Leeds Health & Care Partnership

NHS West Yorkshire Integrated Care Board

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

Wednesday 21 May 2025, 13:15 until 16:30
(Private pre-meet for members 13:00, public meeting 13:15)
HEART: Headingley Enterprise & Arts Centre, Bennett Rd, Headingley, Leeds, LS6 3HN

AGENDA

No.	Item	Lead	Page	BAF Link	Time
LC 01/25	**Welcome, Introductions**	**Rebecca Charlwood** Independent Chair	-	N/A	13:15
LC 02/25	**Apologies and Declarations of Interest** - To note and record any apologies - A register of interests of members can be found at mydeclarations.co.uk. Once redirected to the portal, please select 'filter', and in the 'All decision-making groups' field, select 'Leeds Committee of the WYICB' from the drop-down box.	**Rebecca Charlwood** Independent Chair	-	N/A	-
LC 03/25	**Minutes of the Previous Meeting** - To approve the minutes of the meeting held 26 February 2025	**Rebecca Charlwood** Independent Chair	4	N/A	-
LC 04/25	**Matters Arising** - To consider any outstanding matter arising from the minutes that is not covered elsewhere on the agenda	**Rebecca Charlwood** Independent Chair	-	N/A	-
LC 05/25	**Action Tracker** - To note any outstanding actions	**Rebecca Charlwood** Independent Chair	12	N/A	-
LC 06/25	**People's Voice** - To receive a lived experience of health care services in Leeds: Abdul's Story.	**Healthwatch Leeds Co-Chair**	-	-	13:20
LC 07/25	**Questions from Members of the Public** - To receive questions from members of the public in relation to items on the agenda	**Rebecca Charlwood** Independent Chair	-	N/A	13:35
LC 08/25	**Place Lead Update** - To receive a verbal update from the Place Lead - To note the Model ICB Blueprint	**Tim Ryley** Place Lead	-	N/A	13:45
ROUTINE REPORTS					

No.	Item	Lead	Page	BAF Link	Time
LC 09/25	**Quality & People's Experience Sub-Committee Update** - To receive an assurance report from the Chair of the sub-committee	**Rebecca Charlwood** Independent Chair & Chair of the Quality and People's Experience Sub-Committee	14	-	14:00
LC 10/25	**Finance, Value & Performance Sub-Committee Update** - To receive an assurance report from the Chair of the sub-committee	**Cheryl Hobson** Independent Member & Chair of Finance, Value & Performance Sub-Committee	17	-	14:05
FINANCE					
LC 11/25	**End of Year Finance Update for 2024/25 and Progress on Plans for 2025/26** - To receive an update on the financial position at the end of 2024/25 - To receive the final financial plan submission for 2025/26	**Alex Crickmar** Director of Operational Finance	20	3.2	14:10
BREAK 14:35 – 14:45					
ITEMS FOR DECISION / ASSURANCE / STRATEGIC UPDATES					
LC 12/25	**Neighbourhood Working Guidance 2025/26** - To receive an update on the national guidance for neighbourhood working	**Nicola Nicholson** Associate Director for Strategy & Programmes	53	1.3	14:45
13/25	**Oulton Medical Centre: Application to transfer services from Swillington Health Practice** - To approve the merger of services	**Kirsty Turner** Associate Director of Primary Care	64	3.1	15:05
14/25	**Consolidating VCSE Mental Health Contracts** **a) Community Support and Social Recovery** - To approve the contract award **b) Employment and Peer Support** - To approve the contract award	**Helen Lewis** Director of Pathway and System Integration	110 124	1.3	15:20
GOVERNANCE / RISK MANAGEMENT					
LC 15/25	**Leeds Health and Care Partnership Memorandum of Understanding (MoU)** - To review and agree the updated MoU	**Sam Ramsey** Senior Partnership Development Lead	139	-	15:45

No.	Item	Lead	Page	BAF Link	Time
LC 16/25	**Annual Governance Review** - To review the annual report of the Leeds Committee and the amended terms of reference, prior to submission to the WY ICB - To review the annual reports and approve amended terms of reference for each of the sub-committees	**Sue Baxter** Head of Partnerships Governance	176	-	15:50
LC 17/25	**High Level Risk Report: Cycle 1 2025/26 (April 2025 – June 2025)** - To receive and consider the risk management information provided	**Tim Ryley** Place Lead Supported by: **Asma Sacha** Risk Manager	233	All	16:05
FORWARD PLANNING					
LC 18/25	**Items for the Attention of the ICB Board** - To identify items to which the ICB Board needs to be alerted, which it needs to be assured, which it needs to action and positive items to note	**Rebecca Charlwood** Independent Chair	-	N/A	16:15
LC 19/25	**Forward Workplan 2025/26** - To consider the workplan and any further items to be added	**Rebecca Charlwood** Independent Chair	260	-	16:20
LC 20/25	**Any Other Business** - To discuss any other business	**Rebecca Charlwood** Independent Chair	-	N/A	16:25
LC 21/25	**Date and Time of Next Meeting** The next meeting of the Leeds Committee of the WY ICB will be held on 3 September 2025 13:15 – 16:30 (private pre-meet for members 13:00, public meeting 13:15)	**Rebecca Charlwood** Independent Chair	-	N/A	-

Leeds Health & Care Partnership

NHS West Yorkshire Integrated Care Board

Draft Minutes

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

Wednesday 26 February 2025, 1.15pm – 4.00pm

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

Members	Initials	Role
Kashif Ahmed (deputising for CB)	KA	Deputy Director, Integrated Commissioning, Leeds City Council
Rebecca Charlwood	RC	Independent Chair, Leeds Committee of the WY ICB
Alex Crickmar	AC	Director of Operational Finance, ICB in Leeds
Victoria Eaton	VE	Director of Public Health, Leeds City Council
Phil Evans (deputising for JL)	PE	Chief Officer - Resources, Transformation and Partnerships, Leeds City Council
Dr Sarah Forbes	SF	Medical Director, ICB in Leeds
Pip Goff	PG	Volition Director, Forum Central
Cheryl Hobson	CH	Independent Member – Finance and Governance
Yasmin Khan	YK	Independent Member – Health Inequalities
Jane Mischenko	JM	Co-Chair, Healthwatch Leeds
Dr Sara Munro	SM	Chief Executive, Leeds and York Partnership Foundation 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, WYICB
Helen Lewis (From Item 76 onwards)	HL	Director of Pathway and System Integration
Asma Sacha (Item 78 only)	AS	Risk Manager, WYICB
Harriet Speight	HS	Corporate Governance Manager, WYICB
Apologies		
Caroline Baria	CB	Director of Adults and Health, Leeds City Council
Selina Douglas	SD	Chief Executive, Leeds Community Healthcare NHS Trust
Jo Harding	JH	Director of Nursing and Quality, ICB in Leeds
Julie Longworth	JL	Director of Children and Families, Leeds City Council
Prof. Phil Wood	PW	Chief Executive, Leeds Teaching Hospitals NHS Trust

Members of public staff observing – 1

65 WELCOME AND INTRODUCTIONS

The Chair opened the meeting of the Leeds Committee of the West Yorkshire Integrated Care Board (WY ICB) and welcomed all attendees to the meeting.

66 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. None were raised.

67 MINUTES OF THE PREVIOUS MEETING

The public minutes of the meeting held 27th November 2024 were approved as an accurate record, subject to a minor amendment relating to the conflict of interest of PG, since rectified and submitted to the WYICB Board.

The Leeds Committee of the WY ICB:

- Approved the minutes of the previous meeting held on 27 November 2024.

68 MATTERS ARISING

No matters were raised.

69 ACTION TRACKER

All actions had been completed.

70 PEOPLE'S VOICE

JM introduced a video from the 'how does it feel for me?' series from Healthwatch Leeds with Abdul from Harehills, where Abdul spoke positively about his experience of healthcare services in Leeds following a stroke and how his cultural needs had been addressed by staff, particularly at North Leeds Medical Practice.

Abdul did however also describe some challenges he had experienced, particularly with making ends meet and the need for more financial support, despite he and his wife receiving workplace pensions. Members highlighted the need for signposting to available services, such as carer support services and other commissioned services, and it was confirmed that Healthwatch had referred Abdul and his family to carer support services. It was noted that building neighbourhood health must be a crucial part of the role of the NHS moving forward in addressing the impact of poverty, using population health management approaches to prioritise those with needs for specific financial support following major health issues, such as strokes.

Additionally, Abdul described challenges with repeat prescriptions and delivery of his prescriptions. Members noted the significant financial pressure experienced by Community

Pharmacies, impacting their ability to provide additional services. This was flagged as an issue for attention at West Yorkshire level, including potential for regional communications to patients to raise awareness.

71 QUESTIONS FROM MEMBERS OF THE PUBLIC

There were no questions submitted on this occasion.

72 PLACE LEAD UPDATE

TR provided an overview of the report, noting several changes to leaders across the Leeds and West Yorkshire footprint, including Ed Whitting as the new Chief Executive of Leeds City Council, and the resignations of Selina Douglas as Chief Executive of Leeds Community Healthcare NHS Trust (LCH) and Cathy Elliot as the Chair of the WYICB, who were both moving on to health leadership roles outside of the region.

TR also highlighted the significant winter pressures, particularly within acute hospitals, GP settings and mental health provision, however noted the positive impact of the HomeFirst programme in mitigating impacts of pressures across the system and that LTHT had continued to minimise ambulance turnaround delays enabling a relatively good ambulance performance in West Yorkshire for category 2 response times.

From a national perspective, TR advised that there had been strong indication of more direct leadership and control from the Department of Health and Social Care, with more progress with provider partnerships at local level.TR noted that ongoing working to develop neighbourhood working in Leeds was aligned well to national thinking.

TR also introduced the Leeds Place Annual Equality Report section, as appended to the report for information. YK noted that it would be helpful to understand the work undertaken collectively as a partnership in the future.

There was some discussion around the changes to the Better Care Fund (BCF) allocation and sign-off as set out in the report, and members were advised that the funding formula covers a range of activity that takes place in Leeds to deliver transformation and value for money, which is continuously reviewed.

The Leeds Committee of the WYICB:

- **NOTED** the contents of the report.

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

The Committee received the AAA report on behalf of the Chair. The Chair highlighted the alerts in relation to pathology services and neonatal and maternity services, as set out in the report. TR confirmed that LTHT had led on communications and lessons learned for both issues, with NHS England support.

The Leeds Committee of the WYICB:

- **NOTED** the report.

74 DELIVERY SUB-COMMITTEE ASSURANCE REPORT

The Committee received the AAA report on behalf of the Chair. It was highlighted that the sub-committee considered the proposed changes to the sub-committee structure and recommended to the Leeds Committee that the changes be implemented from 1st April 2025 (Minute 79 refers).

The Leeds Committee of the WYICB:

- **NOTED** the report.

75 FINANCE AND BEST VALUE SUB-COMMITTEE ASSURANCE REPORT

The Committee received the AAA report on behalf of the Chair. The Chair noted that the sub-committee had also reviewed the financial position at Month 9 and alerted the Committee to remaining risk in the system, despite the positive turnaround from earlier months. It was also highlighted that the sub-committee considered the proposed changes to the sub-committee structure and recommended to the Leeds Committee that the changes be implemented from 1st April 2025. (Minute 79 refers).

The Leeds Committee of the WYICB:

- **NOTED** the report.

76 FINANCE UPDATE AT MONTH 9

AC provided a verbal update on Month 10, noting that Leeds Place reported a position of a £600k deficit with a likely year end position of 1.6m favourable to plan. It was noted that some financial risk remained in the system, largely associated with winter pressures, demand for neurodiversity services, high-cost complex care packages, primary care pressures, and the volatile prescribing position.

In response to a query around the right to choose provision impact on financial risk, HL advised that guidance had not been provided for thresholds for referrals, however ensuring considered choice of patients would be a key ambition for the WYICB in the coming year.

