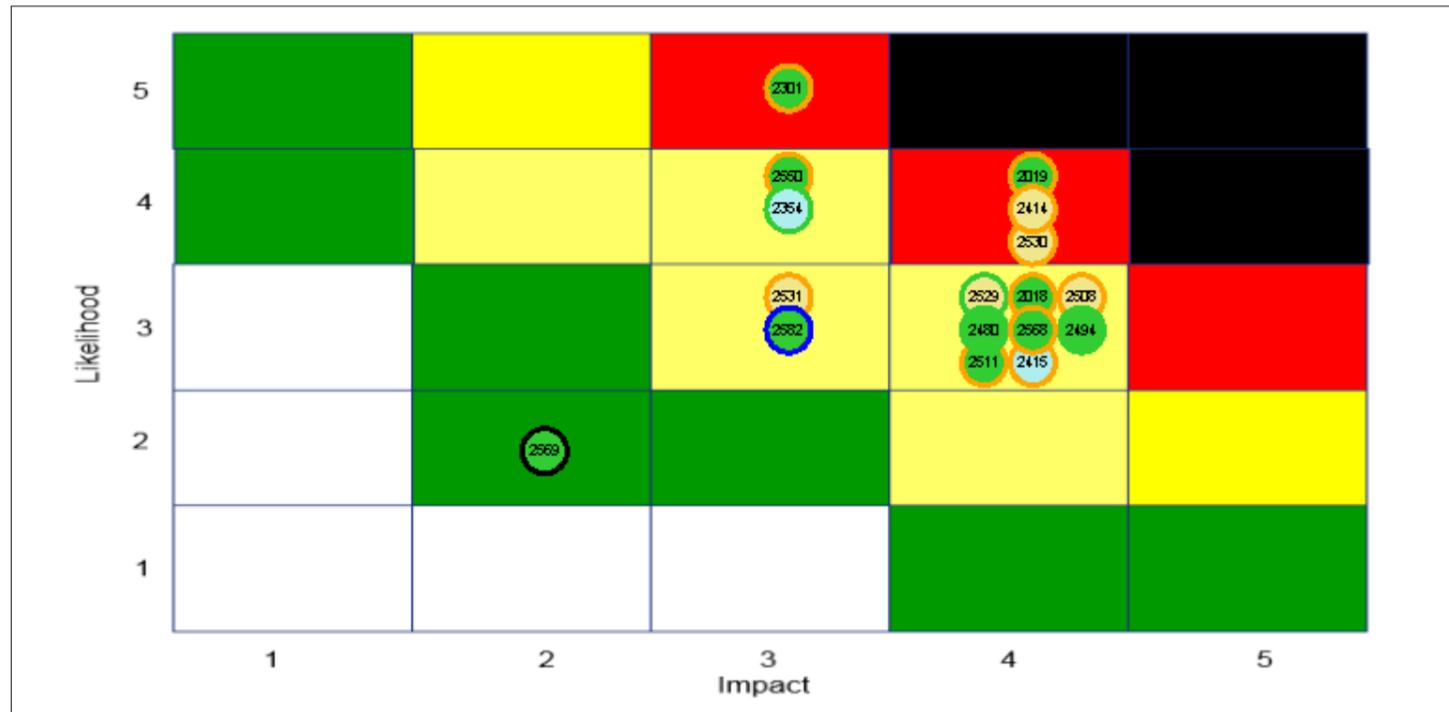
2531	14/04/2025	Finance and Best Value Committee	Enhance productivity and value for money	9 (13x13)	6 (13x12)	Matthew Turner	Alex Crickmar	<p>There is a risk that the ICS/ICB will not manage within the capital limits set by NHS England. This is due to the potential to exceed due to inflationary pressures and other demands, or undershoot due to lead times or delayed funding notifications leaving little time for procurement</p> <p>This would result in:</p> <ul style="list-style-type: none"> - non-delivery of one of the financial statutory targets - reduction in the expected capital allocation in the next financial year - underspend could result in increases in backlog maintenance requirements, detrimental impacts on NHS infrastructure, and lost funding as capital money cannot be carried into future years. 	<ol style="list-style-type: none"> 1. West Yorkshire wide capital plan with robust schemes which are designed to alleviate need fairly across the West Yorkshire service providers 2. Capital plans reviewed and signed off by the System Infrastructure Oversight Group (established in 2024/25) 3. Capital working group now well established which involves all WY NHS providers and the ICB, which meets monthly to oversee year-to-date expenditure, forecasts, risks and opportunities 4. Oversight of capital position by WY ICS Finance Forum 5. Collective understanding and agreement across all WY providers that the over-commitment of 5% allowed in the planning process will need to be managed collectively by the end of the financial year. 6. Capital working group now well established which involves all WY NHS providers and the ICB, which meets monthly to oversee year-to-date expenditure, forecasts, risks and opportunities 7. Oversight of capital position by WY ICS Finance Forum 	<ol style="list-style-type: none"> 1. Detailed plans which detail which elements of the capital plan can be reduced to live within capital allocation 2. Well understood risk-adjusted capital plans that allow for an objective review and prioritisation of risks across the system 	<ol style="list-style-type: none"> 1. NHS England oversight and management; 2. Review of capital plans in West Yorkshire Finance Forum between commissioner and providers; 3. ICB Finance, Investment and Performance Committee oversight; 4. ICB Board overview 	<ol style="list-style-type: none"> 1. System capital expenditure in recent financial years was managed within plan due to controls noted above, and at Month 1 no specific risks are yet identified and forecasts are at planned level 2. Additional allocations in 2025/26 linked to the delivery of constitutional standards may support a reduction in overall infrastructure risk 	<ol style="list-style-type: none"> 1. Currently unclear on approval status of new allocations linked to delivery of Constitutional Standards 2. Difficulty in managing capital allocations on a year-by-year basis 	Static - 3 Archive(s)
2569	13/10/2025	Quality and People's Experience Committee	Improve healthcare outcomes for residents	4 (12x12)	4 (12x12)	Helen Smith	Helen Lewis	<p>There is a risk that there will be insufficient inpatient hospice capacity in Leeds for a period, due to quality improvement in Wheatfields following a CQC inspection and changes in staffing and leadership, and some planned remedial fire door work at St Gemma's, leading to people staying longer in hospital or not being able to access specialist palliative or end of life care when they need it from home.</p>	<ol style="list-style-type: none"> 1. Daily and weekly capacity calls 2. Access to out of area hospices (Sue Ryder and Marie Curie Bradford in particular and others if required) 3. Careful prioritisation by clinical teams 	See above	<ol style="list-style-type: none"> 1. Wheatfields has a development plan to ensure that new staff are successfully trained and the service model is expanded safely to be back up to usual levels by December 2. ICB colleagues are meeting regularly with Wheatfields to review KPIs and progress 3. St Gemma's has a tightly managed plan to enable the work to be delivered without major impacts and this is in line with its planned timetable 	<ol style="list-style-type: none"> 1. Weekly meetings to track people delayed in any setting 2. ICB has funded additional capacity out of area 	See above	Closed - Reached tolerance

WY ICB Leeds Place, Cycle 4 - 2025/26 Risk on a Page Report

Total Risks	17
Finance & Performance	5 risks
Quality	10 risks
Finance and Quality	2 risks

Movement of Risks		Risk Score Increasing	0
New	1	Risk Score Decreasing	4
Marked for Closure	1	Risk Score Static	11

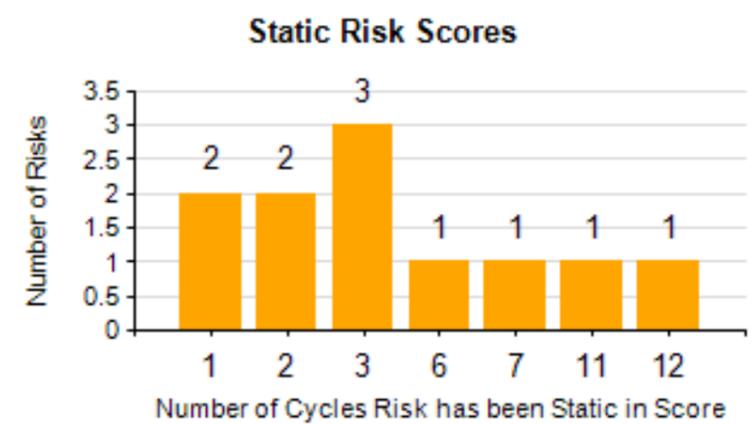
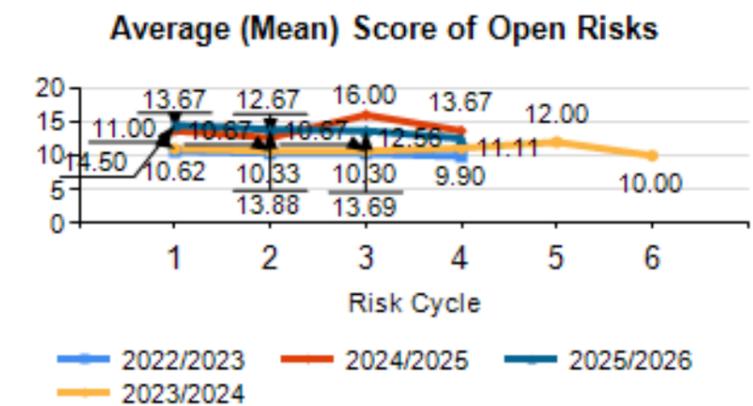
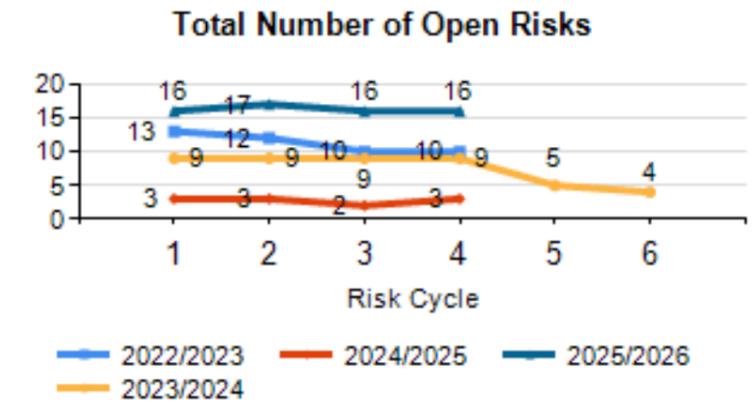
Risk Overview



Key

- Quality and People's Experience Committee
- Finance and Best Value Committee
- Quality and Finance Sub-Committee / Leeds Committee

New Risk	Risk Score Increasing	Score	Risk Level
Closed Risk	Risk Score Decreasing	1-3	Low Risk
Risk Score Static		4-6	Moderate Risk
		8-12	High Risk
		15-16	Serious Risk
		20-25	Critical Risk



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/7017/5395/3821/Risk_Management_Framework_v4.0.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	Minor reduction to health	Moderate reduction in health	Significant reduction in health	Major reduction to health

Health outcomes and life expectancy	outcomes and/or life expectancy for >5% of a given population.	outcomes and/or life expectancy for >15% of a given population.	outcomes and/or life expectancy for >30% of a given population.	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	Investigation by Health Service Ombudsman	Multiple complaints	Litigation certain
		Local resolution	Minor out-of-court settlement	Judicial review	Criminal prosecution
	Negligible effect on quality of clinical care	Noticeable effect on quality of care	Significant effect on quality of care / significantly reduced effectiveness		Litigation expected
Single failure to meet internal standards		Repeated failure to meet internal standards	Non-compliance with national standards with significant risk to patients if unresolved.	Civil action – no defence	Totally unacceptable level or quality of treatment / service
	Minor implications for patient safety if unresolved	Major patient safety implications of findings are not acted on			Gross failure of patient safety if findings not acted on
	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	Gross failure to meet national standards
					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					
Compliance (includes H&S and other legal or governance factors such as procurement, information governance etc.)	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
	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: 13	Date: Dec 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	16	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	Lou Auger	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
	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	Lou Auger	ICB Board
(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	12	Ian Holmes	ICB Board
	4.2	There is a risk that we are unable to achieve our ambitions on equality diversity and inclusion due to ingrained attitudes that persist in society and across our health and care organisations.	Bold	8	12	Ian Holmes	Quality Committee
	4.3	There is a risk that threats to our people and physical and digital infrastructure, e.g. from cyber-attacks, terrorism and other major incidents, prevents us from delivering our key functions and responsibilities.	Averse	9	12	Lou Auger / 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 13				Dec-25			
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	6	9	6	12	9	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	16	8	16	8	12	8	16	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	9	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	16	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	6	12	4	12	4	12	4	9	4	12						
	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	9	20	9	20	9	20	9	20	9	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	12	8	8	8	8	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	6	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: 13	6 October 2025
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. No change to risk score.
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.						
5	As part of the organisational change programme the ICB is establishing a strategic commissioning function, this function will establish capabilities to understand and respond to inequalities						
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					2120 - reduction/loss of VCSE services; 2402 - access GP services; 2106 - Cancer health inequalities; 2308 - Neurodivergent population 2503 - maternity	
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)						
Bradford District and Craven (BD&C) Place lead: Therese Patten						Nominated lead for this risk: Sohail Abbas 07.01.26	
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 has started from April 2025, work ongoing (2025/26) 4. Core20Plus5 initial evaluation is complete, we are now working on the economic evaluation of the programme (2025/26) 5. BDC Health and Care Strategy is in development and underpinned by the work of Population Health Management and reducing inequalities teams on assessing our population health and care needs (2025/26) 6. Bradford District Council growth plans (including city of culture 2025) are in development and will have an impact on the overall healthcare of our population. 7. We are working with the VCS alliance to continue the core20plus5 projects that showed significant improvements in health inequalities from April 26 onwards. 8. RIA is holding meetings with provider colleagues to discuss how the learning and work on health inequalities continue in provider partnership following the ICB changes.	
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?)						Links to Place Risk Register	
1	Reducing inequalities alliance - regular meetings - Papers and Mins					2317, 2386, 2477, 2418, 2221	
2	Health and Wellbeing Board - Papers and Mins						
3	The Core20Plus5 and health inequalities premium dashboards						
4	Outcomes focused performance report for HCP Board capturing health inequalities						
Calderdale Place lead: Robin Tuddenham						Nominated lead for this risk: No update	
ICB risk appetite	Place risk scores					Rationale for current place score	
	Target (Calderdale)			Current (Calderdale)			As WYICB outlines above. The CCPB focuses regularly on health inequalities. Presentation due in September 2025 Committee on latest intelligence and how we will use linked data sets to provide greater insight into the Integrated Neighbourhood Health work.
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. Public have produced population data packs for each PCN and Integrated Neighbourhood health team.	
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?)						Links to Place Risk Register:	
1	Progress against the ICB metrics on inequalities is reviewed regular by HWBB and CCPB					2224, 2476, 2149, 1998, 1493, 62, 2469, 2484,	
2	Local JSNA						
3	Council Director of Public Health- attends Partnership Board						
Kirklees Place lead: Vicky Dutchburn						Nominated lead for this risk: No update	
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 framework (one of top tier partnership strategy) Power of one, power of many, working other for equity and fairness linked to the inclusive communities framework (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?)		2. The Kirklees ICB committee committed to continue with their work and actions were agreed as part of this work (November 2025)	
1 Regular reports to Health and Wellbeing Board		3. Focus on addressing inequalities is key to how we deliver the Kirklees Healthy Working Life programme (for example the VCSE sector has a prominent role in helping to deliver this) 2025/26	
2 Regular reports to Partnership Forum / ICB committee/ and other place governance		Links to place risk register: 2475, 2240, 2445	
3 Project reports			
Leeds		Place lead: Tim Ryley	
ICB risk appetite		Nominated lead for this risk: No update	
BOLD		Place risk scores	
		Rationale for current place score	
		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. Risk score remains the same.	
Target (Leeds)		Current (Leeds)	
Likelihood	4	16	Likelihood 5
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 Partnership Leadership Team and Health and Wellbeing Board meetings in Leeds - allow influence of wider		1. Continued participation and support for Leeds City Council's Marmot City ambition	
2 The Delivery and Inequalities Sub-Committee - highlighting impact of wider factors		2. Leveraging ICB's role at place as a (small) anchor institution, and influence over other (larger) anchor institutions (NB this may not take place during vacancy freeze/restructure)	
3 Marmot City Programme - provides joint working mechanism to address wider determinants			
4 Ongoing contracting with the third sector - provide additional resource flow into local economy and areas of need			
Sources of assurance (Where is the evidence that the controls work?)		Links to place risk register: 2415, 2354, 2301, 2018	
1 Minutes from PLT / HWB meetings, particularly sessions with a wider strategic focus			
2 Minutes from Delivery and Inequalities Sub-Committee			
3 Programme reports from the Marmot city programme			
4 Financial accounts recording proportion of spend in this area			
Wakefield		Place lead: Mel Brown	
ICB risk appetite		Nominated lead for this risk: No update	
BOLD		Place risk scores	
		Rationale for current place score	
		Local position reflects the WYICB position. Current likelihood is high due to significant pressures in the system.	
Target (Wakefield)		Current (Wakefield)	
Likelihood	4	16	Likelihood 5
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. A further community of practice event has been planned for November 2025	
2 Economic Strategy is in place led by the local authority. Elements that impact on health inequalities are reported to Health and Wellbeing Board		2. The work to develop the place response to reducing economic inactivity is currently taking shape (2025/26)	
3 Joint post working across health and the Local Authority addressing inequalities is in place		3. Wakefield is working with funding from Health Determinants Research Collaborative (HDRC) to establish research capacity around health inequalities (2025/26)	
4 Joint Steering Group established		4. The development of our integrated neighbourhood health model (2025/26)	
5 We are now established as an enabler programme in our transformation and delivery collaborative			
6 Community of Practice event being took place in May 2025			
7 Some of our uncommitted core spend for 2025/26 will be focusing on COPD			
8 The economic accelerator programme is now established.			
9 Development of a district plan			
Sources of assurance (Where is the evidence that the controls work?)		Link to Place Risk Register	
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		2481	
2 Wakefield Joint Strategic Needs Assessment			
4 Report to WDHCP Committee in November 2024 on the evaluation and principles of allocation of resource for CORE20PLUS			