On behalf of the Committee, the Chair recognised and thanked teams in Leeds for their work to achieve the forecast delivery against plan along with the efficiency target, despite the challenging figures presented throughout the year.

The Leeds Committee of the WYICB:

- **NOTED** the Month 9 and 10 positions, specifically the emerging risks and mitigating actions.

SM left the meeting at 2.00 p.m. during discussion of this item.

77a NHS PLANNING GUIDANCE UPDATE

TR introduced the report, which included an update on the NHS Planning Guidance received and asked members to note the timescales set out for submission, recognising that the timescales mandated did not align with the Committee cycle and a further update would be provided at the Committee Development Session in April 2025. TR noted that the financial allocation continued to be very challenging.

GW noted the intention for the ONS Health Insights survey to inform access to primary care, as set out in the planning guidance, however noted that the response rate to the survey had historically been very low and disproportionate to societal groups, therefore not a representative sample, and expressed concern at this being used as a single metric. Members agreed that further communication would need to be developed to encourage patients to complete the survey and be clear on its intended use.

Members queried the opportunities to build on transformation given the tight financial allocation and were advised that the approach would be to work differently to achieve efficiencies, such as utilising the digital change agenda.

The Leeds Committee of the WYICB:

- **NOTED** and **CONSIDERED** the content, expectations and constraints of the planning guidance and associate timescales.
- **PROVIDED** strategic direction on key issues and priorities, as set out above.
- **NOTED** submission timescales and Accountable Officer (Leeds) responsibilities.

77b FINANCIAL PLANNING PROCESS

AC delivered a PowerPoint presentation on the principles of the approach to financial planning for the core allocation of £1,647m for Leeds, with a focus on delivery within the resources available as opposed to cost to deliver all current services as well as minimising the impact on the most disadvantaged parts of our community. Members were advised that the plan for 2025/26 must deliver in-year financial, quality & performance expectations and long-term health improvement aligned to supporting the ambitions of value-based healthcare and a move from sickness to prevention; acute to community; and analogue to digital. AC noted that the final submission, following peer review, would be by the end of March 2025.

AC presented the areas of focus for West Yorkshire and Leeds specific transformation schemes, including weight management, high-cost packages, ADHD policy, primary care and voluntary sector resilience, prescribing policies, HomeFirst 2, community mental health transformation, children with complex needs and prevention work for cardiovascular and hypertension. AC also set out several areas for focus in terms of efficiencies for 2025/26, including, reducing high-cost package spend further, capping activity levels and alternative pathway changes for some services following measures introduced by NHS England, working with partners to agree approach to procedures of limited clinical value, enforcement of commissioning policies, and review of current services which are not aligned to Healthy Leeds Plan priorities for potential decommission. TR added that potential

capping measures introduced by NHS England for specific services such as neurodiversity would allow teams to ensure that the most 'at risk' groups are given the highest priority.

In response to a query, Members were advised that the plans had been peer reviewed at Leeds and West Yorkshire levels by colleagues from a range of disciplines, not just finance.

Members encouraged further the alignment between priorities set out and the longer-term ambitions of the Leeds Health and Care Partnership, specifically the approach taken through the Marmot City work and the Healthy Leeds Plan priorities, in terms of the commitment to prevention and early intervention to reduce health inequalities, and in recognition that this agenda requires cross-organisational work and focus on prioritising those most at risk. It was also noted that that health inequalities would be a direct responsibility of the Leeds Committee, following the implementation of the proposed sub-committee structure changes (minute 79 refers), which would be positive moving forward for this work.

The Leeds Committee of the WYICB:

- **NOTED** the contents of the verbal update and **SUPPORTED** the principles and approach set out.

77c DRAFT MEDIUM TERM FINANCIAL PLAN

AC introduced the report and advised that the Finance and Best Value Sub-Committee had discussed the plan in detail and were supportive of the approach. It was noted that the plan would be updated in light of the final 2025/26 plan submission and iterated each year thereafter and linked to place based strategies and interventions. The report set out that modelling had shown a £435m deficit before efficiencies at the end of the 5-year period, with a £169m gap for 25/26, demonstrating significant financial challenge.

Reflecting on the previous item (minute 77b refers), CH commented that the plan presented provided starting position to work from and revisit, enabling alignment of transformation priorities discussed as the years progress.

The Leeds Committee of the WYICB:

- **REVIEWED** the Medium-Term Financial Plan
- **NOTED** the next steps as detailed in the report

78 RISK MANAGEMENT AND BOARD ASSURANCE FRAMEWORK REPORT

TR introduced the report, highlighting that all of the high scoring risks had been discussed or included in reports submitted to the meeting, therefore providing assurance that the risks are monitored and actioned.

TR introduced AS as the new Risk Manager for West Yorkshire. AS noted two new risks for Leeds Place relating to Tier 3 Weight Management services and the current financial risk for adults hospices in Leeds. Members noted disparity in funding for hospices across the region and that it had been agreed that a fair funding formula would be implemented for hospices across West Yorkshire over a 3-to-5-year period.

An emerging risk was also highlighted in relation to supporting young people through crisis and ensuring joined up care, which would be discussed further outside of the meeting and updates provided in the subsequent report.

In reference to the 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' - VE noted that local Health Protection Boards lead on this work and queried why updates were not required from each Place, as referenced in Appendix 2. AS agreed to feedback and provide an update in the next report.

ACTION – 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.'

The Leeds Committee of the WYICB:

- **RECEIVED** and **NOTED** the High-Level Risk Report, Risk Log and Risk on a Page Report as an accurate representation of the Leeds place risk position, following any recommendations from the relevant sub-committees.

79 PROPOSED CHANGES TO THE LEEDS PLACE SUB-COMMITTEE STRUCTURE FROM 1 APRIL 2025

TR introduced the report, setting out the proposal to move from three to two assurance sub-committees from 1st April 2025, to bring together finance, performance and outcomes under the remit of one sub-committee to enable greater integration of all three aspects and reduce duplication.

Members were supportive of the proposal, noting the recommendation from both sub-committees to proceed, and that this work was in line with the recent review of Place Partnerships, which encouraged the rationalisation of governance within the system to ensure effective assurance mechanisms and support agile decision making.

The Leeds Committee of the WYICB:

- **APPROVED** the proposal to dissolve the Delivery Sub-Committee from 1st April 2025 and realign responsibilities as set out in the report.

80 ITEMS FOR THE ATTENTION OF THE ICB BOARD

The Chair outlined that the Committee would submit a report to the West Yorkshire ICB on items to be alerted on, assured on, action to be taken and any positive items to note. The key areas to highlight were set out as follows:

- People's Voices – Community Pharmacy Provision and Neighbourhood Support Services

- The agreed changes to the Leeds Place sub-committee structure
- The updates and assurances provided on financial and performance planning for 2025/26
- Assurance regarding the ambulance turnaround effectiveness in Leeds
- Assurance that the high scoring risks featured throughout the meeting, demonstrating effective monitoring and action taken

62 ANY OTHER BUSINESS

The Chair noted that the committee effectiveness annual survey would be circulated shortly and asked members to please complete, as the results would help to inform discussions around planning for next year and any changes required to the terms of reference. The Chair confirmed that the annual report and draft terms of reference will be submitted to the next meeting in May 2025 for discussion in advance of the WYICB meeting in June 2025.

63 DATE AND TIME OF NEXT MEETING

The next meeting of the Leeds Committee of the WY ICB was confirmed as 1.15 pm on Wednesday 21st May 2025.

The meeting closed at 4.00 p.m.

Action Tracker

Leeds Health & Care Partnership

Leeds Committee of the WY ICB

Action No.	Meeting Date	Item Title	Actions agreed	Lead(s)	Accountable body / board / committee	Status	Update
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 to be provided at meeting 21/05/25
Completed Actions							
09/24	**22 May 2024**	**Place Lead Update**	To circulate the link to the recent Joint Targeted Area Inspection (JTAI) report.	**HS**	**LCICB**		Circulated 17/06/2024
17/24	**22 May 2024**	**Risk Management Report**	To review the articulation of risks included on the Leeds Place risk register to ensure that descriptions and mitigations are person-centred and reflect strategic risks set out within the BAF.	**SR/TR**	**LCICB**		Risk Register reviewed by Directors on 21/08/2024. Outputs are set out in the Risk Management Report (11/09/2024)

Updated: 08 May 2025

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 05/12/2024.
58/24	**27 November 2024**	**Risk Management Report**	To add the risk associated with the suspension of Tier 3 Weight Management services to the Leeds Place risk register.	**AS**	**LCICB**		Risk added. Detail provided in the risk management report (26/02/2025).

Leeds Health & Care Partnership

NHS West Yorkshire Integrated Care Board

Committee Escalation and Assurance Report – Alert, Advise, Assure

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

Date of meeting: 23 April 2025

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

Date of meeting reported to: 21 May 2025

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

Key escalation and discussion points from the meeting
Alert:
N/A
Advise:
Independent Review: Action Plan Update (Leeds Place Risk 2494) The sub-committee received an update on actions being taken following the independent investigation and recommendations into the care of a young person in Leeds. A case study was presented which described the process by which a young person was discharged to a suitable placement involving twice weekly Multidisciplinary Team (MDT) oversight and escalation meetings. Clinicians and services were supported to work in an integrated way, resulting in the development of a jointly owned formulation, care, treatment and contingency plan for the young person. The sub-committee agreed that it had received reasonable assurance regarding the recommendations for Leeds in the review report and would continue to seek assurance on continuous improvement work via the ICB Quality Highlight Report and the Leeds Place risk register.
Assure:
People's Voice The sub-committee received the WY Healthwatch Briefing Paper on Health Inequalities: People's experiences of services before, during and after pregnancy. The paper comprised of existing insight, as well as conversations with local Maternity and Neonatal Voices Partnerships Leads, Leeds Gate and the Yorkshire & Humber (YH) Perinatal Mental Health (PNMH) Co-production Group. The report identified barriers to early booking to antenatal care including lack of knowledge, particularly for newly arrived people, cultural differences, language barriers, fear of judgment and online booking difficulties. There was positive feedback on care in PNMH services, although barriers to accessing the services

included stigma, cultural factors, interpreting issues and distrust of services in some communities.

The report highlighted people's experiences of racism, discrimination and cultural bias in maternity care. Continuity of Care and specialist midwifery services were valued by people, as was recognition of initiatives in Leeds such as an ante-natal group for Black African women in Harehills run by the Health Equity Midwifery Team in Leeds and community-based initiatives such as the Maternal Journal.

The sub-committee was assured that Leeds Teaching Hospitals NHS Trust (LTHT) was committed to implementing the report's recommendations. A new Maternity and Neo Natal Programme Board would have oversight of the quality improvement (QI) work which would be undertaken via six workstreams, two of which would focus on health inequalities and service user engagement.

Quality Highlight Report
The sub-committee noted the most recent Care Quality Commission (CQC) inspection of Claremont Nursing Home in December 2024 had resulted in a rating of 'Good' from 'Requires Improvement'. Manston Surgery had also received a CQC rating of 'Good' overall after previously being rated as inadequate

The sub-committee was updated on maternity and neonatal services following unannounced CQC inspections at LTHT in December 2024 and January 2025. Following a Rapid Quality Review (RQR) meeting on 31 January 2025, a decision had been made for perinatal services to receive support from the Maternity Safety Support Programme (MSSP) and a written report was expected in the following weeks. In Neonatal services, a potential Urgent Enforcement Action under Section 31 had been averted following immediate remedial actions by LTHT, including a revised escalation process and designation adjustments. The service would be subject to a monitoring period.

Risk Management Report (Leeds Place Risk 2494, 2510, 2509)
The sub-committee received the Leeds Place risk report for risk cycle 1 of 2025/26. Six high-scoring risks were aligned to the QPEC, one of which was shared with the Finance, Value and Performance Sub-Committee and the Leeds Committee.

Three new risks had been aligned to the QPEC Sub-Committee: Risk: 2494 - 'There is a risk that children and young people 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'; Risk 2510 - there is a risk of an inability to deliver all of the statutory functions of the ICB in regard to All Age Continuing Care (AACC) in Leeds due to challenging workforce pressures; and Risk 2509 - there is a risk of the ICB not being able to source high quality and cost-effective care for individuals eligible for NHS Continuing Health Care (CHC) in Leeds due to gaps in cost for care and affordable budgets.

Leeds Integrated Sexual Health Service
The sub-committee received a presentation on the new integrated sexual health service in Leeds that had been launched on 1 April 2024 which comprised of a

number of partners including Leeds Community Healthcare NHS Trust (LCH), LTHT, Forum Central and the Leeds GP Confederation.

The service was informed by stakeholder and service user consultation and was intended to provide community outreach for the most at-risk populations, with a focus on digital access and self-care, with a specific focus on health inequalities. In addition to the service hub at Beeston Hill Health Centre, the service was delivered from a number of 'spokes' and outreach points across the city with increased out of hours access.

Annual Governance Review
The sub-committee received the QPEC Annual Report 2024/25 which included the results of its committee effectiveness survey and terms of reference. It was noted that Yasmin Khan, Independent Member for Health Inequalities, would be Deputy Chair for the QPEC Sub-Committee.

Leeds Health & Care Partnership

NHS West Yorkshire Integrated Care Board

Committee Escalation and Assurance Report – Alert, Advise, Assure

Report from: Leeds Finance, Value and Performance Sub-Committee

Date of meeting: 30 April 2025

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

Date of meeting reported to: 21 May 2025

Report completed by: Karen Lambe, Corporate Governance Officer, WY ICB, on behalf of Cheryl Hobson, Independent Member and Chair of Finance and Best Value Sub-Committee

Key escalation and discussion points from the meeting
Alert:
<u>Financial Position Update (Month 12 Provisional Position Subject to Year End Audit)</u> The sub-committee was informed that the Leeds Health and Care Partnership (LHCP) reported a year end position of £11.4m surplus which was £13.8m ahead of plan. The improved financial position was attributed partly to additional Elective Recovery Fund (ERF) being received from NHS England (NHSE) The ICB in Leeds reported an £11.5m deficit which was £0.8m ahead of plan. The main overspending areas within the ICB were within Mental Health (MH) and Continuing Health Care (CHC) services which were offset by underspending in acute, prescribing, ICB running costs and community services. Deep dive reviews of CHC and neurodivergence (ND) 25/26 efficiency plans would be brought to the next sub-committee meeting for assurance. The sub-committee noted that the use of non-recurrent funding had been instrumental in delivering the deficit financial plan for 24/25 and further work was needed to improve the underlying financial position in 25/26. The sub-committee discussed the balance of accountability of Places contributing to the WY deficit. Members expressed concern that additional stretch targets would be applied in 2025/26. **Leeds Quarterly Performance Report** Members were informed that there had been 29 out of area (OOA) placements against a plan of 12 in March 2025. Work was ongoing to examine whether there was a correlation between the increase in OOA placements and the financial efficiencies plan. The increase in OOA placements represented a significant financial risk for Leeds and York Partnership NHS Foundation Trust (LYPFT) and the LHCP. **Final Financial Plan 2025/26** The sub-committee received the 2025/26 Financial Plan which had been submitted on 21 March 2025 including a balanced position for WY with a system risk of

£33.2m held against the WY ICB. It was noted that this system risk will be allocated out to Places as a further stretch on plans.

The Sub-Committee noted that Leeds Place had submitted a fully balanced plan for 2025/26, having improved from its previous deficit position submission of £40.2m in February 2025.

The sub-committee noted the mismatch in the Leeds Teaching Hospitals NHS Trust (LTHT) position which included £5m of assumed income from the ICB which it did not have in its position relating to NRTR patients. Assurance was given that it remained a priority to address the mismatch.

Members were informed of a total Place financial risk of £112m. Key risk areas included: unidentified or high risk efficiency plans, high cost packages in CHC, s117 and OAPs, non-elective demand, demand for ND and weight management services, delivery of referral to treatment (RTT) targets, as well as risk of inflationary pressures.

With regard to the ICB in Leeds, efficiencies of £30.7m were required in order to deliver the balanced financial plan.

The sub-committee noted that due to additional uncertainties around workforce and changing national guidance since the submission of the financial plan, the changes presented additional risk to the delivery of the Financial Plan.

Advise:

Leeds Quarterly Performance Report
The sub-committee received the Leeds Quarterly Performance Report. The A&E four hour performance had significantly improved in March 2025 at 79.3%, above its target of 78%.

With regards to demand for ND referrals and assessments, a RAG rating system had been implemented, meaning that patients rated as red would be waiting for six weeks, while amber-rated patients would be waiting 13 weeks. Members were informed that ND waiting lists data was only currently available from NHS trusts and not from right to choose (RTC) private providers, although future reaccreditation would require private providers to submit waiting list data.

Assure:

People's Voice
The sub-committee received a video of interviews with people living with chronic pain and their recommendations on how to improve healthcare services in Leeds. A number of themes ran through the video including: the need for coordinating systems between services; access to one consistent GP or care navigator; a fear of stigma if requesting mental health support in addition to pain management; the benefits of social prescribing, support for families; and the benefits of alternative pain relief therapies not available via the NHS. The sub-committee discussed the complexity of addressing challenges in chronic pain management.

Planning Guidance 2025/25
The sub-committee was assured that Leeds had submitted compliant plans for workforce, finance and activity as part of the NHS Operational Planning process 2025/26. Members discussed the challenge of modelling and risk assessing elective performance for patients with complex cases who were not clinically urgent.

Risk Management Report (Leeds Place Risks 2508, 2480)
Members received a report on the Risk Register for risk cycle 1 of 2025/26. Four risks were aligned to the Finance, Value and Performance (FVP) Sub-Committee, one of which was shared with the Quality and People's Experience Sub-Committee and the Leeds Committee.

A new risk had been added to the risk register and was aligned to the FVP Sub-Committee. 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' had a risk score of 20.

The sub-committee noted ongoing work with Leeds Community Healthcare NHS Trust (LCH) colleagues regarding risk 2480 - 'there is a risk that current commissioned Tier 3 weight management service not being sufficient to meet demand' as an example of how productivity gains could be achieved while also improving patient outcomes.

Annual Governance Review 2024/25
The sub-committee received the 2024/25 Annual Report of the Finance and Best Value Sub-Committee during the period April 2024 to March 2025 which included the terms of reference for the new FVP Sub-Committee. Members agreed to review partner representation on the new sub-committee over the coming year.

Meeting name:	Leeds Committee of the West Yorkshire Integrated Care Board
Agenda item no.	LC 11/25
Meeting date:	21 May 2025
Report title:	End of Year Finance Update for 2024/25 and Progress on Plans for 2025/25
Report presented by:	Alex Crickmar, Director of Operational Finance
Report approved by:	Alex Crickmar, Director of Operational Finance
Report prepared by:	Alex Crickmar, Director of Operational Finance

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

Previous considerations:

Finance and Best Value Sub Committee
Directors Team Meeting

Executive summary and points for discussion:

The purpose of the first part of this report is to provide an update to the Committee on the Month 12 financial position (subject to audit) of the ICB in Leeds, the wider Leeds Place and West Yorkshire Integrated Care System (ICS) Position. The key points to note being:

- The Leeds Health and Care Partnership (LHCP) is reporting a year end position of £11.4m surplus which is £13.8m ahead of plan.
- The financial position has improved due to additional Elective Recovery Fund (ERF) of £30m (£11.9m for LTHT) being received into WY at the end of the financial year from NHS England (NHSE). The other improvement is due to redistribution of £20m surplus within the WY ICB position (not ICB in Leeds) to Providers of which £5.8m was for Leeds Teaching Hospitals NHS Trust (LTHT).
- The month 12 position for the ICS was a £0.1m surplus against a planned balanced position; a positive variance against plan of £0.1m.

The purpose of the second part of this paper is to present the financial plan for 25/26. The key points to note being:

- The WY ICS, Leeds and Health Care Partnership and the ICB in Leeds has submitted a balanced financial plan for 25/26.
- However, the West Yorkshire position includes system risk held against WY ICB of £33.2m which is yet to be allocated out to organisations/places (planned to be allocated in Q1).
- There are significant efficiency assumptions within plans including:

- £426.1m across WY ICS
- £152.2m across the Leeds and Health Care Partnership
- £30.7m for the ICB in Leeds

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 draft Month 12 financial position
2. **Support** the 25/26 financial plan submission

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

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

Appendices

1. 24/25 Month 12 Draft Financial Position

Acronyms and Abbreviations explained

1. ICS - Integrated Care System
2. LHCP - Leeds Health and Care Partnership
3. ERF - Elective Recovery Fund
4. LTHT - Leeds Teaching Hospitals NHS Trust
5. NHSE – NHS England

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	

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Health and Care Partnership

NHS West Yorkshire
Integrated Care Board

24/25 Month 12 Draft Financial Position

ICB in Leeds Integrated Care Board (ICB) Month 12 Financial Position

ICB in Leeds Month 12 - £0.8m surplus

NHS West Yorkshire Integrated Care Board

	Annual Plan £000	M12 Position £000	Annual Variance £000
RESOURCE			
Allocation - Programme	1,661,259	1,661,259	0
Allocation - Primary Care Co-Commissioning	174,919	174,919	0
Allocation - Running Costs	6,090	6,090	0
TOTAL RESOURCE	**1,842,268**	**1,842,268**	**0**
SPEND			
Acute	911,916	909,598	2,318
Mental Health	254,100	261,085	(6,985)
Community	232,877	230,703	2,174
Continuing Care Services	84,606	88,373	(3,768)
Prescribing and Primary Care	177,304	172,971	4,333
Primary Care Co-Commissioning	181,068	180,428	639
Other	6,749	6,595	154
Programme Reserves	(140)	(925)	785
Subtotal Programme spend	**1,848,479**	**1,848,829**	**(350)**
Running Costs	6,090	4,944	1,146
TOTAL SPEND	**1,854,568**	**1,853,773**	**796**

ICB in Leeds Month 12 Financial Position

NHS West Yorkshire
Integrated Care Board

In the final year end position, the ICB in Leeds is reporting a £11.5m deficit which is £0.8m ahead of plan.

The main overspending areas within the ICB were within Mental Health (MH) and Continuing Health Care (CHC) services offset by underspends in acute, prescribing and community services.

- MH had a £7.0m overtrade due to rehab placements, ADHD referrals (impact of right to choose) and S117 costs. Within CHC there was a £3.8m overspend driven by a historic case issue (c.£0.7m) along with under-delivery of efficiency plans (£0.9m forecast vs £2.2m plan).

These are both being offset by underspends within:

- Prescribing (c.£2.3m) based on most recent data
- Primary Care (c.2.6m) due to several benefits including £1m underspend on GPIT, £0.6m migrant funding, £0.5m list size offset by £0.5m pressure due to LIMS issue in secondary care.
- Community Services (£2.2m) – driven by NR underspends in children's services and £0.6m non-recurrent benefit on capitalisation of equipment.
- Acute Services (£2.3m) – due to ERF recovery in the independent sector
- The running costs for the ICB show an underspend of £1.1m at month 12.

Leeds Place
Month 12 Financial Position

Leeds Place - Month 12 Financial Position

NHS West Yorkshire
Integrated Care Board

Organisation	FINAL POSITIONS - M12		
	FOT Plan £m	FOT Surplus / (Deficit) £m	FOT Variance £m
Leeds ICB	(12.3)	(11.5)	0.8
Leeds and York Partnership NHS Foundation Trust	1.0	1.2	0.2
Leeds Community Healthcare NHS Trust	1.0	1.9	0.9
Leeds Teaching Hospitals NHS Trust	7.9	19.8	11.9
Leeds Place Total	**(2.4)**	**11.4**	**13.8**

The Leeds Health and Care Partnership is reporting a draft year end position of £11.4m surplus, which is £13.8m ahead of plan.