WYICB - Board Assurance Framework - ICB and places						Version 13	7 October 2025
Mission 1	Failure to manage strategic risk could result in a failure to REDUCE INEQUALITIES					Lead director(s) / board lead	Ian Holmes / Jonathan Webb
Strategic risk 1.2	There is a risk that operational pressures and priorities impact our ability to target resources effectively towards improving outcomes and reducing inequalities for children and adults.					Lead committee / board	Finance, Investment and Performance Committee
ICB risk appetite	ICB risk scores						Rationale for current ICB score
	Target (ICB)			Current (ICB)			
OPEN	Likelihood	3	9	Likelihood	4	16	Significant financial and operational pressure continues to impact on our ability to deliver wider ambitions. The organisational change process and capacity will impact on the operational pressure.
	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, agreed plans that deploys £10.75m Health Inequalities funding across all Core 20PLUS5 priorities - specific workstream headed by Improving Population Health (IPH) Board with remit to recommend allocation of specific funding across the ICS					1. EQIA process on any proposed service change and commissioning policy change (2025/26). 2. As part of developing the ICB operating model we are building a strategic commissioning function that will help ensure that the organisation has the right focus on reducing health inequalities and improving outcome, 2025/26 3. Our approach to integrated neighbourhood healthcare is predicated on population health management principles which ensure there is the right focus on communities with the greatest need. 4. As part of the economic accelerator programme we are focusing on improving economic participation in communities where inequalities and poor outcomes are highest.	
2	The first 3 ambitions in our Strategic Plan relate to inequalities. Plans for these are set out in the Joint Forward Plan which provides the foundation to prioritisation by the ICB Board. The Plan has a refreshed set of metrics to ensure that a difference can be made and measured.						
3	Measurement of inequalities relating to key operational priorities - such as elective recovery and ambulance waiting times.						
4	Board approved WY ICS Finance Strategy confirms importance of health inequalities as key element of how deploy resources.						
5	Committee overview of commissioning policies and quality impact by the Transformation Committee and Quality Committee respectively.						
6	Inclusion Health Unit, whose focus is on the sustainability of inclusion health services, supporting the system to improve the health of population groups.						
Sources of assurance (Where is the evidence that the controls work?)						Links to ICB risk register (Reference numbers/brief description)	
1	Partnership Board focus on 10 big ambitions					Risk 2309 - demand for CYP mental health services; 2451 - Delays in gender identity specialist services; 2525 - delays in health assessments of CiC; 2479 - children's hospice care	
2	ICB Board - performance dashboard and deep dives into health inequalities						
3	SOAG updates against 10 big ambitions						
4	ICB Annual Report summarises work on improving outcomes and reducing inequalities						
5	Internal Audit 'Health Inequalities Partnership Working' review - Significant Assurance - June 2024						
6	Integrated neighbourhood health board						
7	Health and wellbeing boards (sign off integrated neighbourhood healthcare plans)						
Bradford District and Craven (BD&C)						Place lead: Therese Patten	
ICB risk appetite						Nominated lead for this risk: Sohail Abbas 07.01.26	
OPEN	Place risk scores						
	Target (BD&C)			Current (BD&C)			
OPEN	Likelihood	3	9	Likelihood	3	12	There are higher levels of inequality in BDC as compared to other places. The organisational changes and wider environments makes it difficult to reduce inequalities. The risk score remains the same for this cycle.
	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	QEIA assessments in routine use					1. Work is ongoing on population needs assessment and using population health management principles to identify population cohorts for targeting interventions (2025/26) 2. We are in the process of developing our health and care strategies in place together with our partners which will meet our ambitions around improving outcome and reducing inequalities. This work is being led by the Director of partnership and place (2025/26) 3. Alongside the strategy development we are developing our intent around neighbourhood health and have events in the diary both with practices but also as part of our Listen In engagement schedule across our communities to ensure we are developing services in partnership (2025/26) 4. QEIA assessments in routine use (process being refined and reviewed 2025) to ensure that the impact of proposed decisions does not move resource away from critical areas of health inequality (2025/26) 5. Economic evaluation of our health inequalities programme is undergoing which will help us deliver financial case for reducing inequalities (2025/26)	
2	Prioritising action plans to address the main causes of death, inequalities and poor health across BDC HCP (place) within the new Closing the Gap programme. Leadership group has been set up for implementing Core20PLUS5 for the ICS and BDC HCP (place). Targeting reduction of health inequalities by working closely with PCNs and Community Partnerships (and with Local Authority Area teams)						
3	Closing the gap programme has segmented the population and examines trends on health needs against expenditure, and high impact evidence based interventions to reduce inequalities and address pressure points locally.						
4	Inequalities toolkits have been used by our 13 Community Partnerships to guide commissioning (with guidance and separate intelligence packs itemising outliers). Primary care practice priorities have been aligned to Core20 priorities via the health inequality practice premium.						
5	Priority boards maintain a key focus on inequalities through their programmes of work						
6	Developing a System approach to reducing inequalities via improved collaboration between Inequalities, EDI, Research and Prevention programmes (included board readiness toolkit & development sessions to embed work to reduce inequalities through the governance structure).						
Sources of assurance (Where is the evidence that the controls work?)						Links to Place Risk Register	
1	BDC Partnership Board and Exec receive full papers and briefings on progress within the Priorities and Enablers alongside system based committees which provide oversight and assurance on our outcomes.					2386, 2227, 2039, 2221	
2	Inequalities are embedded into our transformation work with Population Health Management (PHM) data identifying key areas of focus for priority. Priority Boards providing ownership of transforming services across all place based partners						
3	Outcomes focused performance report for HCP Board capturing health inequalities						
Calderdale						Place lead: Robin Tuddenham	
ICB risk appetite						Nominated lead for this risk: No update	
OPEN	Place risk scores						
	Target (Calderdale)			Current (Calderdale)			
OPEN	Likelihood	2	6	Likelihood	3	9	Risk score reflects operational performance on NHS targets. There are pressures in the system but it's not impacting on our ability to deliver Core 20+5. There is a significant risk on future finances and the overall change programme announced in March 25 could result in inequalities being impacted. Score will be continually monitored. Reviewed target score and reduced this from 9 to 6, due to a OPEN risk appetite.
	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	Clear plan for place share of £12m led by DPH, reports to HWBB.					1. The data model is being developed to help analyse the use of urgent care to help address and ensure that out-of-hospital services do not create health inequalities - Population health tool is being developed - local drop in sessions will take place with discussion at Board level in 2025-26. 2. Financial pressures continue to be monitored and savings identified recurrently to ensure underlying position does not deteriorate. 3. Change programme and new ICB operating model will impact on this risk and will be monitored.	
2	Tackling inequalities is a core requirement of all papers to comment upon, particularly contract awards / service improvement.						
3	Measurement of health inequalities for elective recovery has been key component for CHFT and its delivery of its waiting lists.						
Sources of assurance (Where is the evidence that the controls work?)						Links to Place Risk Register:	
1	Regular report to HWBB (as above) and CCPB.					2224, 1338, 2476, 2149, 1998, 1493, 62, 2092	
2	Joint Forward Plan will include health inequalities.						
3	Transformation delivery plan signed off by Board on 5 September 2024, one of the key ambitions in reduction in health inequalities						
Kirklees						Place lead: Vicky Dutchburn	
ICB risk appetite						Nominated lead for this risk: No update	
Place risk scores						Rationale for current place score	

ICB risk appetite		Target (Kirklees)		Current (Kirklees)		Outcomes Framework, indicators and proxy indicators, establish network, align core 20 plus 5 , strengthen reporting through PMO and align approaches to VCSE investment and Inclusive communities framework. The elective performances is included in the bi-monthly performance committee. There have been deep dive reports and discussions with our health and care partnership board specifically on child and adult mental health and neurodiversity assessment, there is an action plan. The core 20+5 schemes have been reviewed and built in as business as usual as an outcome of that review. The rigour of internal processes with regards to prioritisation and reviews of all contracts which are due to expire March 2026 - the governance timeline complete until the end of October 2025.	
OPEN	Likelihood	2	6	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 place?)	
1	Health and Wellbeing Strategy					1. Agreed that Kirklees place will develop an action plan on children and young people's neurodiversity to sign off by April 2025 - action plan has been completed and submitted as part of the SEND review - June 2025. 2. Expecting final SEND report end of August 2025 and implementing review actions from Q3, 2025/26 3. Establishment of transformation dashboard as per annual review recommendation (Q2, 2025/26)	
2	Health and Wellbeing Plan						
3	Outcomes Framework						
4	Deep dive reports on high risk areas e.g. child & adult mental health, neurodiversity assessments.						
5	Completed review of the children and young people's mental health model (Kirklees Keeping In Mind) implementation commenced April 2025.						
Sources of assurance (Where is the evidence that the controls work?)						Links to place risk register:	
1	Regular reporting into Health and Wellbeing Board					2240	
2	Regular reporting into place governance such as the Kirklees Quality Committee						
3	PMO reports on projects						
4	Reports and action plans to Transformation Committee						
Leeds			Place lead: Tim Ryley		Nominated lead for this risk: No update		
ICB risk appetite		Place risk scores				Rationale for current place score	
OPEN	Target (Leeds)		Current (Leeds)		Current reduction in ICB resources and associated restructure will be presenting notable challenges to driving work in this area (alongside existing operational pressures - particularly during Winter). Reviewed target risk score in light of a open risk appetite (willing to take reasonable risks and is tolerant to some uncertainty), agreed to reduce the target risk score from 12 to 9.		
	Likelihood	3	9	Likelihood			4
	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	Local strategy with a focus on health inequalities (Healthy Leeds Plan), with key data cut by IMD and other relevant HI metrics.					1. Partnership focus in 25/26 on programme benefits quantification should support greater assessment of potential HI impact (2025/26) 2. Review approach to incentives in line with strategic commissioning role towards the end of this financial year (March 2026) 3. Provide both challenge and support to emerging HealthCare Inequalities Oversight Group, which has a partnership focus across providers (2025/26)	
2	Local governance structures with a focus on inequalities - Delivery and Inequalities sub-committee, Health Inequalities Oversight Group and specific sessions at Partnership Leadership Team						
3	Leeds financial planning process includes mechanisms to minimise impact on inequalities as well as QEIA assessments in routine use (and published)						
4	All delivery plans have a clear focus on addressing inequalities within existing resources.						
5	Inequalities / Core20+5 / transformation funding as part of general practice incentive scheme (GPOP)						
Sources of assurance (Where is the evidence that the controls work?)						Links to place risk register:	
1	HLP document and access to PowerBI reporting					2354, 2301, 2480	
2	Minutes and terms of reference for Delivery Sub-Committee, HIOG and PLT						
3	Online QEIA resource						
4	Business reporting to Leeds Director Team						
5	GPOP scheme documents						
Wakefield			Place lead: Mel Brown		Nominated lead for this risk: No update		
ICB risk appetite		Place risk scores				Rationale for current place score	
OPEN	Target (Wakefield)		Current (Wakefield)		Reflects the Integrated Care Board position. Local places have limited powers to reduce likelihood.		
	Likelihood	3	9	Likelihood			4
	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	Allocation of CORE20plus5 monies					1. Working with the data team to do more deeper evaluation of our CORE20plus funded programmes (2025/26) 2. Working through the investment panel process to secure funding (2025/26)	
2	Healthy Sustainable Communities Oversight Group established for CORE20plus5 and reports through the governance structure						
3	Place Outcomes Framework currently in development						
4	Tackling inequalities is a priority of the Health and Wellbeing Board and associated work programmes						
5	Established CORE20plus5 strategic group which oversees the evaluation of funded programmes. Developed a evaluation framework which will support targeted interventions						
Sources of assurance (Where is the evidence that the controls work?)						Link to Place Risk Register	
1	Health and Wellbeing Board Outcomes Framework - reports to the Health & Wellbeing Board - annually					2128	
2	Performance Report to Integrated Assurance Committee - bi-monthly						
3	Performance Report to Wakefield District Health and Care Partnership - quarterly						