The financial position has improved due to additional ERF of £30m (£11.9m for LTHT) being received into WY at the end of the financial year from NHSE. The other improvement is due to redistribution of £20m surplus within the WY ICB position (not ICB in Leeds) to Providers of which £5.8m is for LTHT.

Leeds Place Month 12 – Efficiencies

NHS West Yorkshire
Integrated Care Board

Organisation	Annual Plan £m	Forecast £m	Forecast Variance £m
Leeds ICB	38.5	39.5	1.0
Leeds and York Partnership NHS Foundation Trust	17.0	17.0	0.0
Leeds Community Healthcare NHS Trust	15.8	15.8	0.0
Leeds Teaching Hospitals NHS Trust	110.4	110.4	0.0
Leeds Place Total	**181.7**	**182.7**	**1.0**

Overall, the Leeds Place has delivered efficiencies of £182.7m which is slightly ahead of plan by c£1m.

The favourable variance in the Leeds in ICB position was due to prescribing savings above plan.

West Yorkshire ICS
Month 12 Financial Position

West Yorkshire ICS Financial position - Month 12

NHS West Yorkshire Integrated Care Board

Organisation	FORECAST - M01 to M12 I&E forecast		
	FOT Plan £m	FOT Surplus / (Deficit) £m	FOT Variance £m
Bradford ICB	(7.8)	(17.1)	(9.3)
Calderdale ICB	0.0	2.6	2.6
Kirklees ICB	(0.0)	1.5	1.5
Leeds ICB	(12.3)	(11.5)	0.8
Wakefield ICB	0.0	(2.5)	(2.5)
WY ICB	21.5	32.1	10.7
West Yorkshire ICB Total	**1.4**	**5.2**	**3.8**
Airedale NHS Foundation Trust	(5.2)	(12.7)	(7.5)
Bradford District Care NHS Foundation Trust	0.0	0.2	0.2
Bradford Teaching Hospitals NHS Foundation Trust	(9.7)	(4.9)	4.8
Calderdale And Huddersfield NHS Foundation Trust	(0.9)	4.2	5.0
Leeds and York Partnership NHS Foundation Trust	1.0	1.2	0.2
Leeds Community Healthcare NHS Trust	1.0	1.9	0.9
Leeds Teaching Hospitals NHS Trust	7.9	19.9	11.9
Mid Yorkshire Hospitals NHS Trust	4.4	(15.2)	(19.6)
South West Yorkshire Partnership NHS Foundation Trust	0.0	0.2	0.2
Yorkshire Ambulance Service NHS Trust	0.0	0.1	0.1
West Yorkshire Provider Total	**(1.4)**	**(5.1)**	**(3.7)**
West Yorkshire ICS Total	**(0.0)**	**0.1**	**0.1**

West Yorkshire ICS Month 12 Financial Position

NHS West Yorkshire
Integrated Care Board

- The month 12 year to date position for the ICS was a £0.1m surplus against a planned balanced position; a positive variance against plan of £0.1m.

- The month 12 £0.1m surplus has improved from the adverse variance at month 11 of £13.2m, an improvement of £13.3m. The improvement in month is due to additional ERF funding of £30m being received from NHSE in Month 11, now fully reflected in the out-turn position, and the impact of actions taken by individual organisations to deliver plan.

- The month 12 final position for the ICB was a £5.2m surplus against a revised planned £1.4m surplus; a £3.8m favourable variance against plan. This position is driven by overspends on CHC and Mental Health, offset by underspends on Prescribing and pay expenditure.

Efficiencies

NHS West Yorkshire Integrated Care Board

Organisation	YTD		
	Plan £m	Outturn £m	Variance £m
West Yorkshire ICB Total	**98.5**	**96.0**	**(2.5)**
Recurrent	42.5	44.6	2.0
Non-Recurrent	56.0	51.4	(4.6)
Airedale NHS Foundation Trust	14.8	15.1	0.3
Bradford District Care NHS Foundation Trust	14.2	5.8	(8.3)
Bradford Teaching Hospitals NHS Foundation Trust	38.9	32.9	(5.9)
Calderdale And Huddersfield NHS Foundation Trust	32.2	32.2	0.0
Leeds and York Partnership NHS Foundation Trust	17.0	17.0	0.0
Leeds Community Healthcare NHS Trust	15.8	15.8	0.0
Leeds Teaching Hospitals NHS Trust	110.4	110.4	0.0
Mid Yorkshire Hospitals NHS Trust	50.5	47.6	(2.9)
South West Yorkshire Partnership NHS Foundation Trust	20.1	20.6	0.5
Yorkshire Ambulance Service NHS Trust	21.7	20.8	(0.8)
West Yorkshire Provider Total	**335.4**	**318.3**	**(17.1)**
Recurrent	250.4	206.4	(43.9)
Non-Recurrent	85.0	111.8	26.8
West Yorkshire ICS Total	**433.9**	**414.2**	**(19.7)**
Recurrent	292.9	251.0	(41.9)
Non-Recurrent	141.0	163.2	22.2

- The month 12 position for the ICS was **£414.2m efficiency delivery** against a **plan of £433.9m**; a shortfall/adverse variance against plan of **£19.7m.**
- There was an increasing unplanned full-year reliance on **non-recurrent** schemes **(£22.2m more than plan**).

Recommendations

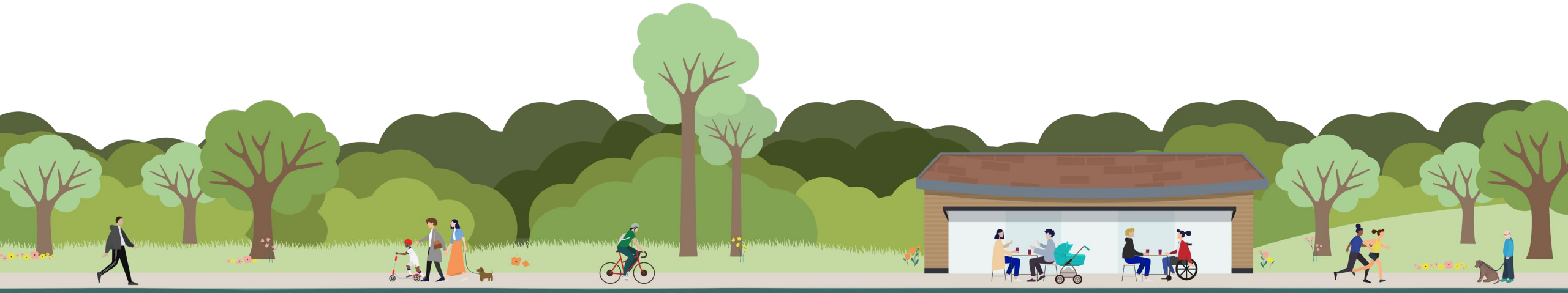
NHS West Yorkshire
Integrated Care Board

The Committee is asked to:

- Review and comment on the ICB in Leeds month 12 draft financial position
- Review and comment on the Leeds Place month 12 draft position
- Review and comment on the West Yorkshire ICS month 12 draft financial position
- Consider any specific areas that they wish to escalate to other Committees or forums for follow up

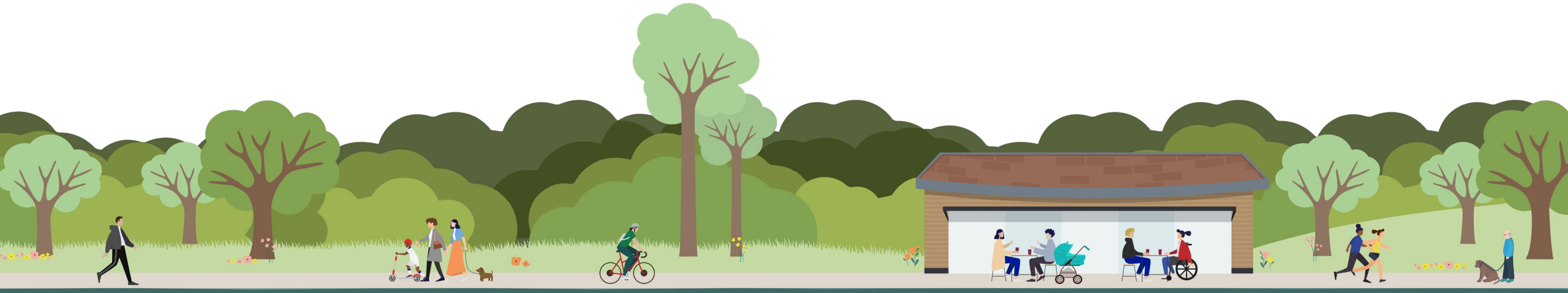
Leeds Health & Care Partnership

25/26 Financial Plan



Leeds Health & Care Partnership

West Yorkshire ICS 25/26 Financial Plan



West Yorkshire Financial Plan Headlines

- Headline plans submitted at 27 February 2025 at **£187m deficit** (after application of £49m transitional support funding)
- Updated headline plans at 14 March 2025 aggregate to **£129m deficit** (after application of £49m transitional support funding)
- Final plan submission at 21 March 2025 **aggregate break-even**
- Includes **system risk** held, for the purposes of planning only, against WY ICB of £33.2m
- Plans include efficiency plans of **£426m (6.6% of overall ICB allocation)**

24/25 outturn to 25/26 plans

Organisation	Normalised FOT (£m)	Plans pre transitional support (£m)	Transitional support (£m)	2025/26 Plan (£m)
Airedale NHS Foundation Trust	(27.9)	(25.5)	10.8	(14.7)
Bradford District Care NHS Foundation Trust	0.2	0.0	0.0	0.0
Bradford Teaching Hospitals NHS Foundation Trust	(14.0)	(22.7)	5.7	(17.0)
Calderdale And Huddersfield NHS Foundation Trust	(31.5)	(58.3)	16.2	(42.1)
Leeds and York Partnership NHS Foundation Trust	1.0	0.0	0.0	0.0
Leeds Community Healthcare NHS Trust	1.9	0.0	0.0	0.0
Leeds Teaching Hospitals NHS Trust	2.1	(9.4)	9.4	0.0
Mid Yorkshire Teaching Hospitals NHS Trust	(49.4)	(29.8)	7.0	(22.8)
South West Yorkshire Partnership NHS Foundation Trust	0.0	0.0	0.0	0.0
Yorkshire Ambulance Service NHS Trust	0.0	0.0	0.0	0.0
TOTAL - Providers	**(117.5)**	**(145.6)**	**49.2**	**(96.5)**
ICB Bradford	(16.4)	0.0	0.0	0.0
ICB Calderdale	3.8	1.7	0.0	1.7
ICB Kirklees	7.6	3.5	0.0	3.5
ICB Leeds	(11.6)	0.0	0.0	0.0
ICB Wakefield	4.7	0.0	0.0	0.0
ICB West Yorkshire	49.9	91.3	0.0	91.3
TOTAL - ICB	**38.0**	**96.5**	**0.0**	**96.5**
TOTAL - ICS	**(79.5)**	**(49.1)**	**0.0**	**(0.0)**

Note: WY ICB includes:

- £33.2m of system risk and
- £40m additional NHSE allocation (distribution in 2025/26 TBC)

25/26 plans including efficiency

Organisation	Plan (£m)	% of T/O	Eff'cy (£m)	% of T/O
Airedale NHS Foundation Trust	(14.7)	(5.4%)	20.0	7.3%
Bradford District Care NHS Foundation Trust	0.0	0.0%	14.3	6.4%
Bradford Teaching Hospitals NHS Foundation Trust	(17.0)	(2.7%)	33.0	5.2%
Calderdale And Huddersfield NHS Foundation Trust	(42.1)	(7.2%)	28.4	4.9%
Leeds and York Partnership NHS Foundation Trust	0.0	0.0%	18.5	6.8%
Leeds Community Healthcare NHS Trust	0.0	0.0%	14.0	6.3%
Leeds Teaching Hospitals NHS Trust	0.0	0.0%	89.0	4.4%
Mid Yorkshire Hospitals NHS Trust	(22.8)	(2.7%)	39.5	4.8%
South West Yorkshire Partnership NHS Foundation Trust	0.0	0.0%	28.2	6.8%
Yorkshire Ambulance Service NHS Trust	0.0	0.0%	18.5	4.1%
Sub Total - Providers	**(96.5)**	**(1.6%)**	**303.4**	**5.1%**
ICB Bradford	0.0	0.0%	17.2	3.8%
ICB Calderdale	1.7	1.1%	5.3	3.3%
ICB Kirklees	3.5	1.1%	9.2	3.0%
ICB Leeds	0.0	0.0%	30.7	5.0%
ICB Wakefield	0.0	0.0%	7.2	2.5%
ICB WY	91.3		53.1	
Sub Total - ICB	**96.5**	**4.5%**	**122.7**	**5.7%**
Total - ICS	**(0.0)**	**(0.0%)**	**426.1**	**6.6%**

Financial Plans – Place Summary

ICS Place	25/26 Plan			
	ICB Place £m	Providers £m	TOTAL £m	% of allocation
Bradford	0.0	(31.7)	(31.7)	(2.3%)
Calderdale	1.7	(21.1)	(19.4)	(4.1%)
Kirklees	3.5	(27.9)	(24.4)	(2.6%)
Leeds	0.0	0.0	0.0	0.0%
Wakefield	0.0	(16.0)	(16.0)	(1.8%)
WY	91.3		91.3	14.8%
YAS		0.0	0.0	0.0%
ICB Total	**96.5**	**(96.5)**	**(0.0)**	**(0.0%)**

ICS System Risk next steps

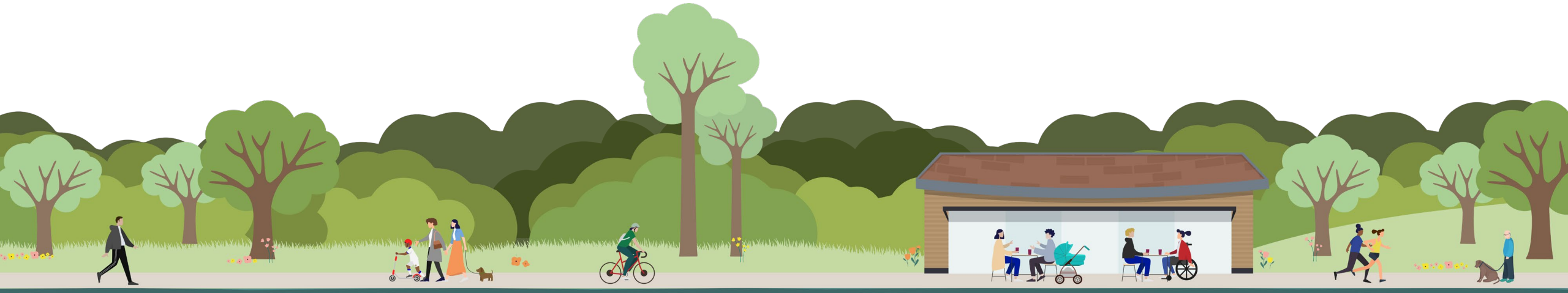
£33.2m ICS system risk

Addressed in following key ways:

- Any allocation upsides – first call against risk reserve.
- Any ICB Place in-year upsides – first call against risk reserve.
- Stretch targets formally set for all 11 statutory NHS organisations in West Yorkshire

Leeds Health & Care Partnership

Leeds Place 25/26 Financial Plan



Leeds Place Financial Position

Headline Plan Summary - Leeds Place				
Organisation	**Plan at 26th Feb £m**	**Transitional Support £m**	**Plan adjustments £m**	**Plan at 10/3/25 £m**
LYPFT	0.0	0.0	0.0	0.0
LCH	(1.5)	0.0	1.5	0.0
LTHT	(33.6)	9.4	*24.2	0.0
ICB in Leeds	(5.1)	0.0	5.1	0.0
Place Total	**(40.2)**	**9.4**	**29.3**	***(0.0)**

Leeds Place has improved its deficit position from £40.2m in the headline submission to breakeven. Within the LTHT position includes *£5m of assumed income from the ICB which it does not have in its position relating to NRTR patients

Key changes to financial plan

Headline Plan Summary - Leeds Place					
	LYPFT £m	LCH £m	LTHT £m	ICB £m	Total Place £m
Plan @ 26th Feb	0.0	(1.5)	(33.6)	(5.1)	(40.2)
Transitional Funding		-	9.4	-	9.4
Depreciation Funding assumption		1.5	-	-	1.5
High-Cost Drugs and Devices			5.0		5.0
Further efficiency and internal improvements			3.2	5.1	5.8
Assumed transfer of risk associated with excess NRTR patient numbers			*5.0		5.0
Removal of inflation funding risk			11.0		11.0
Total	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Scale of risk within plans over £110m

Leeds Health & Care Partnership

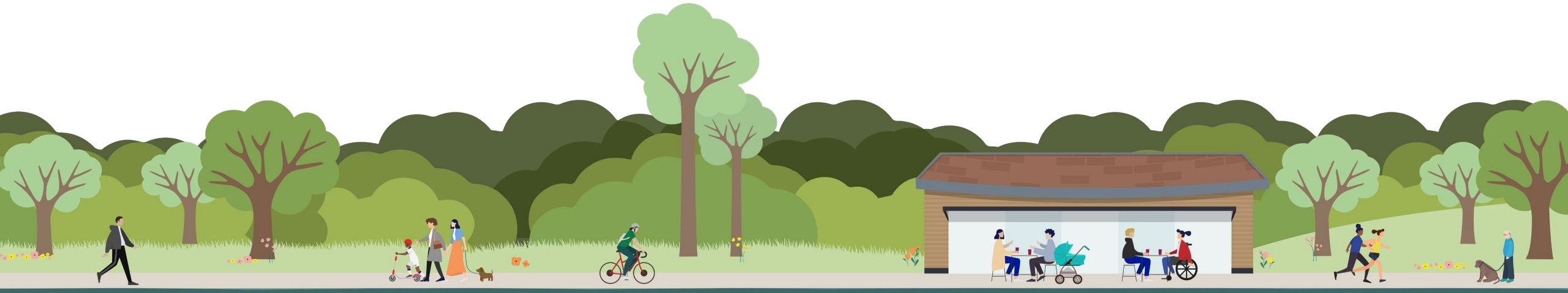
Headline Plan Summary - Leeds Place					
	LYPFT £m	LCH £m	LTHT £m	ICB £m	Total Place £m
Plan @ 21st March	**0**	**0**	**0.0**	**0.0**	**0.0**
Unidentified WRP (Gross rather than risk-adj)	(3.0)	(3.0)	(42.0)	(2.5)	(48.0)
As yet unsecured Spec Comm income			(4.0)		(4.0)
Inflationary cost pressures above funding	(2.3)	(2.3)	(16.0)		(20.6)
Delivery of RTT within funding			(5.0)		(5.0)
Removal of inflation funding (risk given level of inflation in the economy)			(11.0)		(11.0
Benefit realisation from capital investment (risk of constraints on CDEL)		(2.0)			(2.0)
OAP stretch target	(4.1)				(4.1)
Medical Agency reduction	(2.6)				(2.6)
S117 Growth/Demand risk				(2.5)	(2.5)
Efficiencies above productivity packs yet to be identified (CHC/Prescribing)				(4.0)	(4.0)
Demand risk if capping and Commissioning policy on IS not successful (acute, WM, ND)				(6.0)	(6.0)
Primary Care allocations outstanding and conclusion of collective action				TBC	
Total	**(12.0)**	**(7.3)**	**(78.0)**	**(15.0)**	**(112.3)**

System issues/risks to work through as a Partnership

- Activity Management (IS acute, ND and weight management)
- Delivery of RTT targets
- High-cost packages including OAPs, s117 and CHC
- Non-elective demand pressures
- Medicines Management
- Development of neighbourhood health model
- Primary Care – impact of possible continued collective action
- Impact on delivery of efficiency (e.g. meds op, CHC) due to potential reductions in teams following recent national announcements

Leeds Health & Care Partnership

ICB in Leeds
25/26 Financial Plan



Approach

1. Use 24/25 financial plans as starting point
2. Adjust to the 2024/25 recurrent exit position – through the identification and adjustment of non-recurrent items including non-recurrent allocations, non-recurrent expenditure and non-recurrent efficiency savings
3. Apply WY consistent allocation/income and expenditure uplifts for 2025/26
4. Apply Place specific adjustments including cost pressures
5. Apply current efficiency assumptions agreed with budget holders

Allocation and Expenditure - Key Assumptions

Allocations

1. ICB in Leeds Core Allocation: 24/25 Recurrent allocation:
   - Uplifted for 4.068% base growth and 0.11% Convergence
   - £4.8m uplift for DFT
   - Elective recovery fund included
   - SDF allocation after 7-8% national reduction

2. Delegated Primary Care Allocation: Recurrent allocation
   - Uplifted by 3.09% base growth and reduced by 0.08% convergence
   - £1.7m uplift for DFT
   - £16.2m for GP contract settlement including ARRS

3. Running cost allowance remains at £6.1m subject to national announcements

ICB in Leeds Core Allocation	**£000**
Recurrent Allocation @ Month 9	**1,555,641**
2025/26 Base growth (%) 4.068% (after above)	63,352
BCF adjustment	(253)
2025/26 Convergence (%) +0.11%	1,785
Local Convergence (Core allocation only)	4,863
Other	773
Indicative 2025/26 Allocation	**1,625,865**
2025/26 Elective Recovery Funding: Core (£k)	39,007
SDF (£k)	14,942
2025/26 Elective Recovery Funding: Additional (£k)	11,504
2025/26 Covid-19 testing (£k)	1,105
2025/26 Central technology licence arrangement adjustment (£k)	-879
2025/26 Discharge (£k)	7,257
Deficit Support Funding	9,400
CDC Funding	7,452
2025/26 Roll out of OCT (£k) - weighted pop; holding position	-102
2025/26 Corneal Tissue (£k) - weighted pop; holding position	-101
	1,715,747
Delegated Primary Medical Services	**£**
Non Programme-Primary Medical Care Services	160,603
GP Contract Changes Allocation Increase (recurrent)	4,975
	165,578
2025/26 Base growth (%) 3.09% (after above)	5,116
2025/26 Convergence (%) -0.08%	-143
Local Convergence (PC allocation only)	1,729
Additional Growth and ARRS	16,174
	188,453
Running Cost Allowance	**6,103**

Allocation and Expenditure - Key Assumptions

Expenditure – pre-efficiencies

- Cost Uplift Factor of 2.15% applied to Provider's made up of:
  - 4.15% Inflation
  - (2.0%) efficiency

- Other key assumptions:
  - MHIS included at 4.1% in line with growth in allocation
  - BCF 1.7% - applied on LA element (£0.8m)
  - No pressures assumed from SDF or PC allocations

Efficiency- £30.7m (5%)

To deliver the financial plan efficiencies of c£30.7m are required. The majority of which have been identified with £2m unidentified at this point.