WYICB - Board Assurance Framework - ICB and places							Version: 13	6 October 2025
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 <i>(linked to place committees)</i>
ICB risk appetite	ICB risk scores						Rationale for current ICB score	
	Target (ICB)			Current (ICB)			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.	
OPEN	Likelihood	2	8	Likelihood	3	12		
	Impact	4		Impact	4			
Key controls <i>(What helps us mitigate the risk?)</i>						Mitigating actions <i>(What more are we/should we be doing at ICB level?)</i>		
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. There are three pilot programmes running across WY (Leeds, BDC and Wakefield) the learning from these pilots will be shared with other areas and nationally (Approved 2025, work ongoing from 2025/26).		
2 ICB medium term financial plan supports a differential investment towards primary and community care.								
3 All places are developing integrated neighbourhood healthcare plans which will respond to the ICB blueprint and describe and quantify the improvements that will be made locally. These plans will be signed off by the health and wellbeing boards.								
4 Quality Committee and ICB Board receive Integrated Performance Dashboard which reflects progress made towards integrating services and neighbourhoods.								
5 In line with the future strategic commissioning responsibilities the ICB is developing commissioning intentions and contractual mechanisms to enable and incentivise integrated models of healthcare.								
6 Places continue to develop their models of collaboration with a view to implementation in shadow form from Apr 2026.								
Sources of assurance <i>(Where is the evidence that the controls work?)</i>						Links to ICB risk register (Reference numbers/brief description)		
1 Published ICB strategy and local neighbourhood health plans						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 neighbourhood delivery model health 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)								
Bradford District and Craven (BD&C)			Place lead: Therese Patten		Nominated lead for this risk: Sohail Abbas (07.01.26)			
ICB risk appetite	Place risk scores						Rationale for current place score	
	Target (BD&C)			Current (BD&C)			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.	
OPEN	Likelihood	2	8	Likelihood	3	12		
	Impact	4		Impact	4			
Key controls <i>(What helps us mitigate the risk?)</i>						Mitigating actions <i>(What more are we/should we be doing at place?)</i>		
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) 5. Work underway to develop our integrated neighbourhood team model (2025/26) 6. We are working with LMC on reviewing and refreshing the local enhanced service (LES) schemes with a strong emphasis on prevention, proactive care in community and digital transformation.		
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 <i>(Where is the evidence that the controls work?)</i>						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						2221, 2486		
2 Reducing Inequalities Alliance reporting to Exec 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								
Calderdale			Place lead: Robin Tuddenham		Nominated lead for this risk: No update			
ICB risk appetite	Place risk scores						Rationale for current place score	
	Target (Calderdale)			Current (Calderdale)			Integrated care in communities is fundamental to our strategy for improving outcomes and tackling inequalities and a priority for Calderdale.	
OPEN	Likelihood	2	8	Likelihood	3	12		
	Impact	4		Impact	4			
Key controls <i>(What helps us mitigate the risk?)</i>						Mitigating actions <i>(What more are we/should we be doing at place?)</i>		
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 Place Partnership Review (led by Anthony Kealy) and ICB letter March 25 regarding Provider Collaboration will support further development of Place model including provider collaboratives and integration in Places. The ICB's response to the running cost reduction will need to consider the findings of this review in the context of significantly reduced capacity. 3. National focus on integrated neighbourhood health as part of the new Government's 10 year plan create greater focus. This will influence ICB planning for 2025/26 and beyond. The ICB has identified integrated neighbourhood health as a key priority lead by Places. 4. Consideration made for national programme for Integrated Neighbourhood Health, however due to uncertain times first phase application not proceeded with. Further strengthening of data and resource needed for future waves		
2 Transformation deliver plan has integrated neighbourhood team as key objective for the partnership board								
3 Calderdale Community Collaborative Programme board in place 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 <i>(Where is the evidence that the controls work?)</i>						Links to Place risk register: 2476, 2163, 1493, 62, 1977, 2469, 2484, 2092		
1 A year end report will be presented to the partnership board on the transformation delivery plan for which integrated neighbourhood is the key priority								
2 Joint Forward Plan being developed.								
3 Calderdale Community Collaborative Programme board in place led by PCN Directors. Terms of Reference and mins.								
Kirklees			Place lead: Vicky Dutchburn		Nominated lead for this risk: No update			
ICB risk appetite	Place risk scores						Rationale for current place score	
	Target (Kirklees)			Current (Kirklees)			While a strategy is in place, there is a need to focus on the delivery of transformation and improvements across all nine integrated neighbourhood teams and to ensure adequate capacity is freed up by system partners. Risk score remains the same.	
OPEN	Likelihood	2	8	Likelihood	3	12		
	Impact	4		Impact	4			
Key controls <i>(What helps us mitigate the risk?)</i>						Mitigating actions <i>(What more are we/should we be doing at place?)</i>		

1	Core20+5 is being lead by the Public Health team on behalf of the Partnership	1. Programme plan in place to fully implement integrated neighbourhood teams and improve integrated neighbourhood health in line with 2025/26 planning guidance 2. Business case developed for accessing West Yorkshire SDF funds (non-recurrent) to assist with accelerating pace of implementation 3. Identified accelerator site to commence first INT on 2 July 2025, system partners are ready to facilitate engagement and support for accelerator site. 4. Regular fortnightly call in place with SROs for 6 core components of integrated neighbourhood health 5. Workshop held on 27 June 2025 to co-design OD support for system leaders and integrated neighbourhood teams. Next steps will be to share draft programme with stakeholders (2025/26) 6. Planned refresh of the objective within the health and care plan (2025/26) 7. Neighbourhood level data being extracted from primary care and supported by linked data sets to facilitate a population health management approach. Next steps to share with accelerator site and other INTs (2025/26)
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	INT data packs developed and data sharing agreements in place	
4	A number of services including VCSE already aligned around communities	
Sources of assurance (Where is the evidence that the controls work?)		Links to place risk register 2475
1	Published Health and Wellbeing Strategy	
2	The local Health and Care Plan follows directly on from the Health and Wellbeing Strategy	
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	
5	Delivery collaborative - notes	
6	PCN meetings - notes	
7	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.	
8	WY INH Board in place	

Leeds	Place lead: Tim Rley	Nominated lead for this risk: Helen Lewis (23.12.25)
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ICB risk appetite	Place risk scores						Rationale for current place score
	Target (Leeds)			Current (Leeds)			
	Likelihood	2	8	Likelihood	3	12	
OPEN	Impact	4	Impact	4		Strong work plans already within the Leeds Health and Care Partnership, 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.	

Key controls (What helps us mitigate the risk?)			Mitigating actions (What more are we/should we be doing at place?)			
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1	Strong LCPs and PCNs.	1. Developing integrated neighbourhood clinics are in place and considering further developments (2026/27) 2. LCH and GP confederation looking at neighbourhood integration opportunities as part of the system neighbourhood health model (2026/27) 3. Community mental health programme engaging all relevant partners to improve service integration and focus on those people most at risk (new contract with VCSE 2026/27) 4. All Neighbourhood Health work proceeding at pace, including input from OD to look at the cultural barriers to integration - work ongoing 2026/27
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, add neighbourhood health is one of the partnership leadership priorities and programme is reviewed regularly and overseen by partnership leadership team	
4	LCH and Leeds City Council now have a joint digital clinical record enabling therapy and care staff to work on the same note, and with therapists jointly overseeing and designing care with the reablement team	

Sources of assurance (Where is the evidence that the controls work?)	
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1	Access to Leeds data model/power BI platforms, and RAIDR to review data sets.
2	Notes of LCP/PCN meetings.
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: No update
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ICB risk appetite	Place risk scores						Rationale for current place score
	Target (Wakefield)			Current (Wakefield)			
	Likelihood	2	8	Likelihood	3	12	
OPEN	Impact	4	Impact	4		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.	

Key controls (What helps us mitigate the risk?)			Mitigating actions (What more are we/should we be doing at place?)			
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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	
4	This work is connected to the work to develop a neighbourhood model	

Sources of assurance (Where is the evidence that the controls work?)	
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1	Transformation and Delivery Collaborative Chair's report to Wakefield District Health and Care Partnership highlights key discussions - bi monthly	Links to Place Risk Register 2397, 2429
2	Provider Alliance deep dive regarding progress against priorities reported to Transformation and Delivery Collaborative - monthly	
3	Medical Director for Integrated Community Services attends Fuller Board	

WYICB - Board Assurance Framework - ICB and places							Version: 13	31-Oct-25
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. The current workforce reduction programmes within both the ICB and provider Trusts will impact on the ability to attract and retain staff across the workforce. In addition, the system awaits further detail in relation to any potential growth as part of the NHS long term workforce plan, currently undergoing calls for evidence, and Adult Social Care workforce strategy.	
OPEN	Likelihood	4	8	Likelihood	4	16		
	Impact	2		Impact	4			
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, The ICB EMT organisational change programme board - 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. Draft revised People Strategy will be presented to the WY People Board on 26 November 2025.		
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.						2. 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 2025/26		
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						3. One of the agreed terms of reference for the Strategic Workforce Transformation Forum centres on influencing regionally and nationally. The Forum has now agreed its core 4 priorities with delivery groups established to respond to each - 2025/26 - work is ongoing.		
4 Workforce Place Leads and place-based plans (for further details, see Place BAF below)						4. The ICB has commenced a review of its operating model (Apr 2025) in response to the further targeted reduction of 50% of costs. There will be a large scale organisational change programme to deliver the required response to this announcement. This is currently paused and awaiting further national guidance.		
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. International recruitment is currently very low.						5. NHS providers across West Yorkshire are also required to review their growth in corporate service costs since 2019/2020 and reduce these by 50%. This is in addition to the workforce reductions indicated within the operating planning submission. ICB to monitor the impact of this - 2025-27.		
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.						6. ICB workforce strategy team responding to national call for evidence, which is part of the process to refresh the NHS Workforce Plan (2025/2026)		
7 The ICB received detail from each NHS provider of their current workforce planning and control mechanisms. These will be used to help NHSE monitor each Trusts workforce position against its operating planning submission (2025/26)								
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; 2402 - general practice workforce; 2557 - ICB workforce; 2535 - ICB workforce 2537 - ICB workforce		
2 Place leads meet with local NHS providers to ensure progress is monitored across WY against the operating planning submission. 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.								
4 Active data flow across wider People agenda, which is presented to the People Board and Strategic Workforce Transformation Forum.								
5 (NHS specific) Staff Survey annual results								
Bradford District and Craven (BD&C)						Nominated lead for this risk: Andrew Milner 06.01.26		
Place lead: Therese Patten								
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 significant challenge. Current financial and organisational circumstances mean recruitment across healthcare organisations continued to be limited. As a result, risk score remains at 16.	
CAUTIOUS	Likelihood	4	8	Likelihood	4	16		
	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 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 We have made progress in supporting the social care workforce with initiatives to help retain staff. As a part of the health and work accelerator programme multiple interventions including the provision of mental health and physiotherapy support are being commissioned to support the social care workforce. This builds upon learning from successful employee assistance programmes operating within our NHS provider organisations. We are building on this by working with the Bradford Care Association.		
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.						2. Work with Skills House within Bradford Metropolitan District Council on developing sustainable recruitment pipelines from within the Bradford and Craven area continues, with lead responsibility now being passed to BMDC. Engagement with NHS and Social Care organisations to identify an appropriate delivery mechanism within the current organisational change programmes (ongoing 2025/26 and beyond).		
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.						3. Working across the system within partners including Higher Education Institutions to develop a pipeline for registered health and care roles. System wide approach has been developed for optimising placement capacity and aligning educational and service capacity (Ongoing 2025/26 and beyond)		
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 Programme Board								
3								
Calderdale						Nominated lead for this risk: No update		
Place lead: Robin Tuddenham								
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.						1. Provider workforce plans led by Acute and Primary Care leads 2025/26		
2 Operating model is in place						2. Local group looks at recruitment and development 2025/26		
Sources of assurance (Where is the evidence that the controls work?)						Links to Place Risk Register:		
1 Update to the partnership board						2224, 1338, 2149, 1493, 62, 1977, 2092		
Kirklees						Nominated lead for this risk: No update		
Place lead: Vicky Dutchburn								

ICB risk appetite	Place risk scores						Rationale for current place score
	Target (Kirklees)			Current (Kirklees)			
CAUTIOUS	Likelihood	4	8	Likelihood	4	16	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. The workforce controls around the 2025/26 planning round makes this challenging. Some of the challenges are structural [such as rates of pay within social care and potential changes for international staff particularly in the independent care sector and recent NI changes] and therefore are difficult to address in the short term. Current ongoing changes to where the responsibility for strategic workforce planning sits within the NHS make this more challenging. 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 increased from 12 to 16 in line with WY ICB.
	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 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 Kirklees and Calderdale Care Association, for example, to support staff wellbeing within care homes roadshow which took place in May 2025. Compassionate cultures conference took place in June 2025, supporting staff with health and wellbeing. However, this is an area where we continue 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 on 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) for example the development of new Radiography course.
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.							
3 Placement work on pharmacy is now complete, the placement arrangements and systems will continue 2025/26							
Sources of assurance (Where is the evidence that the controls work?)							Link to place risk register:
1 Evidence on the impact of projects and initiatives is monitored within the appropriate Working Group for each of the pillars.							2498
2 Each of the 3 Working Groups reports into our Joint Workforce Steering Group to present evidence of impact of their projects and initiatives.							
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 Rley		Nominated lead for this risk:	No update
ICB risk appetite	Place risk scores						Rationale for current place score
	Target (Leeds)			Current (Leeds)			
CAUTIOUS	Likelihood	3	9	Likelihood	4	12	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. Current pressures on services and the cost of living increase creates significant risk of retention, particularly 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.
	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. The last review took place on April 2025. The next review will take place in April 2026. 2. Continue to increase and diversify student placement opportunities and experience, and support transition from education to employment. This is a priority strategic project in the Leeds One Workforce Programme due for review in November 2025. 3. Health and growth accelerator programme providing additional support to retain staff in work (2025/26)
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.							
Sources of assurance (Where is the evidence that the controls work?)							Link to place risk register:
1 Minutes from Leeds One Workforce Strategic Board (LOWSB), LCRG and Leeds H&W CoP							None.
2 Academy Steering Group quarterly reports							
3 Leeds One Workforce City Risk profile							
Wakefield			Place lead:	Mel Brown		Nominated lead for this risk:	No update
ICB risk appetite	Place risk scores						Rationale for current place score
	Target (Wakefield)			Current (Wakefield)			
CAUTIOUS	Likelihood	4	8	Likelihood	4	12	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. Currently there is a significant risk to the workforce as a result of the 50% reduction in ICB funding however, in Wakefield we are to some extent protected from this because of the way the PMO is currently funded. There is still residual risks to the social care workforce associated with a lack of the national strategy and funding arrangements.
	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 initiatives 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
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.							

<p>Positive Assurance The current Programme within the Wakefield People Plan focuses on the following priorities:</p> <ul style="list-style-type: none"> - 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. - System approach to the pooling of the apprenticeship levy and developing resources specifically for young people to increase the number of apprenticeships in the system and grow our own from the future generation - 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. - Recently launched economic accelerator programme that supports people in the current workforce who are at risk of becoming economically inactive. Commissioned a range of services to support this cohort. 	<p>bridge the gap between academic learning and real-world application.</p> <p>The Wakefield People Alliance addresses retention through its Pillars 1-3 Programmes. Initiatives include: (timescale - 2025/26)</p> <ol style="list-style-type: none"> 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. Continues for 2025/26.
	<p>Links to Place Risk Register</p> <p>2129</p>

WYICB - Board Assurance Framework - ICB and places							Version: 13	30-Oct-25
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)			Continued formal assurance is needed through Transformation Committee and Partnership Board. With the changes in Digital leadership, we are assured that there is maintained links between digital and innovation. Uncertainty around the implications of current changes with ICBs and the impact on the WY ICB research and innovation function, risk score remains the same in Cycle 3, 2025/26.	
	Likelihood	2	6	Likelihood	2	8		
Impact	3		Impact	4				
OPEN								
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. Continues in 2025/26	
2	Research via Applied Research Collaborative (ARC)						2. Annual review to bring additional rigour with lens on innovation and research (2025/26)	
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						2108 - Cancer workforce plan	
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 09.01.26	
ICB risk appetite	Place risk scores						Rationale for current place score	
	Target (BD&C)			Current (BD&C)			Recognise the impacts of the changes to the form and function of the ICB from April 2026, the reduced resource availability at BD&C Place, the ongoing emergence of the provider collaborative and the supporting governance and assurance structures. To sit against the revised strategy 'Our plans for health, care, and wellbeing in Bradford District' (September 2025) BDC Risk score remains at 9 due to the ongoing period of change.	
	Likelihood	2	4	Likelihood	3	9		
Impact	2		Impact	3				
OPEN								
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. Work ongoing to identify future arrangements as Place to ensure the provision of assurance to the BDC system on the quality of services provision post April 2026. Until March 2026, the system quality insight and assurance group (SQAIG) 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. It is proposed that, alongside the Finance, Performance and Quality Forum (FPQ), the SQAIG or similar remains in place as an interim						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 and onwards.) 2. Work is progressing on the BDC clinical strategy and the role of the Clinical and Professional Forum to support streamlining of clinical pathways - January 2026 3. Governance system structures and alignment to support the wider collaborative have been revised, including workstreams for integrated neighbourhood health.	
2	Prioritisation exercise to maximise use of resources - We are completing a strategic review of the work of each priority area (prioritisation exercise) to ensure that available resource is focused on the areas of highest priority against national, regional and local priorities including Financial and Quality criteria whilst focussing on outcomes for the population						Links to Bradford place risk register: 2419	
3	Model of Distributive leadership remain in place up to March 2026 in BDC with HCP for Chief Nurse which provides opportunities to provide assurance and oversight, share best practice, learning and improvement opportunities between partner organisations							
4	Quality Team input into ICB Efficiency Savings Programme Meeting and Efficiency Plan to ensure that QEIA completed for each efficiency scheme - to ensure that risks and potential impacts to service provision and outcomes/inequalities are recognised, communicated and mitigated where possible							
5	Quality requirements are represented with all providers and monitored through the consolidated WY ICB 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 and Professional Forum and SQC/SQG and ICB governance structures - through AAA updates from assurance and governance committees (combined F&PC SQAIG and meet monthly) and priority and enabler programmes.							
2	Redeveloped model/way of working for the Place (BDC) 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 Minutes.							
3	Supported by shared system committees for Finance and Performance, Quality and Safety, and our Clinical Forum. The Place 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/QEIA's, output from the prioritisation tool and demonstrate strategic fit. Equity, Quality Impact Assessment (EQIA) / Quality, Equality Impact Assessment (QEIA) embedded.							
Calderdale Place lead: Robin Tuddenham							Nominated lead for this risk: No update	
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 Partnership Board to discuss key issues as a system. Clear weakness in WY data/analytics for system overview. No significant resource locally to compare with other resource. Recognise work ongoing to produce consistent WY data.	
	Likelihood	2	4	Likelihood	2	6		
Impact	2		Impact	3				
OPEN								
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.						1. Calderdale lead on a number of WY elective recovery programmes, ensuring greater	

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						consistency in single contracts, to help avoid variation. Consistent Independent Sector waiting times recently agreed across WY.
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?)							
1	Regular reporting to Calderdale Care Partnership Board.						Links to Place risk register: 1338, 2476, 2163, 2149, 1493, 62, 1977, 2092
Kirklees Place lead: Vicky Dutchburn							
						Nominated lead for this risk: No update	
ICB risk appetite	Place risk scores						Rationale for current place score Kirklees place reflects the current WYICB wide score.
	Target (Kirklees)			Current (Kirklees)			
OPEN	Likelihood	2	4	Likelihood	2	8	
	Impact	2		Impact	4		
Key controls (What helps us mitigate the risk?)							
1	Kirklees ICB Transformation Sub-Committee, supported by the Kirklees Delivery Collaborative as mechanism to enable shared learning across providers						Mitigating actions (What more are we/should we be doing at place?) 1. Increase visibility and understanding of the West Yorkshire Innovation Leadership Collaborative and the interface between this network and place (Review 2025/26) 2. Establish clearer connections between the WY ICB and the West Yorkshire Innovation Leadership Collaborative (Review 2025/26) 3. Chief Digital and Information Officer attending Kirklees Board Development Session to share learning, next steps (Q2, 2025/26)
2	Working across places and with WY programmes to share learning and experience, identify variation, and opportunities for improvement						
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.						
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.						Link to place risk register: 2445
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: No update	
ICB risk appetite	Place risk scores						Rationale for current place score Earlier in the year the Leeds governance arrangements were established with a wide range of stakeholders, these were relatively new and 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 prioritisation. Our partnership governance arrangements have become more mature and we have identified some priority areas to collectively focus on as part of the Healthy Leeds plan. The biggest barriers to progress in these programmes tend to be digital and this is complex across competing providers with different needs as well as the Leeds digital infrastructure being a challenge when compared with the WY strategic approach.
	Target (Leeds)			Current (Leeds)			
OPEN	Likelihood	2	4	Likelihood	3	12	
	Impact	2		Impact	4		
Key controls (What helps us mitigate the risk?)							
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 and Finance & Best Value).						Mitigating actions (What more are we/should we be doing at place?) 1. There has been a lot of progress amongst senior clinical leaders to understand the wide range of interface issues in the city and a programme has been established to try and manage some of these better (2025/26) 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. Although these governance arrangements are starting to become clearer they are also highlighting some of the competing ambitions between different partners. They are not yet in a clearer enough form for senior leaders to prioritise. There is a piece of work to look at developing provider collaborative in line with the direction the government is taking the NHS and in line with the ICB blue print which will hopefully address some of the digital issues. 3. All Leeds partnership across Leeds health and social care were 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. Unfortunately Leeds was unsuccessful in the bid but there is ongoing conversation to see how the partnership can capitalise on the work so far anyway.
2	Regular contribution and representation at the ICB Quality Committee and System Quality Group						
3	Regular contribution and representation at the WY ICB Safeguarding Oversight and Assurance Partnership						
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,						
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.						Link to place risk register: 2480, 2487
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 08.01.26	
ICB risk appetite	Place risk scores						Rationale for current place score We continue to experience a high level of system pressure in Wakefield, which can lead to variations in care from what may be experienced in other areas of the WY system. We have been particularly challenged in urgent and emergency care, access for into certain health and social care services and we have specific concerns around the quality of care delivered in the care home sector in Wakefield. There has however been several pieces of improvement work happening over the last 12 months in Wakefield to improve patient flow in urgent care and access, and we continue to work closely as a system on quality improvement in our care home sector. The score remains at a 12.
	Target (Wakefield)			Current (Wakefield)			
OPEN	Likelihood	2	4	Likelihood	3	12	
	Impact	2		Impact	4		
Key controls (What helps us mitigate the risk?)							
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						Mitigating actions (What more are we/should we be doing at place?) 1. The acute provider in Wakefield has commenced a trust wide improvement programme called 'working together' adopting principles of continuous improvement and daily management to ensure better access and flow across the organisation - 2025-27 2. Clinical and professional engagement takes place across the district and is collated and monitored as part of our approach - ongoing 3. Wakefield and district health and care partnership have commenced a neighbourhood health programme of work focusing on the 6 key elements of neighbourhood health in preparation for the 10 year plan (2025 - 27) 5. Wakefield place based partnership is currently in development and will be operating in shadow form from April 2026.
2	Experience of Care Network - sharing good practice following feedback from service users						
3	Transformation and delivery committee established to which shares good practice and focus on improving services						
4	Patient safety priorities, development of place quality priorities, and alignment with West Yorkshire quality priority areas in place						
5	Wakefield District plan 2025-2035 sets out a joint vision for health and care services across the district, with 6 ambitions including helping people to live healthy lives and developing strong services that work for people						
6	Shared quality frameworks in place						
Sources of assurance (Where is the evidence that the controls work?)							

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 performance dashboards and improvement plans	None.

WYICB - Board Assurance Framework - ICB and places						Version: 13	29-Sep-25
Mission 2	Failure to manage the strategic risk could result in a failure to MANAGE UNWARRANTED VARIATION IN CARE					Lead director(s) / board lead	Lou Auger
Strategic risk 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.					Lead committee / board	Finance, Investment and Performance Committee
ICB risk appetite	ICB risk scores						Rationale for current ICB score
	Target (ICB)			Current (ICB)			
OPEN	Likelihood	2	6	Likelihood	3	9	The current likelihood is possible , given the limited business intelligence capacity in the ICB, limited access to near real-time performance data and lack of a comprehensive, shared performance dashboard. Failure to control this risk will lead to moderate impact on system performance. We could see a failure to meet national standards, a failure to address unwarranted variation, an inability to provide mutual aid in a timely way and regulatory breaches.
	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 A comprehensive performance dashboard and exception report shared by the Board and its committees						1. Development of Business intelligence (BI) capacity across the ICB (Q3, 2025/26).	
2 A system co-ordination centre is live to consolidate information and action on UEC pressures. The SCC meets the revised national specification.						2. High focus areas are published and shared in national and regional NHSE data packs so we all have the same information and can be used to improve performance (continuous, 2025/26)	
3 Securing access to, and review of, comprehensive, up-to-date management data						3. As the federated data platform matures, oversight of performance will be enhanced (2025/26)	
4 System-wide meetings to share intelligence, review risk and agree mitigating actions						<input type="checkbox"/>	
5 UEC-Raidr app is active and continues to be developed						<input type="checkbox"/>	
Sources of assurance (Where is the evidence that the controls work?)						Links to ICB risk register (Reference numbers/brief description)	
1 Minutes of Board and committee meetings						None identified	
2 Minutes and action logs of System Oversight and Assurance Group (SOAG), FIPC and other system groups							
3 Evidence of access by system leaders to UEC app and national data sources							
4 3 x daily SCC reports to NHSE Regional Team and shared with senior leaders							
Bradford District and Craven (BD&C) Place lead: Therese Patten						Nominated lead for this risk: Sohail Abbas and Kerry Weir (30.12.25)	
ICB risk appetite	Place risk scores						Rationale for current place score
	Target (BD&C)			Current (BD&C)			
OPEN	Likelihood	1	2	Likelihood	2	4	Good processes and systems in place to monitor performance and capacity across providers and BD&C place. Performance dashboards which are regularly taken to System committees and transformation programmes. Ability to pull out performance data quickly on an ad-hoc basis when required.
	Impact	2		Impact	2		
Key controls (What helps us mitigate the risk?)						Mitigating actions (What more are we/should we be doing at place?)	
1 BDC HCP (place) governance assurance through sub-committees System Finance and Performance Committee to the Partnership Board						1. Reviewed governance arrangements, which will help to triangulate performance across the range of areas (2025/26)	
2 BDC HCP (place) governance assurance through sub-committees System Quality Committee to the Partnership Board						2. Dashboards and performance reports to be updated to reflect 2026/27 operational planning requirements.	
3 HCP programme boards							
4 Partnership Board level outcomes report has been developed and includes health and inequalities metrics							
5 Finance, performance and quality forum (inbetween the FIPC and QC quarterly meetings) performance reported monthly to the extended leadership team (ELT)							
Sources of assurance (Where is the evidence that the controls work?)						Links to Place Risk Register	
1 Performance dashboard at System Finance and Performance Committee and robust processes in place to review performance (range of dashboards, reports to SF&P and HCP board)						2168, 2423	
2 Sub Committee of Quality committee receives performance dashboard focussing on patient experience and outcomes and statutory requirements, issues discussed at Quality Committee							
3 Regular update on performance provided to WYICB to support development of SOAG report							
4 3 times weekly system resilience dashboard circulated across HCP partners							
5 Regular Performance reports to HCP programme boards and ICB executive meeting							
6 Core 20+5 and health inequality premium performance reporting							
7 Triple A reports from finance and quality committees to Health and Care Partnership Board							
8 Core 20+5 and health inequality premium performance reporting (assurance)							
Calderdale Place lead: Robin Tuddenham						Nominated lead for this risk: No update	
ICB risk appetite	Place risk scores						Rationale for current place score
	Target (Calderdale)			Current (Calderdale)			
OPEN	Likelihood	1	2	Likelihood	2	6	Established performance monitoring process across commissioners and providers. Recognise we have potential BI capacity issues but we are currently performing as expected.
	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 Oversight framework used as base of performance monitoring at CCPB.						(See WY response above regarding BI)	
2 Working with partners to provide singular view at WY and place level.						1. Calderdale has good oversight on the key national performance metrics and outperforms in a number of areas.	
						2. Joint UECB across CHFT footprint monitoring urgent care performance, including winter, discharge and ambulance performance.	
Sources of assurance (Where is the evidence that the controls work?)						Links to Place Risk Register:	
1 Performance monitoring at CCPB. Papers and Minutes.						2476, 2149, 62	
Kirklees Place lead: Vicky Dutchburn						Nominated lead for this risk: No update	
ICB risk appetite	Place risk scores						Rationale for current place score
	Target (Kirklees)			Current (Kirklees)			
OPEN	Likelihood	1	2	Likelihood	2	8	Kirklees has processes in place that monitor the current performance with main providers and as a Kirklees position. This is reported to the Kirklees Finance and Performance Sub-Committee. A local framework for daily escalations and service capacity is in place and monitored through our CHFT/ MYTT silver escalations.
	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 Detailed performance reports presented to Kirklees Finance and Performance Sub-Committee and ICB						1. The local dashboard and indicators will transition into the new national RAIDR KPIs when signed off (2025/26)	
2 Partnership processes for sharing timely data across the system partners						2. Data sharing agreement across primary and secondary care with regards to integrated neighbourhood team development (100% by Q2, 2025/26)	
3 Speciality level reports at Elective Care and Urgent Care Boards							
4 A Urgent and Emergency Care Board (UECB) has a system dashboard							
5 Community service and primary care performance indicators now in place in a local dashboard (reviewed daily)							
Sources of assurance (Where is the evidence that the controls work?)							

1	Minutes of Finance and Performance Sub-Committee and Kirklees Health and Care Partnership Board					Link to place risk register: None.	
2	Action logs and performance slide packs from Elective Boards						
3	Minutes from system silver escalation calls						
4	Review the UECB dashboard and agree actions						
5	Data sharing agreement by the end of Q1, data flow is 80% and by the end of Q2, 100%						
Leeds			Place lead: Tim Ryley		Nominated lead for this risk: No update		
ICB risk appetite	Place risk scores						Rationale for current place score Reasonable oversight already of activity, capacity and performance via excellent place based relationships and working arrangements. Continues to be timely, automated and wide availability of data. Risk score remains.
	Target (Leeds)			Current (Leeds)			
	Likelihood	1	2	Likelihood	2	6	
OPEN	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	System Resilience Operational and Coordination groups in place, and daily pressures meeting.					1. There is a wider set of dashboards, metrics and indicators that have been developed and are used to track both operational and transformational activity across Leeds. All data that feed the various dashboards in Leeds have been automated and all dashboards are accessible to individuals across a range of organisations as per access controls. Individuals and organisations (including the Population and Care Delivery Boards) use these data to manage strategic risk of unwarranted variation of care. 2. During Q1 2025/26, the Opel dashboard has been improved and General Practice data flows are being included (2025/26). The audience has widened and this dashboard provides timely awareness of pressures right across Leeds. The dashboard has high use with almost 100 managers and service leaders across Leeds accessing this on a daily basis.	
2	Daily data shared via Opel System gives good oversight of volumes of attendances and pressures across sectors.						
3	Regular feedback from Trust Boards about performance risks and issues feeding local dashboards and delivery groups.						
4	The system visibility tool/ dashboard to support daily oversight of capacity and demand around system flow is in place and is mature						
5	The Opel dashboard is also available across the Leeds system, harnessing data from UEC-RAIDR and supplementing it with data from Leeds City Council/ Adult Social Care. Across the Leeds system all partners have access to this data and alerts our providers where thresholds are exceeded						
Sources of assurance (Where is the evidence that the controls work?)			Link to place risk register:				
1	Minutes of meetings.					None	
2	Partner Board reports demonstrate tight tracking on behalf of the system via their IQPRs.						
3	The use of data and insight (as evidence) is fast becoming central to a number of governance boards. For example, the Population and Care Delivery Boards have a compelling score card that describes performance for each population segment.						
Wakefield			Place lead: Mel Brown		Nominated lead for this risk: No update		
ICB risk appetite	Place risk scores						Rationale for current place score Good processes and systems in place. Performance dashboards which are regularly taken to Integrated Assurance Committee. Responsive narrative on a monthly basis to central core team. Ability to pull out performance data quickly on an ad-hoc basis when required. Risk score remains the same in Cycle 2.
	Target (Wakefield)			Current (Wakefield)			
	Likelihood	1	2	Likelihood	2	6	
OPEN	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 District and Health Care Partnership Committee, Integrated assurance committee and Transformation and Delivery Collaborative receives activity and performance report at each of its meetings					1 Currently working on the flow of community data to extend the OPEL framework to incorporate community services (2025/26) 2 Continue to strengthen collaborative / joint working between ICB BI and MYTT BI to support the efficient sharing of performance information, single version of the truth, access to live data and removal of duplication. MYTT will migrate to PowerBI across 2025 which will improve the accessibility of live information across the system - supporting the ability to make rapid decision making based on live data and intelligence (by March 2026) 3. Mid Yorkshire Teaching Hospital are actively engaging with the national federated data platform, adopting a number of applications that support performance delivery and access to timely data to support daily decision making (OPTICA, shared Patient Treatment List) Ongoing development 2025/26	
2	System Outcomes Framework in place and is being re-evaluated as part of a new District Plan.						
3	Each transformation programme has it's own performance dashboard or a dashboard is in development which tracks performance, progress and supports evaluation						
4	MYTT share daily sit-rep data (DSIT) with the ICB BI team so we are sighted on current performance						
5	Investment in Business Intelligence, including the shared PowerBI tenancy with MYTT allows colleagues with easy access to performance information and 'live' performance information from within the Trust						
6	Recently appointed Data & Analytic Business Partners to support collaborative performance reporting / analytics across the Wakefield system / MYTT						
Sources of assurance (Where is the evidence that the controls work?)			Link to Place Risk Register				
1	Minutes and papers from the Wakefield District and Health Care Partnership Committee, Integrated assurance committee and Transformation and Delivery Collaborative					None	
2	Tracking of key constitutional and local priority metrics through dashboards and reports - presented to Integrated Assurance Committee, Transformation Delivery Collaborative, Transformation programmes and Wakefield District Health and Care Partnership.						
3	The system visibility of tools/reports to support daily oversight of capacity and demand around system flow is in place and is mature (one suite of reports shared across ICB/MYTT)						
4	Use of RAIDR UEC Dashboard, OPEL information and feedback from System Meetings (to support on call and system command)						
5	Through collaborative working / shared BI roles across ICB/MYTT, the ICB is kept informed of any upcoming or changes to risks to performance and reporting.						