Efficiencies by Function	£000
Acute	2,000
Mental Health (inc ND)	8,723
Community	3,530
CHC	3,757
Prescribing/Meds Optimisation	10,000
Other	500
Unidentified Efficiency	2,161
Total	**30,671**

Financial Plan – Break even

Leeds	25/26 Plan Pre-Efficiencies	Efficiency	Final 25/26 Plan
ALLOCATION	(1,910,303)	-	(1,910,303)
Sub-total Allocations	**(1,910,303)**	**-**	**(1,910,303)**
ACUTE	916,874	(2,000)	914,874
MENTAL HEALTH	315,509	(8,723)	306,786
COMMUNITY HEALTH SERVICES	209,539	(3,530)	206,009
CONTINUING CARE	96,048	(3,757)	92,291
PRIMARY CARE	191,485	(10,000)	181,485
PRIMARY CARE CO COMMISSIONING	195,931	(500)	195,431
OTHER COMMISSIONED SERVICES	6,458	(25)	6,433
PROGRAMME	3,028	(2,136)	892
Sub-total Programme	**1,934,871**	**(30,671)**	**1,904,200**
RUNNING COSTS	6,103	-	6,103
Total Planned Expenditure	**1,940,974**	**(30,671)**	**1,910,303**
Surplus / (Deficit)	**(30,671)**	**30,671**	**(0)**

Meeting name:	Leeds Committee of the West Yorkshire Integrated Care Board
Agenda item no.	12/25
Meeting date:	21 May 2025
Report title:	Neighbourhood Health Guidance and Leeds Approach 2025/26
Report presented by:	Nicola Nicholson, Associate Director for Strategy and Programmes Leeds ICB
Report approved by:	Helen Lewis, Director of Pathway and System Integration Leeds ICB
Report prepared by:	Joanna Howard, Manraj Khela, Vicky Womack, Kim Adams, Nicola Nicholson

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

Previous considerations:

Executive summary and points for discussion:

The government has issued initial guidelines on developing and implementing neighbourhood health services in response to the Darzi Report (The State of the NHS in England), with further detail expected as part of the 10 Year Health Plan. This paper provides a summary of that approach and how we are implementing neighbourhood health in Leeds, aligned to our agreed partnership transformation programmes.

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 national guidelines on developing and implementing neighbourhood health and the alignment to our approach in Leeds.
2. **Note** the self-assessment for the Leeds Health and Care Partnership against the six core components of neighbourhood health and our high-level delivery plan aligned to our partnership transformation programmes

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 a neighbourhood health approach supports adults, children and young people with complex health and social care needs who require support from multiple services and organisations. By moving to a neighbourhood health service, delivering more care at home or closer to home will improve people's access, experience and outcomes, and ensure the sustainability of health and social care delivery.
Through developing our neighbourhood health approach with an immediate focus on preventing preventable unplanned care utilisation (Goal 1 Healthy Leeds Plan) and shift towards secondary prevention (Goal 2 Healthy Leeds Plan), we will support delivery of our system goals and our overarching Best City Ambition.

Appendices

Appendix 1: Overview of Leeds Health and Care Partnership Transformation Programmes
Appendix 2: Leeds Health and Care Partnership self-assessment against the 6 core components of neighbourhood health
Appendix 3: Leeds Health and Care Partnership Delivery Plan summary

Acronyms and Abbreviations explained

CYP – Children and Young People

HLP – Healthy Leeds Plan

LCP – Local Care Partnerships

LHCP – Leeds Health and Care Partnership

MDT – Multi-disciplinary Team

MGP – Modern General Practice

NH MDT – Neighbourhood Health Multi-disciplinary Team

PCN – Primary Care Network

PLT – Partnership Leadership Team

SMI – Severe Mental Illness

VCFSE – Voluntary, Community, Faith and Social Enterprise

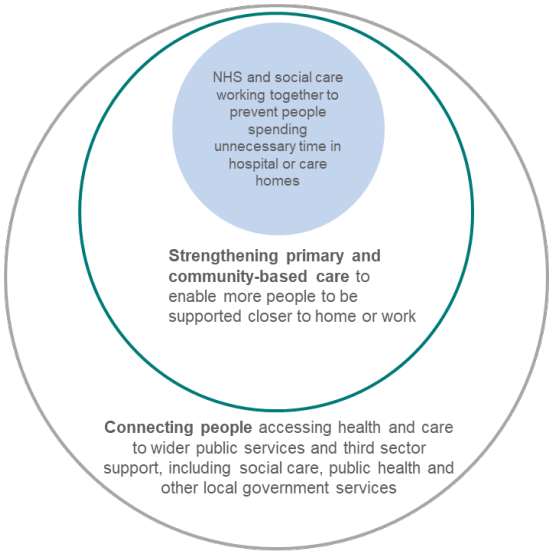
WYICB - West Yorkshire Integrated Care Board

1. Introduction

1.1 The Government issued a new mandate to reform the NHS in response to the Darzi Report (the state of the NHS in England) and seeks to address the urgent challenges facing the health and care system, reflecting patients' priorities to cut waiting times, improve access to primary care and improve urgent and emergency care. In addition, the mandate lays the foundations for longer-term reform, focussing on bringing care closer to communities, prioritise prevention over treatment, embracing digital transformation and embedding financial discipline within the system. In advance of the publication of the 10 Year Health Plan (expected June 2025), the government's vision and mandate provide a strong emphasis on developing neighbourhood health this year. The guidance states that systems are to set the foundations of the neighbourhood model by continuing to embed, standardise and scale core components of existing practice, including taking a consistent, system wide population health management approach to patient segmentation and risk stratification (Neighbourhood health guidelines).

1.2 We need to move to a neighbourhood health service that will deliver more care at home or closer to home, improve people's access, experience and outcomes, and ensure the sustainability of health and social care delivery, as indicated in Fig. 1 the national delivery framework.

Figure 1: Aim for all neighbourhoods over the next 5 to 10 years



1.3 Neighbourhood health reinforces our approach to integrated working and building on the work we have already started in Leeds. Neighbourhood health will be achieved by better connecting and optimising health and care resource through three key shifts at the core of the government's health mission:

- **From hospital to community –** providing better care closer to or in people's own homes, helping them to maintain their independence for as long as possible, only using hospitals when it is clinically necessary for their care.
- **From treatment to prevention –** promoting health literacy, supporting early intervention and reducing health deterioration or avoidable exacerbation of ill health.
- **From analogue to digital –** greater use of digital infrastructure and solutions to improve care.

1.4 National guidance provides an in-year focus to build on current momentum for a neighbourhood health approach to ensure the ongoing sustainability of health and social care delivery, through:

- **Standardising the six core components of existing practice** to achieve greater consistency of approach (see section 3 and appendix 2 of this report).
- **Bringing together the different components into an integrated service offer** to improve coordination and quality of care, with a focus on people with the most complex needs.
- **Scaling up** to enable more widespread adoption.
- **Rigorously evaluating** the impact of these actions, ways of working and enablers both in terms of outcomes for local people an effective use of public money.

Further detail on our approach to Neighbourhood Health in Leeds can be found in section 3 of this report.

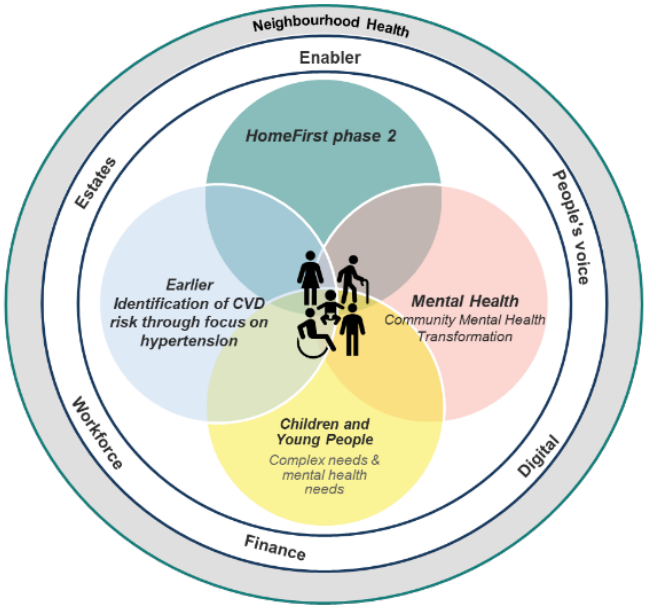
2. Leeds Health and Care Partnership Transformation Programmes

2.1 The national guidance states that the focus in 2025/26 should be on supporting adults, children and young people with complex health and social care needs who require support from multiple services and organisations, emphasising reducing demand through developing our neighbourhood health approach with an immediate focus on preventing preventable unplanned care utilisation (Goal 1 Healthy Leeds Plan) and shift towards secondary prevention (Goal 2 Healthy Leeds Plan).

2.2 To support delivery of the Healthy Leeds Plan, the Leeds Health and Care Partnership (LHCP) have identified and agreed four partnership transformation programmes, with neighbourhood health identified as a fifth cross-cutting programme that will create the infrastructure to support delivery of neighbourhood health at scale in Leeds (fig. 2 Leeds Transformation

Programmes 2025/26). An overview of the LHCP transformation programmes can be found in appendix 1

Figure 2: Leeds Health and Care Partnership Transformation Programmes



3. Developing neighbourhood health in Leeds

3.1 Leeds is well placed for the increased focus on neighbourhood health with strong foundations to support this work, building on the strong collaborative working approach across partners in Leeds within Local Care Partnerships and wrapped around Primary Care Network footprints.

3.2 There are six core components associated with an effective neighbourhood service, as identified within national guidance, which include:

- Population Health Management
- Modern General Practice
- Standardising community services
- Neighbourhood multi-disciplinary teams
- Integrated intermediate care with a 'home first' approach
- Urgent neighbourhood services

3.3 Our focus in Leeds has been on the delivery of the six core components for 2025/26 and working with partnership colleagues to develop a neighbourhood health mandate that will outline the delivery plans for the entirety of neighbourhood health in Leeds. An initial self-assessment against the six core components of neighbourhood health has been completed for Leeds, an overview of which can be found in appendix 2.

3.4 Following the initial self-assessment, work has already started, in partnership across the transformation programmes, to create a delivery plan against the core components of a neighbourhood health model aligning our transformation programmes. An overview of the delivery plan can be found in appendix 3.

3.5 In addition to the six core components defined nationally, in Leeds we will be focussing on the delivery of locally defined building blocks. These building blocks (or capabilities) are also required to be in place for the successful delivery of the partnership transformation programmes. Work is already underway for some of these which will be driven forward over the coming year:

- **Aligned incentives, payment approach(es) and financial flows:** to look at aligned incentives and financial flows to reward successful delivery of neighbourhood health and wellbeing, improving the outcomes of people. As part of this we will need to agreed how to manage risk as a partnership.

- **Shared digital approach:** In particular, meeting the needs of front line staff to be able to share information easily and efficiently across teams and organisational boundaries (where appropriate and legal) to provide integrated care.

- **Shared estates approach:** Considering how partners can access, share and utilise each other's workspaces in communities and how we can eliminate or reduce cross-charges and barriers to shared estates.

- **Shared workforce approach:** In Leeds we have a well-deployed One Workforce Strategy. This needs to be reviewed in the context of what is required to go further faster in delivering integrated working at front-line level to embed neighbourhood health and wellbeing. This will need to include a shared OD approach to support changes and cultural shifts at all levels.

4. Next Steps

4.1 The work to develop our neighbourhood health approach in Leeds is progressing at pace and work with partnership colleagues is underway to develop a detailed

blueprint and clear city vision to support implementation. Partners will agreed specific measures (qualitative, quantitative and key deliverables), baselines for each and expected trajectories to know if neighbourhood health is having the expected impact for the population of Leeds.