WYICB - Board Assurance Framework - ICB and places						Version: 13	7 October 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)			
OPEN	Likelihood	3	9	Likelihood	4	16	This risk relates to two specific areas; - significant backlog maintenance, unsuitable and aged physical estate and medical equipment replacement delays. - 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.
	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 Development and approval of ISC infrastructure strategy.						1. Continue to consider approaches to 'carve out' an element of operational capital to support schemes more strategic in nature (specifically including a currently assessed shortfall on the Calderdale Royal Hospital development).	
2 Regular oversight and assurance from ICS infrastructure strategy oversight group.						2. Work with NHS England NEY and WY NHS Providers on the arrangements that will be put in place in 2026-27 in relation to management, decision making and oversight of all capital allocations and expenditure (as signalled in the model ICB blueprint)	
3 Digital Programme Board - oversight of digital strategies and risks						3. Digital investments to be aligned with the model region and model ICB blueprints, and in addition to be increased to support the NHS 10 year plan. 4. (Digital) - evaluating the current operating model in alignment with the restructuring of digital, data and technology according to model region and model ICB blueprints. 5. Seeking more clarity from NHSE for overall structure of digital, data and technology in delivering the 10 year plan (2025/26)	
Sources of assurance (Where is the evidence that the controls work?)						Links to ICB risk register (Reference numbers/brief description)	
1 Minutes from - ICS Infrastructure Strategy Oversight Group; ICS Finance Forum; Digital Programme Board						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	
2 ICB / Regional digital projects are well planned with resources allocated. No milestone delays due to resource constraints.						2036 - Airedale Hospital plan 2522 - NHS infrastructure investment	
3 Initial feedback from NHSE national digital maturity assessment has shown considerable improvement from the previous year.							

Bradford District and Craven (BD&C) Place lead: **Therese Patten** Nominated lead for **this risk**: **Matt Sandford 05.01.26**

ICB risk appetite	Place risk scores						Rationale for current place score
	Target (BD&C)			Current (BD&C)			
OPEN	Likelihood	3	9	Likelihood	4	16	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. The utilisation and modernisation fund for primary care has the potential to mitigate some of these issues, but funding for year 2 onwards remains to be confirmed, risk score will remain the same in this cycle.
	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 Estates is an enabler in BDC HCP (place) operating model and is key to supporting the shift of services into the community.						2. Place health and wellbeing strategy has been 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. This will also support the development of neighbourhood health services for BDC localities.	
3 BDC HCP continues to be supported by the BDC Digital Programme Board 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.						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. 4. 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)	
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 health and wellbeing strategy and regular updates to PLE.							
3 Minutes of the BDC Digital Programme Board.							

Calderdale Place lead: **Robin Tuddenham** Nominated lead for **this risk**: **No update**

ICB risk appetite	Place risk scores						Rationale for current place score
	Target (Calderdale)			Current (Calderdale)			
OPEN	Likelihood	3	9	Likelihood	4	16	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.
	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 affordability. This hasn't been addressed fully. Local support purchased to enable involvement in WY Infrastructure Strategy for primary care (2025/26)	
2 Calderdale is a member of: ICS Capital Infrastructure Board; Finance Forum; Digital Strategy Board						2. Work still ongoing to identify local capacity for estates going forward (2025/26)	
3 General practice PCN estate strategies in plan with support procured from external organisation for national bids.						3. Digital need to be addressed by new Digital Director (2025/26) 4. Recruitment for CKW GP estates post hampered due to cost control (2025/26) and business case approved to use external company to support bids for national capital pot.	
Sources of assurance (Where is the evidence that the controls work?)						Link to place risk register	
1 Reports to Committee						None	

Kirklees		Place lead: Vicky Dutchburn		Nominated lead for <u>this</u> risk: No update		
ICB risk appetite	Place risk scores					Rationale for current place score
	Target (Kirklees)			Current (Kirklees)		
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. Estates lead continues to focus on key developments in estates within the place and wider ICB.		
2 IT Strategy				However, potential estates operational support is currently provided by independent consultant. This contract has ended June 2025. Paper has gone to panel to extend this support (2025/26)		
3 Estates and IT leads				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 develop primary care estate 2025/26.		
4 Kirklees - one public estates forum now established				3. Ensure funding available flows into the Kirklees place.		
5				4. Work with partners and stakeholders to access capital resources to support development in primary care (2025/26)		
Sources of assurance (Where is the evidence that the controls work?)				5. On going round table meeting of senior leaders to support the ongoing development of the CHFT reconfiguration		
1 Estates Forums				Link to place risk register:		
2 IT and Digital Groups				None.		
3 Reports to Committee						
4 Kirklees Estates Forum (partnership with providers) monthly						
5 Meeting with senior leaders to discuss CHFT reconfiguration						
Leeds		Place lead: Tim Ryley		Nominated lead for <u>this</u> risk: No update		
ICB risk appetite	Place risk scores					Rationale for current place score
	Target (Leeds)			Current (Leeds)		
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 Leeds City Strategic Estates Board and its Specific Programme Boards meet				1. LTHT working through medium term alternatives to the Leeds Way due to national delays until 2030 and beyond, this includes working with Leeds City Council to consider alternatives to the innovation hub.		
2 City Wide Digital Resources are combined across Health and Social Care jointly				2. Exploring innovative joint ventures/schemes and strengthen a one city estates strategy across NHS and Local Authority and cutting-edge digital solutions with detailed plans in place by March 2026		
3 Providers have strong infrastructure to manage capital planning and building.				3. City Wide Digital and Estates Strategies linked to our wider H&WB plans (2025/26)		
Sources of assurance (Where is the evidence that the controls work?)				Link to place risk register:		
1 Providers have strong infrastructure to manage capital planning and building.				2530		
2 Minutes of Strategic Estates and Programme Boards.						
Wakefield		Place lead: Mel Brown		Nominated lead for <u>this</u> risk: No update		
ICB risk appetite	Place risk scores					Rationale for current place score
	Target (Wakefield)			Current (Wakefield)		
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 place?)		
1 Wakefield Place Digital Strategy in place and now being aligned across partners				1. Place digital forum brings together all sector and it delivers on the place digital strategy (2025/26)		
2 Wakefield Place Finance Working Group linking into the West Yorkshire Integrated				2. Both business as usual replacement and innovation investment.		
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?)				Link to place risk register:		
1 Minutes from Digital Programme Board				2481, 2440		
2 Place nominated lead on West Yorkshire groups						
3 Digital maturity assessments (annually) - national programme						

WYICB - Board Assurance Framework - ICB (no requirement for places to complete)				Version: 13		29-Sep-25		
Mission 2	Failure to manage the strategic risk could result in a failure to MANAGE UNWARRANTED VARIATION IN CARE			Lead director(s) / board lead		Lou Auger		
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 of 16 (4Lx4I).	
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. Awaiting findings of the national Covid inquiry to incorporate learning into plans. Specific recommendations around the NHS continues. 2. Oversight of adherence to EPRR core standards and working with providers on their compliance				
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			2456 - Health protection				
2	Local Health Resilience Partnership meets quarterly to review learning from incidents and exercises.							
3	Local Resilience Forum (multi agency) meets quarterly							

WYICB - Board Assurance Framework - ICB and places						Version: 13	7 October 2025	
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 to consider issuing direction to all Places that there should be a shift of investment from acute hospital services to community, primary and prevention programmes as part of 2026/27 and medium term plans (2025-27) 2. Place Committees and the emergent place provider collaboratives to develop plans in line with this intent (2026/27)		
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								
Bradford District and Craven (BD&C)			Place lead:	Therese Patten		Nominated lead for this risk: Karen Parkin (29.12.25)		
ICB risk appetite	Place risk scores						Rationale for current place score	
	Target (BD&C)			Current (BD&C)			1. Agree with the WYICB scores and these are relevant for place too. 2. There has not been investment in community services in the Bradford & Craven Place other than within the ring-fenced SDF such as Core20+5 and accelerator funding - small pots of funding for specific purpose. The acute sector has had higher growth compared to community. Target score increased from 4 to 6 (impact increased from 2 unlikely to 3 possible) in line with WY ICB.	
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 place?)		
1 BDC Place will follow the WYICB strategy to apply 2% growth and 4.3% for additional service improvement with the objective that it reduces NEL & A&E growth						1. Financial Plans for 2026/27, first draft, build in an indicative 6.3% for community services: 2% provider growth and 4.3% for additional community services. However plans for additional services / improvement to existing services have yet to be developed (2026/27) 2. The structure of the Place Provider Partnership is in development. Requires a final model and to be implemented (Apr 2026) 3. The integrated neighbourhood health is now being developed at pace. Population cohorts have been identified and schemes are being worked up along with a timetable for implementation. (Apr 2026) 4. Primary Care LES being re-negotiated with new LES schemes that concentrates on INH and population health, more treatment in community and primary care to keep people out of hospital. (2026/27)		
2 A new established governance framework which includes relevant committees and business meetings. This has a clear reporting structure. The INH delivery group will oversee the development of services and deployment of the increased resource. The Place strategy has also been published and shared with all stakeholders which aligns with the left shift to community services and is consistent with the NHS 10 year plan.								
3 The BDC ICB financial plan will align with WYICB planning assumptions and strive to align with provider plans.								
4 There is now a new governance framework across BDC with three priority programmes, one is Airedale Bradford Collaboration of Acute Services (ABCAS), second is implementation of integrated neighbourhood health and the third is corporate services review and progressing with closing the gap. All of these have efficiency saving targets to meet.								
Sources of assurance (Where is the evidence that the controls work?)						Link to Place risk register: 2447, 2386, 2227, 2486, 2040		
1 New governance framework across BDC								
2 INH Delivery Group								
3 Performance Report alongside Finance Report into Finance Investment and Performance Committee and ICB Board								
4 Internal Audit Plan and External Audit VFM opinion								
Calderdale			Place lead:	Robin Tuddenham		Nominated lead for this risk: No update		
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. Development of Provider collaboration in its infancy and with 10 year plan we should be able to develop strategies for more proportionate distribution of funding.	
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?)						Link to place risk register: 2163, 2469		
1 Finance and performance a key component of partnership board meetings. Papers and Minutes.								
2								
3								
Kirklees			Place lead:	Vicky Dutchburn		Nominated lead for this risk: No update		
ICB risk appetite	Place risk scores						Rationale for current place score	
	Target (Kirklees)			Current (Kirklees)			The planning guidance and funding allocations does not allow for significant investment within primary care and the community. As stated in the WY narrative, funding is heavily weighted to the acute sector. Kirklees place whilst working collaboratively across the system, due to these challenges and the contractual form does not allow funding to flow around the system to allow services to align and increase investment in those areas. Review of target score against risk appetite, agreed to reduce the target risk score from 8 to 4 as the place is willing to take reasonable risks and tolerant of a certain amount of uncertainty.	
OPEN	Likelihood	2	4	Likelihood	3	12		
	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 Place committees, which comprise of partner organisations to discuss utilisation of resources						1. Continue the development of the provider collaborative and the Wells agenda 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 (2025/26)		
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.					resources (2023/24) 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, 2025/26				
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. Papers and Minutes.					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: No update				
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. Additional challenges in Q3 and Q4 anticipated given reduction in ICB resources and associated restructure.	
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 decisions on resource allocation across the LHCP. To be actioned within the medium term financial plans (2025/26) 2. Increasing focus on quantifying impact for and transformational change for larger partnership programmes and release of benefits (alongside their quantification)				
2 Analysis of spend through lens of populations and sub-groups as well as service lines.									
3 Strategic Finance Executive Group and Joint Planning Process across the partnership									
4 Finance sub-committee oversees financial planning and decisions.									
5 Regular attendance of DOFs at LHCP Partnership Exec Group and guiding priority programme ambition									
Sources of assurance (Where is the evidence that the controls work?)									
1 Finance sub-committee receives financial planning and decisions. Papers and Minutes					Links to Place Risk Register 2414				
2 DOFs at LHCP Partnership Exec Group. Papers and Minutes									
3 Benefits realisation assessments for priority programmes									
Wakefield					Place lead: Mel Brown				
					Nominated lead for this risk: No update				
ICB risk appetite		Place risk scores						Rationale for current place score	
		Target (Wakefield)			Current (Wakefield)			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. Risk score increased from 9 to 12 in line with WY ICB.	
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 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. A balanced financial plan was submitted, monitoring continues on a monthly basis (2025/26).				
2 The Wakefield Place Finance Leaders meeting is now established, forming a wider financial strategy, including the voluntary sector and local authority.									
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)					Links to Place Risk Register None.				
2 Honorary contracts in place									
3 Regular reporting mechanisms for quality, performance and finance in place									
4 Monthly review at Wakefield Senior Leadership Team meeting									

WYICB - Board Assurance Framework - ICB and places						Version: 13	7 October 2025
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	
CAUTIOUS	Target (ICB)			Current (ICB)			Despite a number of years of strong performance as an ICS, the 2024/25 position and 2025/26 plan were only balanced after receipt of significant non-recurrent financial support from NHS England, and as such there is a challenging plan to deliver this year and risks are materialising.
	Likelihood	3	9	Likelihood	4		
	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 for 2025-26 agreed by FIPC						1. Continued Chief Executive, Chair and Director of Finance targeted meetings with any NHS provider showing significant risk of non delivery of plan (2025-27).	
2 All Plans are signed off by the organisational Boards						2. Joint process with NHS England for the mid year reviews scheduled for Oct 2025.	
3 Escalation and joint approach with NHS England for Trusts.						3. Development of a robust and credible medium term financial plan (2025-27)	
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						2521 - Financial risk	
2 Quarterly ICB led mutual accountability meetings with all five places and outcome letters							
3 Internal Audit and External Audit							
4 External review commissioned into Finance by WYAAT (July 2024) and across the ICS (November 2024).							
5 Agendas, reports and minutes of all meetings above							
Bradford District and Craven (BD&C) Place lead: Therese Patten						Nominated lead for this risk: Karen Parkin (29.12.2025)	
ICB risk appetite	Place risk scores					Rationale for current place score	
CAUTIOUS	Target (BD&C)			Current (BD&C)			As per WYICB score and rationale. In addition, BDC part of the ICB will not achieve its financial plan target in 2025/26 and will remain financially challenged within current resource allocation.
	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 place?)	
1 BDC follows the West Yorkshire established principles and process.						1. All actions focused on achieving the best case identified in the mid-year review process plus continued stretch on efficiency savings programmes 2026/27.	
2 Participation in Mid Year Review process including a plan to move to best case scenario						2. Financial planning underway for 2026/27 showing recurrent improvement (but still underlying deficit). Assumptions align to WY and cost pressures built in where known. The plan still requires assessment of efficiency savings. 2026/27	
3 Regular detailed reporting to ELT plus fortnightly efficiency savings meetings to monitor, drive action and deliver programmes.							
4 Collaboration programme board oversees the 3 priority programmes across all BDC NHS organisations including joints plans for ABCAS, INH & Corporate services.							
Sources of assurance (Where is the evidence that the controls work?)						Alignment to place risk register:	
1 Quarterly ICB led mutual accountability meetings with all five places and outcome letters						2433, 2337, 2314, 2039, 2047	
2 Presentations from mid year review meetings, mutual accountability and resulting letters from WYICB							
3 Budget holder review meetings and presentations as part of mid year review process							
4 Regular monthly finance reports to ELT and minutes of meetings							
5 BDC system F&P committee approved financial and operating plans in April 2025. Regular monthly monitoring of financial and operating plans.							
Calderdale Place lead: Robin Tuddenham						Nominated lead for this risk: No update	
ICB risk appetite	Place risk scores					Rationale for current place score	
CAUTIOUS	Target (Calderdale)			Current (Calderdale)			As a place we are in deficit due to acute pressures. Whilst we are assessing the risk at place level a lot of this is controlled via WY working at DoF level and little influence on this via ICB place team. Its monitored and understood but difficult to influence for the BAF. Target risk score increased from 6 to 9 due to cautious risk appetite.
	Likelihood	3	9	Likelihood	4		
	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	
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?)						Link to place risk register:	
1 Financial Framework as agreed by FIPC.						2163, 2469	
2 Bi-monthly monitoring at CCPB, evidenced in minutes. Detailed board reports.							
Kirklees Place lead: Vicky Dutchburn						Nominated lead for this risk: No update	
ICB risk appetite	Place risk scores					Rationale for current place score	
CAUTIOUS	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. Target risk score increased from 6 to 9 due to cautious risk appetite.
	Likelihood	3	9	Likelihood	4		
	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 Review of Financial position and plans by Kirklees Finance Sub-Committee and ICB Committee, both locally and at a West Yorkshire level.						2. Develop priority setting of resources within Kirklees place (2025/26)	
3 Kirklees & Calderdale Recovery group						3. We have developed a 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 (2025/26)	
4 Collaborative meetings to discuss how services can be undertaken differently to maximise resources						4. We have developed a working group across Kirklees place and neighbouring partners to review all services and spend that can improve the financial position of the Kirklees system (2025/26)	
5 Utilisation of the cross- partner Finance Forum to strengthen ownership of place based solutions.						5. Review of all contracts commissioned by the ICB as to whether they can be stopped	
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							

<p>3 Aligned to West Yorkshire ICB approach to planning and final plan signed off by WY Committees</p>	<p>oration of all contracts commissioned by the ICB as to whether they can be stopped or reduced (2025/26)</p> <p>6. We have developed a PMO process to develop recurrent efficiency schemes to improve the financial sustainability within the current year and future (2025/26)</p> <p>Link to place risk register: 2533</p>
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Leeds		Place lead: Tim Ryley		Nominated lead for this risk: No update		
ICB risk appetite	Place risk scores					Rationale for current place score Due to the current financial pressures there is a significant risk that Leeds Place will fail to operate within current resource envelopes. Target risk score increased from 6 to 9 due to cautious risk appetite.
	Target (Leeds)			Current (Leeds)		
	Likelihood	3	9	Likelihood	4	
CAUTIOUS	Impact	3	Impact	5	20	
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)		
2	Strategic Finance Executive Group			(2) Review of potential opportunities and mitigating financial actions within each organisation and across Place, including delaying/stopping spend, focus on efficiencies and productivity		
3	Financial Framework and controls within each organisation at Place			(3) Integrated Commissioning Executive share plans between LCC and NHS and present jointly to Adults and Health Scrutiny (ongoing).		
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			
			2530			

Wakefield		Place lead: Mel Brown		Nominated lead for this risk: No update		
ICB risk appetite	Place risk scores					Rationale for current place score Due to the current financial pressures there is a real risk that Wakefield Place will fail to operate within current resource envelopes. Target risk score increased from 6 to 9 due to cautious risk appetite.
	Target (Wakefield)			Current (Wakefield)		
	Likelihood	3	9	Likelihood	4	
CAUTIOUS	Impact	3	Impact	5	20	
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 was submitted February 2025)		
2	Monthly monitoring of Wakefield partners financial position to assurance and partnership committees			2. Set financial plans in line with planning guidance (2025/26)		
3	Robust budget setting with place programmes			3. Agree Quality, Improvement and Performance Productivity (QIPP) to identify savings and reduce pressures whilst improving patient quality (2025/26)		
4	Regular sharing of information and agreements via the Integrated Care System Finance Forum			4. Work with all system partners to increase efficiency and effectiveness (2025/26)		
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.					
3	Principles already established at Wakefield District Health and Care Partnership Committee					
			Links to Place Risk Register			
			2329			

WYICB - Board Assurance Framework - ICB and places						Version: 13	9 October 2025
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	
OPEN	Target (ICB)			Current (ICB)			The changes to the arrangements in NHS England, Regions, ICB and providers are now much more aligned, with timescales that are much more likely to deliver capacity and resources in the right places. There are substantial risks of delays causing gaps in capacity, hence the need for agility and prioritisation. The EMT and Board have worked closely with partners to understand and mitigate risks. However, the current arrangement suggest the impact on our work of changes could have a higher impact than the target score. Risk score remains the same.
	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. Structured programme for organisational change overseen by EMT and Board Committees.	
2	Agreed objectives for all directors, including places, cascaded throughout the ICB					2. Organisational development work to across Executives to support level of agility and prioritisation required in current context.	
3	Business planning processes that align capacity to our plans					3. Place Partnership Delivery (led by Anthony Kealy) to support the development of Place model and infrastructure will be implemented by April 2026.	
4	Place partnership intentions received in October 2025 with subsequent development programmes.					4. Co-production with region of the model region and ICB to ensure smooth transition.	
5	MAUs with provider collaboratives specifying their responsibilities for delivery						
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 digital priorities	
2	CEO and director appraisals, with outcome reported to Remuneration and Nominations Committee					2522 - Infrastructure risk	
3	Annual review of governance and statement of internal control, reported through Audit to Board						
4	Outputs of the programme board						
Bradford District and Craven (BD&C)						Place lead: Therese Patten	
						Nominated lead for this risk: Matt Sandford 05.01.26	
ICB risk appetite	Place risk scores					Rationale for current place score	
OPEN	Target (BD&C)			Current (BD&C)			Ongoing vacancy controls and increasing number of vacancies related to the organisational change process means that similar to other Places, Bradford Place is carrying an increased and increasing number of vacancies. A further impact will be felt following the Voluntary Redundancy process, introduced as part of the organisational change programme in Q3. 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.
	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 Oversight 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	System transformation priorities and enablers established through our operating model using a distributed leadership approach					2. Annual business planning process to align resources to required activity/ priorities	
3	Place based lead influence deployment of ICB resource for BDC HCP					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	
4	Corporate Services Review and Difficult Decisions Strategy Delivery Group with scope to review Place level capacity and incorporate investment/ Business Case review.					4. Place level 'difficult decisions' programme to target resources at activity that delivers strategic and financial priorities. Place level prioritisation work well underway, addressing both capacity and priority as well as identifying work that will cease from April 2026 under new ICB operating model, providing updates to Partners where it is felt this work should continue as part of the PPP as well as identifying work that will transfer to central WY ICB teams etc	
5	Difficult Decisions programme has commenced and incorporates all partners across the system. This provides targeted focus on delivery of our efficiency programme whilst identifying risks associated with capacity.					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)	
6	Place Clinical Strategy (Health, Care and Wellbeing Strategy); Place Financial Recovery Plan and ICB Place 'Resource Office' now fully mobilised, focused entirely on ICB capacity and priorities – providing greater oversight and allocation of resource					6. Specific Integrated Neighbourhood Team (INT) development work is underway across the BDC system is ongoing as part of national INHP pilot 2026-27	
7	Developed Health, Care and Wellbeing strategy (clinical strategy) at Place in full co-production with partners including citizens and our workforce. The strategy focuses on clear alignment of services, pathways and models of care driven by population health needs. This strategy will enable us to target and deploy resources in the most effective way. Three strategy delivery boards have been established focused on integrated acute services, integrated neighbourhood services and integrated corporate services, as our core priorities for delivery and resource management across BDC					7. Work has begun locally on the development of a BDC provider collaborative approach with Place Provider Partnership development also underway - to be implemented by April 2026	
8	3 x Strategic Delivery Group meetings (Integrated Acute Care; Integrated Neighbourhood Health & Care; Integrated Corporate Support & Closing the Gap) will bring together all partners across the system to provide greater oversight on delivery of the core priorities we have set out in our health, care and wellbeing strategy.					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	3 x Strategic Delivery Group meetings (Integrated Acute Care; Integrated Neighbourhood Health & Care; Integrated Corporate Support & Difficult Decisions) will bring together all partners across the system to provide greater oversight on delivery of the core priorities we have set out in our health, care and wellbeing strategy. The SDGs report into the Collaboration Programme Board, with senior partnership representatives and WY ICB representatives - with a focus on capacity and capability across place to deliver against standards and priority programmes. The Collaboration Programme Board reports into POE, for full oversight and scrutiny.						
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 out the way we work, including our operating model, SORD and Terms of Reference.						
4	Difficult Decisions programme – Partnership led and supported – Reviewed via System Finance and Performance Committee, Collaboration Programme Board and Partnership Board.						
Calderdale						Place lead: Robin Tuddenham	
						Nominated lead for this risk: No update	
ICB risk appetite	Place risk scores					Rationale for current place score	
OPEN	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
	Likelihood	1	4	Likelihood	4	16	
	Impact			Impact			

OPEN	Impact	4		Impact	4		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 impact on local resource and will work with colleagues to manage impact.
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 transformational priorities.							2. Senior Leadership team continue to monitor risks relating to resource, intensified given NHS changes and 50% cuts.
3 Prioritisation takes place on a weekly basis to assess place workload and ability to respond to asks.							3. Working collaboration with KW partners on sharing resource in difficult situation of zero recruitment and future reduced resource.
Sources of assurance (Where is the evidence that the controls work?)							Link to place risk register:
1 Transformation delivery plan approved by Calderdale Care Partnership Board.							1998, 2484
2 Prioritisation process as part of annual planning round.							
Kirklees							Place lead: Vicky Dutchburn
							Nominated lead for this risk: No update
ICB risk appetite	Place risk scores						Rationale for current place score
	Target (Kirklees)			Current (Kirklees)			
OPEN	Likelihood	1	4	Likelihood	3	12	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 be 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.
	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. Organisational change review ongoing will include a Kirklees integrator function to be consulted on (Q3, 2025/26)
2 Health & Care Executive to support cross sector prioritisation within the Health & Care Partnership							2. Ongoing development prioritisation and review within and across Teams in Kirklees (2025/26)
3 Business planning processes to support confirmation of priorities							3. Specific Integrated Neighbourhood Team (INT) development work across Kirklees system (2025/26)
Sources of assurance (Where is the evidence that the controls work?)							4. Ongoing local development of the Kirklees provider collaborative approach by September 2025.
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.							Link to place risk register:
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.							None
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: No update
ICB risk appetite	Place risk scores						Rationale for current place score
	Target (Leeds)			Current (Leeds)			
OPEN	Likelihood	1	4	Likelihood	4	16	The move to a new Operating Model in April 2024, where Leeds reduced its capacity by 20% was still bedding in when the national announcement was made for reduction in ICB staff by 50%. Leeds was holding a number of vacancies whilst it settled and due to vacancy control they can no longer be filled. The latest organisational change programme is likely to exacerbate this issue. Failure to address these issues is likely and this could lead to a failure to meet national standards, broadening of inequalities, financial distress and regulatory breaches in line with the definitions. Risk score remains the same.
	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. Apr - Mar 2026
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. However the OD plan has been extended to provide support and resilience training to staff during the organisational change (2025/26)
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 LHCP priority programmes and work has been prioritised to take account of diminishing capacity due to both people leaving and people working on the organisational change
Sources of assurance (Where is the evidence that the controls work?)							4. Action plan on staff survey results most pertinent to Leeds, 2025/26
1 Healthy Leeds Plan and Business Plan reviewed monthly in line with LHCP priority work							5. Leeds Directors will continue to review capacity and reprioritise as necessary (2025/26)
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: No update
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. Wakefield place are working with other places and the strategic commissioning functions between June and September 2025 to mobilise a new operating model to go live in April 2026.
	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. Continue to review gaps in strategic capacity across the leadership team at Wakefield and confirm these objectives through PDR processes in the summer of 2025
2 Agreed objectives for all directors							2. Working with partner organisations across Wakefield district to maximise capacity to and to deliver objectives in 2025/26
3 Wakefield place plan agreement in May 2025, signed off objectives and plans for Wakefield district							3. Reviewing everyone's PDR objectives to ensure any areas that need capacity are appropriately addressed such as EDI leadership (End of Summer 2025)
4 Business planning processes that aligns both to the WY ICB 10 ambitions and the Wakefield district plan (annual review)							4. Contributing to the organisational change programme in place across WY ICB to shape the integrator teams 2025/26
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.							

5 Regular one to ones between Accountable officer and Cheif Executive WY ICB	Links to Place Risk Register
	None.

WYICB - Board Assurance Framework - ICB and places						Version: 13	6 October 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		Ian Holmes
Strategic risk 4.1	There is a risk that partnership working on wider societal issues is deprioritised to meet current operational pressures as a result of the organisational change programme and the reduced ICB capacity.					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. The organisational change programme and ICB blueprint will mean that there is significant less capacity within the ICB and a narrower remit. We will need to carefully prioritise our partnership working in this area to maximise value. Increased likelihood from 2 to 3, increasing the risk score from 8 to 12. Target score and risk appetite remains the same.	
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 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. As part of the organisational change programme, we are working to redesign wider partnership governance with partners including local authorities and combined authority.		
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					These governance arrangements will continue to ensure we have the right focus on wider societal issues. 2025/26		
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.							
6	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.							
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					2535 - Organisational change		
2	ICB Board receives six monthly updates on 10 big ambitions - agenda / minutes							
3	SOAG - minutes evidence review of progress against 10 big ambitions							
Bradford District and Craven (BD&C)						Place lead: Therese Patten		
						Nominated lead for this risk: Matt Sandford 05.01.26		
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.	
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. Our reducing inequalities alliance continues to lead the way in identifying our wider determinants and mitigating the impact, including leading on our economic accelerator programme		
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.					2. The BD&C HC&P has now finalised the healthcare and wellbeing strategy and we are now implementing this through revised governance arrangements . This jointly agrees the safe and sustainable service models and pathways across all partners, driven by the health and care needs of our population, ensuring a holistic approach to delivery (2026/27)		
3	Our Difficult Decisions 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)					3. Ongoing development of the Place Provider Partnership model, to ensure ongoing engagement across all partners, aligning resources to target the health inequalities and population health needs of our communities.		
4	People priority include focus on inclusive community recruitment.					Link to place risk register: 2317, 2386, 2221		
5	All district partners (including those outside health and care) have signed up to a new district strategy to improve the wellbeing, both health and economically in Bradford district (2025 - 2028)							
6	3 x Strategic Delivery Groups (Integrated Acute Care; Integrated Neighbourhood Health & Care; Integrated Corporate Support & Difficult Decisions) will bring together all partners across the system to provide greater oversight on delivery of the core priorities we have set out in our health, care and wellbeing strategy. The SDGs report into the Collaboration Programme Board, with senior partnership representatives and WY ICB representatives - with a focus on place level delivery against standards and priority programmes, ensuring achievement of population health improvements. The Collaboration Programme Board reports into POE, for full oversight and scrutiny.							
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: No update		
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. 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	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:		
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					None		
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: Vicky Dutchburn		Nominated lead for this risk: No update		
ICB risk appetite	Place risk scores						Rationale for current place score
	Target (Kirklees)			Current (Kirklees)			
OPEN	Likelihood	2	8	Likelihood	3	12	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, but progress is being made. Uncertainty around ongoing ICB organisational change and what this will mean for local partnership working in Kirklees and the ICBs ongoing role in this as we potentially move to a CKW footprint. Risk score to remain the same.
	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.			
2 Ownership of these 4 strategies assigned to partnership boards or forums.				There is a programme of work agreed for 2025/26 overseeing by the partnership executive.			
3 Partnership Executive in place which includes business, education in addition to health, care and LA.							
Sources of assurance (Where is the evidence that the controls work?)				Link to place risk register:			
1 Reporting to the relevant board/partnership forum on progress against each of the 4 strategies.				None			
2 Use of other partnership forums to support this e.g. Partnership Forum, ICB committee.							
Leeds			Place lead: Tim Ryley		Nominated lead for this risk: No update		
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. 2025/26			
4 Continuing monitoring of metrics by ethnicity and deprivation as routine				4. 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?)				5. Leeds Health and Care Partnership have signed off four priority programmes all with a strong health inequality focus including links to wider social determinants (2025/26)			
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: No update		
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. Risk score remains the same this cycle.
	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 (statutory, voluntary and commercial sectors), which includes plans to improve population health by addressing wider determinants. Plan will be in place by Autumn 2025.			
2 Wakefield Forward Plan includes work to deliver Health and Wellbeing Board priorities				2. The bid to the local investment panel supported protection for the previous Core 20 plus 5 funding but not protecting all of the uncommitted resource.			
3 Core20plus5 funding directed to addressing social determinants, to be confirmed via the investment panel for 2025/26.							
Sources of assurance (Where is the evidence that the controls work?)				Link to Place Risk Register			
1 Regular reports to Health and Wellbeing Board & Wakefield District Health and Care Partnership Committee on work to address priorities				None.			
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							
3 Impact of investment in Core20plus5 programmes was reported to Wakefield District Health and Care Partnership Committee November 2023							