5. Recommendations

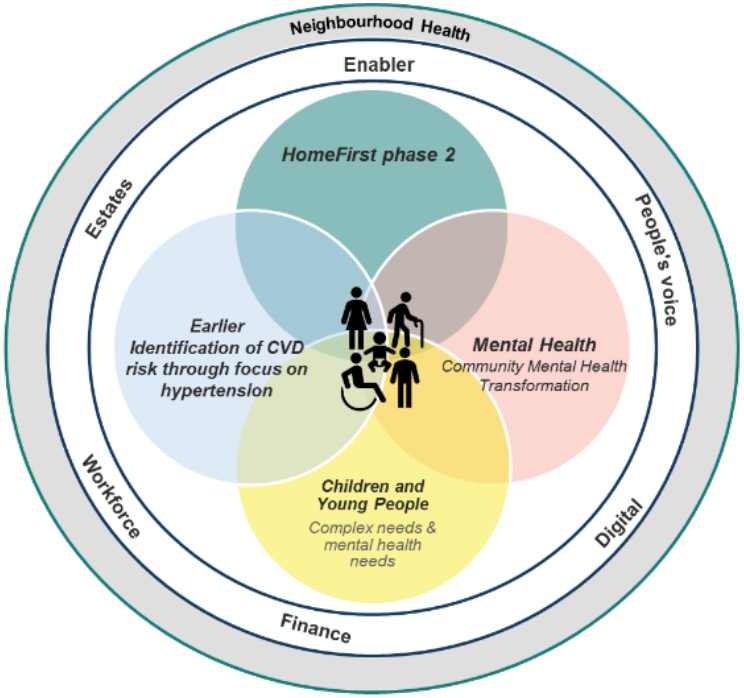
The Leeds Committee of the West Yorkshire Integrated Care Board is asked to:

a) Note the national guidance on developing and implementing neighbourhood health and the alignment to our approach in Leeds
b) Note the self-assessment for the Leeds Health and Care Partnership against the six core components of neighbourhood health and our high level delivery plan aligned to our partnership transformation programmes

6. Appendices

Appendix 1: Overview of Leeds Health and Care Partnership Transformation Programmes
Appendix 2: Leeds Health and Care Partnership self-assessment against the 6 core components of neighbourhood health
Appendix 3: Leeds Health and Care Partnership Delivery Plan summary

Appendix 1: Overview of the Leeds Health and Care Partnership Transformation Programmes



HomeFirst Phase 2: to improve health and care outcomes by creating a culture where collaboration with people in their communities is our primary approach to joined up care and support. Programmes will proactively identify and support adults at risk, implement an enabling neighbourhood model, support people at home, promote independence and preventing deterioration. Programmes include:

- People in Leeds who need intermediate care
- People at end of life with respiratory disease
- People living with frailty at risk of injury
- Proactive care
- People living with 3+ long term conditions and mental illness (SEISMIC)
- Prevention diagnostic

Mental health:

- Community Mental Health Transformation will roll out a city-wide model for community mental health services for people with the highest level of need
- Improving physical health outcomes for people with a SMI – focus on cancer

Children & Young People:

- Management of high-cost complex needs packages
- Redesign of the Autism and ADHD pathways to be 'needs-led'
- Early identification & intervention of mental health needs in school age children

Early Identification of Cardiovascular disease through a focus on **Hypertension**:

- Targeted cohorts
- Improving treatment to target optimisation
- Identification of people at risk through AI

Neighbourhood health programme to create the infrastructure to support delivery at scale across Leeds

- Workforce – OD. Core teams and specialist input
- Digital requirement
- Clinical risk sharing
- Measuring impact at scale across Leeds

Appendix 2: Leeds Health and Care Partnership self-assessment against the 6 core components of neighbourhood health

6 core components of neighbourhood health	Leeds Self-assessment (March 2025)	Status (RAG rated)
Population health management	• Applied systematic data and insight led approach to understanding our population needs, driving transformation to deliver our system goals • Integrated linked data set (Leeds Data Model) enabling the identification of specific cohorts through our population segmentation model to understand health and care utilisation, identify priorities and plan existing or new services. • Building on existing learning such as the Staten Island PPS model, we have applied the model to utilise more targeted approach which is data-driven linked to geographic areas with services, health outcomes and social determinants of health. • Opportunity to strengthen our approach and further embed people's voice and experience at the centre of our approach.	
Modern General Practice	• 68 / 87 practices have applied and received the MGP funding, with a focus on improving access and experience • Opportunities to build on PCN approaches and services such as enhanced access out of core hours including examples of how pooling capacity, experience, knowledge and skills can deliver a seamless primary care service to patients. • Workforce and existing pressures remains a city and national challenge and we continue to build on developments of Integrated Neighbourhood Teams and ambitions of the city's neighbourhood health model. • Continuation of implementing the Primary Care Access Recovery Plan will provide additional tools to support improvements helping people to understand the new model of general practice – being care navigated to another service including community pharmacy or to self-care as well as being directly booked with a professional that is not a GP – will be key in supporting better access and better experience. • ARRS roles such as care co-ordinators, wellbeing coaches and social prescribers are well embedded into LCPs, connecting through to partners within council and third sector as well as other parts of the health system	
Standardising community health services	• Current and future transformation initiatives focus on meeting local needs, such as community mental health, NHS talking therapies, CYP neurodevelopmental pathway review and access to mental health services • Community mental health transformation approach reinforces and enhances integration; including strong cross sector collaboration; maximising continuity of care; and dissolving barriers between primary and secondary care • Opportunities to further enhance approach and potentially test and expand new ways of working with a proactive care model that stimulates a "left shift" of activity, with reductions in unplanned care, promoting greater effectiveness of proactive community intervention in avoiding hospital admission.	

	• Scaling up approaches and maximising opportunities linked to national drivers. Recent example of Marmot programme influencing developments such as local GP template' for use based on the eight Marmot principles, enabling practitioners to actively review people's social and economic circumstances and provide easy referrals to key services including those addressing fuel poverty and benefits advice.	
Neighbourhood multidisciplinary teams (MDTs)	• MDTs are central to a range of approaches in Leeds ensuring a seamless, co-ordinated and effective support and a 'getting it right first time' response e.g. Early help hubs. • Opportunity to embrace this approach further in the development of integrated neighbourhood teams whilst embracing options which utilise and enhance trusted community connections e.g. community hubs • Multidisciplinary coordination of care for people with complex health and social care needs and dedicated care coordinator • Further strengthen the relationship between services and local communities, utilising the community anchor approach to provide connections through local people	
Integrated intermediate care with a 'Home First' approach	• Building on the foundations of the impact of the HomeFirst programme, further developing our vision to enable a sustainable, person centred, home first model of intermediate care • Embedded case managers, from across the partnership, working with people at the point of hospital discharge to support the Home First approach • National guidance has a strong emphasis on reducing demand through developing our neighbourhood health approach with an immediate focus on preventing preventable unplanned care utilisation (Goal 1 Healthy Leeds Plan) and shift towards secondary prevention (Goal 2 Healthy Leeds Plan). • In Leeds we are well place to go further and faster and utilising key components such as strong leadership, promoting collaboration, data-driven decisions and leveraging digital tools has shown to deliver improved outcomes in this space.	
Urgent neighbourhood services	• Strengthening community-based urgent response - Continue work on Urgent Community Response, See and Treat / Hear and Treat pathways, and Community Diagnostic Centres • The positive impact of virtual wards in Leeds has already been seen including reductions in the average length of patient stay by five days. Care teams have centralised view of patient data to support clinical decision-making and enabling early intervention. Expanding this approach presents a further opportunity to improve efficiencies and relieve pressures on the wider system. • Realising the opportunities of digital solution could enable us to see further improvements to improved health and wellbeing outcomes	

Appendix 3: Leeds Health and Care Partnership Delivery Plan summary 2025/26

Core components of neighbourhood health	Leeds plans for delivery (March 2025/26)
Standardising community health services	**HomeFirst phase 2** will deliver: • Standardised Community Services for physical health **Community Mental Health Transformation** will deliver standardised community services • Improving primary care access to mental health • Improving access to community-based mental health services • Improving access to talking therapies **CYP complex needs programme** will deliver: • Join up mental health support teams in schools as highlighted in standardizing community services
Neighbourhood multidisciplinary teams (MDTs)	**HomeFirst phase 2** will deliver: • Neighbourhood MDTs, incl. health, social care, VCFSE and wider partners for populations with complex needs who require multiple services/organisations to deliver proactive, responsive care • Holistic joint assessment through NH MDT • Complex Case Management through NH MDT • Care Coordination through NH MDT **Community Mental Health Transformation** will deliver: • Neighbourhood MDTs, incl. health, social care, VCFSE and wider partners for populations with complex needs who require multiple services/organisations to deliver proactive, responsive care **CYP complex needs** programme will deliver: • Neighbourhood MDTs for Children and Young People
Integrated intermediate care with a 'Home First' approach	**HomeFirst phase 2** will deliver: • Integrated Intermediate Care with a 'Home First' approach • Step up pathways into integrated intermediate care
Urgent neighbourhood services	**HomeFirst phase 2** will deliver: • Aligning community response and virtual wards to local demand

Meeting name:	Leeds Committee of the West Yorkshire Integrated Care Board
Agenda item no.	13/25
Meeting date:	21 May 2025
Report title:	Oulton Medical Centre: Application to transfer services from Swillington Health Practice
Report presented by:	Kirsty Turner (Associate Director of Primary Care)
Report approved by:	Kirsty Turner (Associate Director of Primary Care)
Report prepared by:	Vicky Annakin (Senior Manager Primary Care Integration)

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

Previous considerations:

In November 2024 Primary Care Operational Group gave approval for Oulton Medical Centre to commence a period of engagement on transferring all services from Swillington Health Practice (SHP) with a view to closing the premises in August 2025.

A period of engagement was undertaken in January and February 2025 and the outcome of the engagement was presented to the Primary Care Operational Group (PCOG) on 20 March 2025. PCOG reviewed the findings of the engagement report, and the recommendations and additional actions applied as a result of that discussion are outlined in this paper.

Executive summary and points for discussion:

In October 2024 Leeds Integrated Care Board (ICB) received an application from Oulton Medical Centre to transfer all services from their branch surgery at Swillington Health Practice with a view to closing the premises from 31 August 2025.

Oulton Medical Centre currently serves a list of 15,230 patients (November 2024) operating from 3 sites, Oulton Medical Centre in Oulton, Marsh Street Surgery in Rothwell and Swillington Health Practice in Swillington.

The main driver for the application is due to the costs of operating from SHP becoming financially unviable due to incremental increases in costs imposed by the landlord. Due to this financial pressure the future of the branch site has become unsustainable, and despite the practice and the ICB working closely with the landlord over the past 18 months to explore opportunities to make efficiencies and reduce the overall costs they have continued to significantly increase year on year.

The practice ceased offering GP face to face appointments from Swillington during the pandemic in March 2020 and has not been reinstated since. The services that are currently provided at

Swillington are nursing, physiotherapy, and midwifery sessions. A recent audit shows that only 30% of these appointments are used by patients at Swillington the other 70% were patients having to travel from Oulton and Rothwell.

Patients have been travelling to the other 2 practice sites for over 5 years to access GP appointments and the practice proposal is to also transfer all other existing service provision to these locations from 31 August 2025. The practice has confirmed there will be no overall reduction in service provision and all appointments will be transferred with the corresponding staff to the other 2 sites.

A robust engagement excise has taken place over a period of 6 weeks and this paper summarises the key outcomes from the feedback, the practice response and the impact the closure of Swillington Health Practice and sets out the recommendations for the Leeds Committee of the ICB to consider.

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 on the impact of the branch closure
2. **NOTE** the recommendations and additional actions implemented by the Primary Care Operational Group
3. **APPROVE** the application from Oulton Medical Centre to transfer services from Swillington Health Practice and close the branch site by the end of August 2025

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

Not applicable.

Appendices

1. Site and Boundary Map
2. Engagement Report
3. Equality and Impact Assessment

Acronyms and Abbreviations explained

1. OMC – Oulton Medical Centre
2. SHP – Swillington Health Practice
3. NHSPS – NHS Property Services
4. ICB – Integrated Care Board

5. EIA – Equality Impact Assessment

What are the implications for?