WYICB - Board Assurance Framework - ICB and places						Version: 13	6 October 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	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)			
BOLD	Likelihood	2	8	Likelihood	3	12	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.
	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) Equity and Fairness Strategy was approved Partnership Board in January 2025. This will be overseen by the Partnership Board including a number of objectives for delivery by the Partnership Board. Transformation Committee will oversee ICB actions in relation to the strategy.	
2	Development of commissioning intentions that reflect our ambitions around equity and fairness.					(2) The Race Equality Review undertaken in 2020 will be reviewed by Donna Kinnair during 2025/26. The findings reported to the Partnership Board in January 2025 and actions identified were included in the Equity and Fairness Strategy.	
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						
8	Transformation Committee discussion and oversight of strategy action plan.						
Bradford District and Craven (BD&C) Place lead: Therese Patten						Nominated lead for this risk: Kez Hayat 08.01.26	
ICB risk appetite	Place risk scores						Rationale for current place score
	Target (BD&C)			Current (BD&C)			
BOLD	Likelihood	2	8	Likelihood	3	12	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'. Risk reviewed and the risk score remains the same.
	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. 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.					Continue with three priorities which align with the WY ICB strategic equality objectives; 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	A comprehensive equality impact assessment has been developed with a mitigating action plan ensuring ethnically diverse staff are adequately supported throughout the organisational change process					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	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.					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.	
Sources of assurance (Where is the evidence that the controls work?)						Link to place risk register:	
1	Minutes of the Bradford EDI group					None	
2	Assurance provided via Partnership Oversight Executive - Minutes						
3	BDC Extended Leadership Team meeting, minutes.						
4	NHSE website for WRES and WDES data. WYICB PSED report on website						
Calderdale Place lead: Robin Tuddenham						Nominated lead for this risk: No update	
ICB risk appetite	Place risk scores						Rationale for current place score
	Target (Calderdale)			Current (Calderdale)			
BOLD	Likelihood	2	8	Likelihood	3	12	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.
	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. Supporting the EDI strategy in West Yorkshire (2025/26)	
Sources of assurance (Where is the evidence that the controls work?)						Link to place risk register:	
1	Outcomes of staff survey is discussed at Calderdale senior leadership team meetings					None	
Kirklees Place lead: Vicky Dutchburn						Nominated lead for this risk: No update	
ICB risk appetite	Place risk scores						Rationale for current place score
	Target (Kirklees)			Current (Kirklees)			
BOLD	Likelihood	2	8	Likelihood	3	12	Place have history of tackling issues related 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.
	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 (assurance). This will be overseen by the Partnership Board including a number of objectives which have been developed for delivery by the WY Partnership Board. The Kirklees objectives of the EDI strategy have been developed and agreed and work is progressing (2025/26)	
2	EQIAs embedded as part of PMO functions						
3	Community champions / Community voices						
Sources of assurance (Where is the evidence that the controls work?)						Link to place risk register:	
1	ICB (Kirklees) self-assessment against the ICF during 2025/26 (last completed 2023)					None	
2	Examples of EQIAs and subsequent action / mitigation						
3	Examples of voice and influence from diverse population in planning and transformation						

Leeds		Place lead: Tim Ryley				Nominated lead for this risk: No update	
ICB risk appetite	Place risk scores						Rationale for current place score
	Target (Leeds)			Current (Leeds)			
	Likelihood	2	6	Likelihood	3	9	
BOLD	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 Compliance with the requirements of the Equality Act 2010 Public Sector Duties in relation to our workforce and commissioning responsibilities.						1. Supporting the EDI strategy in West Yorkshire (2025/26) and leading on the development of Leeds EDI priorities	
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.						2. Increased focus on personal wellbeing within objective setting which will include EDI components (2025/26)	
3 Integration of our Equality Impact Assessment and Quality and Equality Impact Assessment within all decision making processes						3. On going improvement and development in relation to the integration of Equality Impact Assessments within the business process cycle and all decision making processes	
4 Ongoing interaction/partnership working in relation to our insights, communication and involvement team and equality, diversity, and inclusion.						Link to place risk register: 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 and in relation to decisions.							
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.							
Wakefield		Place lead: Mel Brown				Nominated lead for this risk: No update	
ICB risk appetite	Place risk scores						Rationale for current place score
	Target (Wakefield)			Current (Wakefield)			
	Likelihood	2	8	Likelihood	3	12	
BOLD	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 and other cohorts continuing (2025/26)	
2 Local equality objectives in place						2. Supporting delivery of WY wide equality and fairness strategy through localised objectives. The delivery will be monitored via the People Panel.	
3 Work programme to ensure compliance with Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), Public Sector Equality Duty (PSED)						3. Workforce alliance has a dedicated pillar of work in addressing equality, diversity and inclusion in all aspects of workforce, recruitment, development and training (2025/26)	
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							
6 Communication, Involvement and EDI at place							
Sources of assurance (Where is the evidence that the controls work?)						Link to place risk register: None.	
1 People panel (partnership committee) receives and scrutinises delivery of equality agenda							
2 Formal reports - WRES,DES, PSED, Equality Delivery System to People Panel							
3 Equality and fairness strategy has been presented to the People Panel, to place management team and Healthcare Inequalities Steering Group							

WYICB - Board Assurance Framework - ICB (no requirement for places to complete)						Version: 13	7 October 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	Shaukat Ali Khan/ Lou Auger
Strategic risk 4.3	There is a risk that threatens 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 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. Evaluating impact of recent NHS structural changes and the delivery of digital data and technology mandate across the ICB (2025-27)	
2 Training at senior level - Principles of Health Command Training - Strategic Health Commander						2. Consolidation of BI and GPIT (2025-27)	
3 WY CIO Forum inc Place CIOs						3. To ensure resilience of the ICB on-call rota, we are consulting on a new potential structure which we will take to Social Partnership Forum (SPF) on 28 October 2025 for discussion and wider consultation with staff throughout November 2025.	
4 System Winter Plan with mitigating actions for surge and escalation inc Strategic Coordination Centre						4. We are currently reviewing the learning following business continuity incidents impacting on some GP practices in Bradford and Craven from which the learning will be used to inform our West Yorkshire EPRR processes (Update SOAD in Nov and full report in December 2025).	
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.							
9 EPRR Team have completed testing and exercising of business continuity plans in March 2025							
10 Directorates and Places have completed Business Impact Assessments in June 2025 to support further development of business continuity plans.							
11 Data Security Protection Toolkit in Apr 2025 is complete.							
12 Cyber Security Discovery exercise is complete: we have undertaken a cyber security discovery to identify risks and mitigation to improve cyber security resilience. An action plan has been developed and implementation by June 2025.							
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						2547 - industrial action	
2 Minutes of Audit Committee and Internal Audit Meetings						2036 - Airedale Hospital structural RAAC	
3 WY EPRR exercises - outputs, from papers and Mins.						2166 - Risk of a successful cyber attack, hack and data breach on ICB.	
4 Significant learning from incidents						2234 - Risk of cyber attack on commissioned services	
5 Regular reporting on progress with DSPT annual self-assessment to WY ICB Audit Committee and internal audit assurance of DSPT submission						2295 - Business continuity arrangements	

WYICB - Board Assurance Framework - ICB (no requirement for places to complete)				Version: 13		6 October 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		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)				
OPEN	Likelihood	4	12	Likelihood	4	16	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).	
	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			1. There is a degree of uncertainty on future roles and responsibilities in relation to the green agenda as set out in the ICB blueprint. We will continue to work closely with partners to ensure that any changes in role and responsibilities is managed effectively.				
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.							
6	NHS greener plan was agreed in principle at the September 2025 Board meeting.							
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							

Meeting name:	Leeds Committee of the ICB
Agenda item no.	18
Meeting date:	11 February 2026
Report title:	Changes to NHS West Yorkshire ICB Governance Arrangements for 2026/27 (transitional year) and Committee Year End Arrangements for 2025/26
Report presented by:	Sue Baxter, Head of Partnership Governance
Report approved by:	Tim Ryley, Accountable Officer – Leeds
Report prepared by:	Sue Baxter, Head of Partnership Governance WY ICB

Purpose and Action			
Assurance <input type="checkbox"/>	Decision <input checked="" type="checkbox"/> (approve/recommend/ support/ratify)	Action <input checked="" type="checkbox"/> (review/consider/comment/ discuss/escalate)	Information <input type="checkbox"/>
Previous considerations:			
<p>NHS West Yorkshire ICB Board – October 2025 development session; and</p> <p>NHS West Yorkshire ICB Board meeting 16 December 2026 – part of ICB Constitution changes item 23</p>			
Executive summary and points for discussion:			
<p>The current operating context is informed by two areas: firstly, on 1 April 2025, Working together in 2025/26 to lay the foundations for reform letter from Sir James Mackey (CEO, NHS England) outlined the requirement placed on ICBs to reduce costs by 50% with ICBs’ primary focus becoming strategic commissioners. Secondly, through 2026/27 transitional year emerging place provider partnerships will prepare to sign an NHS contract with the ICB for the provision of in-scope services. Taking account of the operating context, the Leeds Memorandum of Understanding (MoU) and governance handbook will support arrangements through this transitional year (2026/27).</p> <p>Changes to Governance Arrangements for the 2026/27 Transitional Year</p> <p>During 2026/27, the transitional year, delegation from NHS West Yorkshire ICB Board to Leeds place will remain via the Leeds Committee of the ICB (a committee of the ICB). The following changes are proposed to the ICB governance arrangements in Leeds (place):</p> <ul style="list-style-type: none"> Leeds Committee’s composition (chair and membership) and focus of responsibilities will be reduced to ensure that this committee of the ICB Board only undertakes decisions that it is required to discharge to enable the smooth transition; 			

- Leeds Committee will continue to meet throughout 2026/27 on a quarterly basis and will cease to meet once the emergent Place Provider Partnership has agreed and signed an NHS Contract with NHS West Yorkshire ICB for in-scope services. The expectation is that this will be by 31 March 2027;
- Leeds Committee will no longer be meeting for Development Sessions; and
- Sub-committees of the Leeds Committee of the ICB will cease by 31 March 2026, including:
 - Quality and People’s Experience Sub-Committee
 - Finance, Value and Performance Sub-Committee
 - All other sub-committees/groups with accountability to the Leeds Committee that do not form part of the Leeds Place Provider Partnership governance arrangements

Year End Arrangements for 2025/26

The committee’s terms of reference require it to produce an annual report, to be submitted to the West Yorkshire ICB Board. Alongside this, the committee would normally review its terms of reference at year end and recommend any changes to the board, as well as developing a work plan for the ensuing year, also for submission to the board.

Given the transitional arrangements outlined above, and the need for documents to be submitted to the ICB board for 24 March 2026, the following streamlined arrangements are proposed for the 2025/26 year-end processes:

- To inform the content of the committee’s annual report, a brief discussion will be held at today’s meeting considering the following questions:
 - What has the committee achieved this year?
 - What challenges did the committee face this year and how were they overcome?
 - What key learning has resulted from this year?
- The annual report will then be drafted by the committee’s Governance Lead in consultation with the Chair and Accountable Officer, and the approval of the final version will be delegated to the Chair and Accountable Officer;
- The draft terms of reference for the reconstituted Leeds Committee of the ICB are attached for discussion/comment prior to being submitted to the ICB Board for approval; and
- An indicative draft work plan for 2026/27 is attached for discussion/comment prior to being submitted to the ICB Board.

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)
<p>The Leeds Committee of the ICB is asked to:</p> <ol style="list-style-type: none"> 1. AGREE and SUPPORT the actions to change the Leeds Committee of the ICB governance arrangements by 31 March 2026, in preparation for the 2026/27 transitional year; 2. CONSIDER the content of its 2025/26 Annual Report in the context of the three questions set out above, and comment as necessary on the draft terms of reference and indicative draft work plan for the reconstituted committee; and 3. DELEGATE the approval of the final version of the Leeds Committee Annual Report 2025/26 to the Chair and Accountable Officer.
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:
None specifically.
Appendices
<ol style="list-style-type: none"> 1. Draft terms of reference for the reconstituted Leeds Committee of the ICB. 2. Indicative draft work plan for 2026/27.
Acronyms and Abbreviations explained
<ol style="list-style-type: none"> 1. ICB – NHS West Yorkshire Integrated Care Board 2. MoU – Memorandum of Understanding

What are the implications for

Residents and Communities	Delegation arrangements support our commitment to meet the health needs of our residents and communities and are changing to support the transition to enable emergent Place Provider Partnerships.
Quality and Safety	Provider Partnerships are developing governance arrangements to provide assurance on quality and financial implications of their considerations.
Equality, Diversity and Inclusion	Committees are required to consider the equality, diversity and inclusion implications of all decisions. No specific implications have been identified from this report.
Finances and Use of Resources	Provider Partnerships are developing governance arrangements to provide assurance on financial and quality implications of their considerations.

Regulation and Legal Requirements	Arrangements are designed to comply with regulation and legal requirements
Conflicts of Interest	The approach to conflicts of interest set out within the ICB Conflicts of Interest Policy, Standards of Business Conduct Policy, and within the Conflicts of Interest schedules appended to each partnership agreement.
Data Protection	There are no specific data protection implications arising from this report.
Transformation and Innovation	There are no specific transformation or innovation implications arising from this report.
Environmental and Climate Change	None identified.
Future Decisions and Policy Making	Partnership agreements are designed to support agile decision making.
Citizen and Stakeholder Engagement	Approach set in the ICB involvement framework.

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

Version control

Version:	5.0 <u>5.01</u>
Approved by:	West Yorkshire Integrated Care Board
Date Approved:	24 June 2025 <u>TBC</u>
Responsible Officer:	Accountable Officer <u>Director of Integration</u> (Leeds)
Date Issued:	25 June 2025 <u>TBC</u>
Date to be reviewed:	June 2026 <u>January 2027</u>

Change history

Version number	Changes applied	By	Date
0.1	Initial draft	Laura Ellis	21.09.21
0.2	Review	Stephen Gregg	29.09.21
0.3	Review	Leeds Governance Network – Place amends	02.11.21
0.4	Review	Sam Ramsey	27.04.22
0.5	Admission from press and public amends	Sam Ramsey	16.06.22
2.0	Annual review	Sam Ramsey	June 2023
3.0	Annual review	Harriet Speight	April 2024
4.0	Annual review	Harriet Speight	April 2025
4.1	Approved by Leeds Committee of the ICB for submission to ICB Board for approval.	Leeds Committee of the ICB	21 May 2025
5.0	APPROVED	WY ICB Board	24 June 2025
<u>5.1</u>	<u>Amendments in preparation for transitional year 2026/27</u>	<u>Nick Lamper</u>	<u>3 February 2026</u>

1. Introduction

- 1.1 The Leeds Committee is established as a committee of the West Yorkshire Integrated Care Board (ICB), in accordance with the ICB's Constitution, Standing Orders and Scheme of Delegation.
- 1.2 These terms of reference, which must be published on the ICB website, set out the remit, responsibilities, membership and reporting arrangements of this Committee and may only be changed with the approval of the ICB Board. The Committee has no executive powers, other than those specifically delegated in these terms of reference.
- 1.3 The ICB is part of the West Yorkshire Integrated Care System, which has identified a set of guiding principles that shape everything we do:
 - We will be ambitious for the people we serve and the staff we employ.
 - The West Yorkshire partnership belongs to its citizens and to commissioners and providers, councils and NHS. We will build constructive relationships with communities, groups and organisations to tackle the wide range of issues which have an impact on health inequalities and people's health and wellbeing.
 - We will do the work once – duplication of systems, processes and work should be avoided as wasteful and potential source of conflict.
 - We will undertake shared analysis of problems and issues as the basis of taking action.
 - We will apply subsidiarity principles in all that we do – with work taking place at the appropriate level and as near to local as possible.
- 1.4 The ICS has committed to behave consistently as leaders and colleagues in ways which model and promote our shared values:
 - We are leaders of our organisation, our place and of West Yorkshire.
 - We support each other and work collaboratively.
 - We act with honesty and integrity, and trust each other to do the same.
 - We challenge constructively when we need to.
 - We assume good intentions; and
 - We will implement our shared priorities and decisions, holding each other mutually accountable for delivery.
- 1.5 The Leeds Health and Care Partnership have a shared bold ambition: Leeds will be the best city for health and wellbeing.
- 1.6 Our clear vision is: Leeds will be a healthy and caring city for all ages, where people who are the poorest improve their health the fastest.
- 1.7 We have also agreed a number of partnership principles:

- We start with people – working with people instead of doing things to them or for them, maximising the assets, strengths and skills of Leeds’ citizens, carers and workforce.
 - Have ‘Better Conversations’ – equipping the workforce with the skills and confidence to focus on what’s strong rather than what’s wrong through high support, high challenge, and listening to what matters to people
 - ‘Think Family’ – understand and coordinate support around the unique circumstances adults and children live in and the strengths and resources within the family
 - Think ‘Home First’ – supporting people to remain or return to their home as soon as it is safe to do so
- We deliver – prioritising actions over words. Using intelligence, every action focuses on what difference we will make to improving outcomes and quality and making best use of the Leeds £.
 - Make decisions based on the outcomes that matter most to people
 - Jointly invest and commission proportionately more of our resources in first class primary, community and preventative services whilst ensuring that hospital services are funded to also deliver first class care
 - Direct our collective resource towards people, communities and groups who need it the most and those focused on keeping people well
- We are Team Leeds – working as if we are one organisation, being kind, taking collective responsibility for and following through on what we have agreed. Difficult issues are put on the table, with a high support, high challenge attitude.
 - Unify diverse services through a common culture
 - Be system leaders and work across boundaries to simplify what we do
 - Individuals and teams will share good practice and do things once

2. Membership

2.1 This part of the terms of reference describes the membership of the Leeds Committee of the West Yorkshire ICB. Further information about the criteria for the roles and how they are appointed is documented separately.

2.2 Core membership

2.2.1 The membership of the Committee will be as follows:

- ~~Independent~~ West Yorkshire Non-Executive Member (Chair)
- ~~Independent Member~~ — Finance

- ~~Independent Member – Health Inequalities and Delivery~~
- Healthwatch Representative
- Executive Members ~~(Leeds Office of the WY ICB)~~
 - ICB Director of Integration (Leeds) Place Lead
 - ICB ~~Leeds~~ Finance Lead
 - ICB ~~Leeds Nurse~~ Quality Lead
 - ~~ICB Leeds Medical Officer~~
- Partner Members
 - 1 x Leeds Teaching Hospitals Trust
 - 1 x Leeds & York Partnership Foundation Trust
 - 1 x Leeds Community Healthcare Trust
 - 1 x Leeds City Council - Adult Social Care
 - 1 x Leeds City Council – Children and Families
 - 1 x Primary Care
 - 1 x Third Sector
 - 1 x Director of Public Health

2.3 Required attendees

- ~~None.~~ ICB Deputy Director of Integration

2.4 ICB officers may request or be requested to attend the meeting when matters concerning their responsibilities are to be discussed or they are presenting a paper.

2.5 Any member of the ICB Board can be in attendance subject to agreement with the Chair.

3. Arrangements for the conduct of business

3.1 Chairing meetings

The meetings will be run by the chair. In the event of the chair of the committee being unable to attend all or part of the meeting, the remaining members of the committee should appoint a chair for the meeting.

3.2 Quoracy

No business shall be transacted unless at least 50% of the membership is present. The quorum is 87 individuals. This must include representation from the following as a minimum:

- ~~The Chair or his/her nominated Deputy Chair~~
- At least one ~~independent~~ WY non-executive member/chair
- ~~ICB Place Lead or ICB Place Finance Lead~~ At least one executive member
- ~~ICB Place Nurse Lead or ICB Place Medical Officer~~
- At least two partner members

For the sake of clarity:

- a) No person can act in more than one capacity when determining the quorum.
- b) An individual who has been disqualified from participating in a discussion on any matter and/or from voting on any motion by reason of a declaration of a conflict of interest, shall no longer count towards the quorum.

Members of the Committee may participate in meetings by telephone, video or by other electronic means where they are available and with the prior agreement of the Chair. Participation by any of these means shall be deemed to constitute presence in person at the meeting.

Members are normally expected to attend at least 75% of meetings during the year.

With the permission of the person presiding over the meeting, the Executive Members and the Partner Members of the Committee may nominate a deputy to attend a meeting of the Committee that they are unable to attend. The deputy may speak and vote on their behalf. The decision of the person presiding over the meeting regarding authorisation of nominated deputies is final.

3.3 Voting

In line with the ICB's Standing Orders, it is expected that decisions will be reached by consensus. Should this not be possible, each voting member of the Committee will have one vote, the process for which is set out below:

- a. All members of the committee who are present at the meeting will be eligible to cast one vote each. (For the sake of clarity, members of the committee are set out at paragraph 2.2.1; attendees and observers do not have voting rights.)
- b. Absent members may not vote by proxy. Absence is defined as being absent at the time of the vote, but this does not preclude anyone attending by teleconference or other virtual mechanism from exercising their right to vote if eligible to do so.
- c. A resolution will be passed if more votes are cast for the resolution than against it.
- d. If an equal number of votes are cast for and against a resolution, then the Chair (or in their absence, the person presiding over the meeting) will have a second and casting vote.
- e. Should a vote be taken, the outcome of the vote, and any dissenting views, must be recorded in the minutes of the meeting.

Conflict resolution

The Leeds Memorandum of Understanding sets out a dispute resolution process~~Committee will be expected to reach a consensus when agreeing matters of business. This will mean that core members are expected to compromise and demonstrate the behaviours listed within the Terms of Reference.~~

~~If the group cannot reach a consensus on a specific matter, the group will consider inviting an independent facilitator to assist with resolving the specific matter.~~

3.4 Frequency of meetings

The Committee will normally meet quarterly~~no less than four times in a 12 month period in public. Development sessions may also be held throughout the year.~~

The Chair may call an additional meeting at any time by giving not less than 14 calendar days' notice in writing to members of the Committee.

One third of the members of the Committee may request the Chair to convene a meeting by notice in writing, specifying the matters which they wish to be considered at the meeting. If the Chair refuses, or fails, to call a meeting within seven calendar days of such a request being presented, the Committee members signing the requisition may call a meeting by giving not less than 14 calendar days' notice in writing to all members of the Committee specifying the matters to be considered at the meeting.

In emergency situations the Chair may call a meeting with two days' notice by setting out the reason for the urgency and the decision to be taken.

3.5 Urgent decisions

In the case of urgent decisions and extraordinary circumstances, every attempt will be made for the Committee to meet virtually. Where this is not possible the following will apply:

- a) The powers which are delegated to the Committee, may for an urgent decision be exercised by the Chair of the Committee and the Director of Integration (Leeds)~~ICB Place Lead~~. If the Chair of the Committee is not an independent non-executive member, then such an individual must also be consulted.
- b) The exercise of such powers shall be reported to the next formal meeting of the Committee for formal ratification, where the Chair will explain the reason for the action taken, and the ICB Audit Committee for oversight.

3.6 Admission of the press and public

Meetings of the Committee will be open to the public.

The Committee may resolve to exclude the public from a meeting or part of a meeting where it would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings.

The chair of the meeting shall give such directions as he/she thinks fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Committee's business shall be conducted without interruption and disruption.

The public may be excluded from a meeting to suppress or prevent disorderly conduct or behaviour.

Matters to be dealt with by a meeting following the exclusion of representatives of the press, and other members of the public shall be confidential to the members of the Committee.

A public notice of the time and place of the meeting and how to access the meeting shall be given by posting it at the offices of the ICB body and electronically at least seven calendar days before the meeting or, if the meeting is convened at shorter notice, then at the time it is convened.

The agenda and papers for meetings will be published electronically in advance of the meeting excluding, if thought fit, any item likely to be addressed in part of a meeting is not likely to be open to the public.

3.7 Declarations of interest

If any member has an interest, financial or otherwise, in any matter and is present at the meeting at which the matter is under discussion, he/she will declare that interest as early as possible and act in accordance with the ICB's Conflicts of Interests Policy. Subject to any previously agreed arrangements for managing a conflict of interest, the chair of the meeting will determine how a conflict of interest should be managed. The chair of the meeting may require the individual to withdraw from the meeting or part of it. The individual must comply with these arrangements, and actions taken in mitigation will be recorded in the minutes of the meeting.

3.8 Support to the Committee

[The committee's lead manager is the Director of Integration \(Leeds\).](#)

Administrative support will be provided to the Committee by the ICB. This will include:

- Agreement of the agenda with the Chair in consultation with the ~~ICB~~ ~~Place~~-Lead Manager, taking minutes of the meetings, keeping an accurate record of attendance, management and recording of conflicts of interest, key points of the discussion, matters arising and issues to be carried forward.
- Maintaining an on-going list of actions, specifying members responsible, due dates and keeping track of these actions.
- Sending out agendas and supporting papers to members five working days before the meeting.
- Minutes to be drafted and quality checked by appropriate Head of/Director within 10 working days. Draft minutes will then be sent to Chair/Lead Director with a request to be reviewed and approved within 5 working days. Draft minutes will then be distributed to all attendees of the meeting following approval by the Chair within one calendar month of the meeting.
- An annual work plan to be updated and maintained on a monthly basis.

4. Remit and responsibilities of the Committee

NHS West Yorkshire ICB's operating model and governance framework has changed to reflect the requirements of all ICBs to become Strategic Commissioners. Through 2026/27 transitional year decision making will continue to be discharged through ICB delegation and therefore Place Committees will continue to meet on a quarterly basis. They will run alongside evolving place provider collaborative governance.

The Leeds Committee of the WY ICB has been provided with delegated authority to make decisions about the use of NHS resources in Leeds, including the agreement of contracts for relevant services. The decisions reached are the decisions of the ICB, in line with the organisation's scheme of delegation.

The West Yorkshire Integrated Care Board high level Scheme of Reservation and Delegation (SoRD) is attached at Appendix 1 and outlines those responsibilities that will be delegated to a Committee or Sub-Committee.

5. Authority

- 5.1 The Committee is authorised to investigate any activity within its terms of reference. It is authorised to seek any information it requires within its remit,

from any employee of the ICB and they are directed to co-operate with any such request made by the Committee.

- 5.2 The Committee is authorised to commission any reports or surveys it deems necessary to help it fulfil its obligations.
- 5.3 The Committee is authorised to obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary. In doing, so, the Committee must follow procedures put in place by the ICB for obtaining legal or professional advice.
- 5.4 The Committee is authorised to create sub-committees or working groups as are necessary to fulfil its responsibilities within its terms of reference. The Committee may not delegate executive powers delegated to it within these terms of reference (unless expressly authorised by the ICB Board) and remains accountable for the work of any such group.

6. Reporting

- 6.1 The Committee shall submit its minutes to each formal ICB Board meeting.
- 6.2 The ~~Leeds ICB Place Lead~~Chair shall draw to the attention of the ICB Board any significant issues or risks relevant to the ICB. The Committee will review all strategic risks on the Place Board Assurance Framework and provide assurance to the Board on the management of these risks.
- 6.3 The Committee's minutes will be published on the ICB website once ratified.
- 6.4 The Committee shall submit an annual report to the ICB Audit Committee and the ICB.
- 6.5 The Committee will receive for information the Alert, Assure and Advise (AAA) reports of sub-committee meetings.

7. Conduct of the committee

- 7.1 All members will have due regard to and operate within the Constitution of the ICB, Standing Orders, standing financial instructions and Scheme of Delegation.
- 7.2 Members must demonstrably consider the equality and diversity implications of decisions they make and consider whether any new resource allocation achieves positive change around inclusion, equality and diversity.
- 7.3 Members of the Committee will abide by the 'Principles of Public Life' (The Nolan Principles) and the NHS Code of Conduct.
- 7.4 The Committee shall agree an Annual Work Plan with the ICB Board.
- 7.5 The Committee shall undertake an annual self-assessment of its own performance against the annual plan, membership and terms of reference.

This self-assessment shall form the basis of the annual report from the Committee.

7.6 Any resulting changes to the terms of reference shall be submitted for approval by the ICB Board.

7.7 Behaviours and practice all members will demonstrate (TBC)

- Act across the Leeds health and care system in line with Nolan's Seven Principles of Public Life: Selflessness, Integrity, Objectivity, Accountability, Openness, Honesty, Leadership.
- Act in the best interests of the population of Leeds.
- Resolve differences between members and present a united front in the best interests of the people of Leeds.
- Openness and transparency in discussions.
- Hold each other to account.
- Offer constructive challenge to improve service delivery and ensure financial balance.
- Openness and transparency in decision making, being explicit of when not agreeing/supporting a decision.
- Undertake the necessary discussions within their own organisations prior to the group meeting in order to make decisions within the meeting.

8. Equality

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

Leeds Committee of the ICB
2026/27 Work Plan

Item	Frequency	Purpose	Lead	Source	May 2026	Aug 2026	Nov 2026	Feb 2027
Opening Items:								
Welcome, introductions, apologies and confirmation of quorum	Each meeting	To note	Chair, WY NEM	Verbal	X	X	X	X
Declarations of interest		Update	Chair, WY NEM	Verbal and link to register	X	X	X	X
<ul style="list-style-type: none"> Draft minutes of the previous meeting for approval Action log/matters arising Previous Leeds Committee of the ICB AAA Report 		Approval	Chair, WY NEM	Paper	X	X	X	X
<ul style="list-style-type: none"> Approve minutes of Leeds Provider Partnership monthly meetings 		Ratification	Director of Integration (Leeds)	Paper	X	X	X	X
Public questions		Information	Chair, WY NEM	Verbal	X	X	X	X
Focus items								
Financial and operational planning round 2026/27					X			X
Financial and operational planning round 2027/28								X
Place-based Provider Partnership Self-Assessment Framework review of readiness for formal contracting arrangement							X	

Item	Frequency	Purpose	Lead	Source	May 2026	Aug 2026	Nov 2026	Feb 2027
WY ICB and Leeds Place-Based Provider Partnership Contract Agreement for in-scope services, and governance arrangements							X	
Any other recommendations for decision taking on service changes that may need to be considered	Ad hoc	Recommendations for approval using ICB Delegation	Director of Integration (Leeds)					
Governance and Assurance:								
Leeds Provider Partnership Memorandum of Understanding	Annual	Assurance/approval	Sam Ramsey, Senior Partnership Development Lead (ICB in Leeds)	Paper	X			
Governance handbook including Leeds Provider Partnership Joint Committee ToR	Annual	Assurance/approval	Sam Ramsey, Senior Partnership Development Lead (ICB in Leeds)	Paper	X			
Leeds Committee of the ICB Annual Report 2025/26	Annual	Assurance/approval	Sue Baxter, Head of Partnership Governance	Paper	X			
Approval of Annual Reports <ul style="list-style-type: none"> Quality and People's Experience Sub-Cttee Finance, Value and Performance Sub-Cttee 	Annual	Assurance/approval	Sue Baxter, Head of Partnership Governance	Paper	X			
Leeds Risk Register and ICB Board Assurance Framework: Place close down report	One	Assurance/approval	Asma Sacha, Risk Manager	Paper	X			
Closing Items:								
Any other business	Each meeting	Discussion	Chair, WY NEM	Verbal	X	X	X	X
AAA Report to NHS West Yorkshire ICB Board		Discussion	Chair, WY NEM	Verbal	X	X	X	X
Date and Time of Next Meeting		Information	Chair, WY NEM	Verbal	X	X	X	