Residents and Communities	The closure of Swillington Health Practice will mean that residents in Swillington no longer have access to the services that currently operate out of that site. Public transport links are available between Swillington and the other 2 practices sites in Oulton and Rothwell GP Services have not been available at Swillington Health Practice since March 2020. Services currently provided from the site are Nursing, Midwifery and Physiotherapy GP home visits are currently and will continue to be offered to housebound patients. Patients will still be registered with Oulton Medical Centre (as they are now) and will be able to access all services that are currently offered at Swillington at either Oulton Medical Centre or Marsh Street Surgery. The closure will result in staff delivering these appointments at the other practice sites and there will be no reduction in capacity or staffing.
Quality and Safety	None identified
Equality, Diversity and Inclusion	See Appendix 3 for the completed Equality Impact Assessment
Finances and Use of Resources	The rising costs associated with the Swillington estate is financially unviable. The cost implications are outlined further in Section 7
Regulation and Legal Requirements	The application to close the branch practice has been enacted in line with section 8.15.13 of the Policy and Guidance Manual
Conflicts of Interest	None identified
Data Protection	None identified
Transformation and Innovation	None identified
Environmental and Climate Change	None identified
Future Decisions and Policy Making	None identified
Citizen and Stakeholder Engagement	The engagement report in Appendix 2 gives full and detailed account of the engagement process undertaken and a full breakdown of the feedback.

1. SUMMARY OF PROPOSAL

1.1 This paper outlines an application from Oulton Medical Centre (OMC) to close their branch surgery at Swillington Health Practice (SHP) from 31 August 2025 and the engagement they have completed to support their application.

1.2 The main driver for the application is due to the costs of operating from SHP becoming financially unviable due to incremental increases in costs imposed by National Health Service Property Services (NHSPS) (the landlord). Due to this financial pressure the future of the branch site has become unsustainable, and despite the practice and the Integrated Care Board (ICB) working closely with NHSPS over the past 18 months to explore opportunities to make efficiencies and reduce the overall costs, they have continued to increase year on year.

1.3 The practice ceased offering GP Face to face appointments from SHP during the pandemic in March 2020 and has not been reinstated since. The services that are currently provided at SHP are nursing, physiotherapy, and midwifery sessions. A recent audit shows that only 30% of these appointments are used by patients residing in Swillington the other 70% were patients who travelled from Oulton and Rothwell.

1.4 Patients have been travelling to the other 2 practice sites since March 2020 to access GP appointments and the practice proposal is to now transfer all other existing services to these locations from August 2025. The practice has confirmed there will be no reduction in service provision and all appointments will be transferred with the corresponding staff to the other 2 sites.

1.5 A robust engagement excise has taken place over a period of 6 weeks and this paper summarises the key outcomes from the feedback, the practice response to this and the impact the closure of SHP will have.

2. PRACTICE INFORMATION

2.1 OMC successfully won a managed allocation process in November 2018 resulting in SHP forming part of the practice portfolio as an additional branch site from April 2019.

2.2 OMC's original boundary remained unchanged apart from extending to incorporate Waterloo Manor Independent Hospital, Selby Road, Garforth. Prior to the takeover there were already approximately 400 patients residing in Swillington registered with the practice.

2.3 OMC currently serves a list of 15,230 patients (November 2024) operating from 3 sites, Oulton Medical Centre, Marsh Street Surgery and Swillington Health Practice. A site and boundary map are included in Appendix 1.

2.4 There is 1.8 mile distance between OMC (main site) and SHP with public transport available between the two sites. There is a 3.1 mile distance between the 2 branch sites (Marsh Street Surgery and SHP).

2.5 OMC has a list size of 7543, Marsh Street has a list size of 6253 and SHP has a list size of 1434.

2.6 The practices' main site is OMC; these premises meet all current DDA and infection control standards. The practice has identified that approximately 50% of patients predominantly use this site, 41% of patients access Marsh Street for their care and 9% attend Swillington.

2.7 None of the sites are a dispensing location

2.8 For many of the patients closest to SHP, OMC will be the closest alternative surgery. Patients will continue to be able to access the Pharmacy in Swillington for prescriptions and any alternative services.

2.9 Accessible car parking is available at OMC and Marsh Street Surgery.

2.10 Regular buses operate between Oulton and Swillington providing patient with transport between the 2 sites, requiring 1 bus ride to complete the journey between the sites. Buses currently operating along this route are the 174, 176,168 & 9C

3. PATIENT AND STAKEHOLDER ENGAGEMENT

3.1 The engagement process began on 6 January and closed on the 14 February (6 weeks).

3.2 The practice 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 3 practice sites.

3.3 The practice held an initial meeting with their PPG to explain the reason for the engagement, how this would be conducted and to seek their views on the process overall. In addition PPG members were emailed a copy of the patient survey to approve. PPG members at the meeting were supportive of the process and some attended the public events held over the engagement period.

3.4 A letter outlining the proposed changes was posted to all registered patients (1 per household) which included details of the survey, how to submit any questions and details of the planned public events.

3.5 The proposed changes were outlined on both practice websites with a link to an online survey. The practice also printed copies of the survey and made these available at all 3 sites to ensure those unable to access the survey online were still able to provide feedback.

3.6 The practices organised and held 2 public events for people to attend to find out more about the proposed changes, providing opportunity for patients to ask questions.

3.7 The first event was at Swillington Village Hall on 13 January, and the second at Oulton Medical Centre on 14 January. An online Microsoft Teams meeting was held on the 16 January. Following feedback from patients about accommodating feedback from those at work, a further online session was scheduled in on Microsoft Teams at a time when working people would be more able to join, this was held on the 27 January.

3.8 A total of 151 people actively engaged in the engagement process through either attending a meeting or submitting a survey. Most responses via the survey were from patients, friends or carers who use services at Swillington Health Practice.

- The practice met with 5 members of the PPG on 3 occasions.
- Approximately 60 people attended the public meeting at Swillington Village Hall
- 4 people attended the public meeting at Oulton Medical Centre
- There were no attendees at the lunch time online meeting
- 3 people attended the evening online meeting
- 79 people completed the survey, including 6 paper copies.

3.9 An FAQ document was created and updated with responses to patients queries and concerns throughout the process. This was updated in response to responses to the survey and questions raised at the public events. A full breakdown of the responses and assurances given to the concerns raised can be found in the full engagement report in Appendix 2.

3.10 The engagement identified several key themes, including:

- **Access and Convenience** – concerns about the difficulty in travelling to the other 2 practice sites specifically relating to the unreliability of public transport
- **Impact on the community** – closure seen as detrimental to the community's wellbeing
- **Financial and Operational** – concern that cost-cutting is being prioritised over patient care
- **Quality of Services and Facilities** – concern as to the quality of the facilities at the other 2 sites and that the demand will overwhelm capacity
- **Support for local services** – strong desire for healthcare services to be maintained or expanded (reinstating GP provision at the surgery)
- **Frustration with decision-making** – concerns around the level of consultation specifically with the elderly population
- **Alternatives and Solutions** – responses included providing limited GP services at the Swillington premises, offering transport for those unable to access other locations, or negotiating better contracts for the building.

3.11 The Engagement Report also details the engagement process and outcomes and includes a key themes table which outlines the practice response to the feedback (see Appendix 2).

4. COMMUNICATIONS AND INVOLVEMENT

4.1 A meeting was held with local councillors, practice partners and the practice manager and representatives from the ICB Primary Care team to discuss the emerging situation with the financial difficulty at Swillington because of rising estate costs. Councillors were updated on the discussions to date between the practice, ICB and NHSPS and that numerous conversations to explore opportunities to reduce the costs had been had over the past 18months. Councillors expressed their concern at the situation but understood the need to engage with patients on the proposal due to the work that has been done to try and resolve.

4.2 A separate meeting was held with the MP for Leeds East, Richard Burgon, and members of the ICB Primary Care team during the engagement period. The MP had been contacted by several constituents raising their concerns over the potential closure. The MP raised questions regarding the work that had been done to date and the rationale for the engagement which were discussed. The MP stated he would be writing to NHSPS to voice concerns and understand why other action could not be taken to reduce costs. It is understood this letter was received and responded to by NHSPS. Concerns and feedback raised both at the meeting with the MP and through corresponding emails have been included within the engagement report.

5. PRACTICE RESPONSE AND CONSIDERATIONS

5.1 The patient engagement process conducted by the practice was a robust and thorough process which allowed patients to access various engagement methods to provide feedback. As stated above, 151 registered patients contributed to the engagement, equating to just under 1% of the total practice population.

5.2 The feedback from many of the patients portrays disappointment, sadness and some anger at the prospect of the closure of Swillington Health Practice and most of the feedback gathered was negative. The main concerns include the lack of transport, the impact on vulnerable groups (especially the elderly), the strain on other surgeries, and the inadequate communication and consultation process. There are also calls for more consideration of local needs and suggestions for alternative solutions like shuttle services or retaining some services at Swillington.

5.3 The practice has provided a response to the feedback received and provided an overview of how they will manage and mitigate the concerns of patients. The full practice response can be seen in the Engagement Report in Appendix 2

5.4 There has been no GP working at Swillington Health Centre since 2020 and patients have been travelling to Oulton or Marsh Street to access their GP appointments. The practice already offers proportionally more home visits in Swillington for housebound patients than any other area they cover which will continue and the practice will consider accommodating further visits for patients who are unable to get to surgery urgently.

5.5 Most services currently offered at Swillington Health Centre are planned care services such as LTC reviews, maternity and physiotherapy which will be moved to the other practice sites. These appointments are booked in advance and therefore easier to for patients to plan travel and arrangements to attend. The practice is committed to offering appointments to suit patient preference at either of the sites that are most convenient for them to attend. There will be a range of clinic times and days to suit availability and offer patient choice.

5.6 Most of the feedback from patients centred on the need for more reliable transport links from Swillington to Oulton. Whilst there are buses that run directly between the sites, feedback from patients is that buses are unreliable and not often enough. The practice is committed to continuing to raise and work with the local councillors on the public transport issues to understand and try and influence any improvements that can be made.

5.7 The population of Swillington equates to approximately 3500 people, and 1434 of those are registered with OMC. During the engagement it was made clear to people that they have the choice to re-register with another practice that might be more convenient for them to attend such as Novia Scotia Medical Centre or Kippax Hall Surgery which are the next nearest practices that other residents of Swillington are registered with.

5.8 Feedback from the engagement highlighted a strong sense of community and many of the suggestions received asked that the practice look at opportunities to work with the Parish Council and local pharmacy to provide care closer to home.

5.9 The practice has already spoken to the local pharmacy who is keen to work collaboratively where possible. The practice will work on options for prescription requests and how they could work with the pharmacy to make this convenient for patients. In addition, the practice is keen to explore opportunities such as delivering vaccination clinics within the pharmacy or utilise space elsewhere in the community (pending infection control compliance).

5.10 Ongoing conversations between NHSPS, the ICB and the practice have been had over the past 18 months to understand and negotiate a decrease in the non-reimbursable costs associated with Swillington Health Practice. Significant time and capacity have been spent to try and reach a resolution which would enable the practice to save costs and make this a financially sustainable option however this has not been found. The practice has declared keeping SHP open is now financially unviable and poses a substantial risk to their future. The practice has exhausted all options which has led to the submission of an application to close the site.

5.11 The practice has informed the PCN of the work and application to close the site at Swillington from the outset with all the local practices being made aware.

6. PROPOSAL

Option	Benefits	Risks
Reject the application to close Swillington Health Practice	Patients accessing services in Swillington continue to receive same level of healthcare provision	There is a significant risk that this puts undue pressure on the practice affecting their resilience and long-term sustainability The practice remains unable to provide GP services out of Swillington The practice will need to reduce workforce capacity and resource to be able to afford the rising NHSPS costs There are concerns around the long-term viability of the premises as a suitable site to provide clinical services To date no interest from local practices has been received to the future of the site at Swillington
Approve the application to close Swillington Health Practice	Supports the practice plans for long term sustainability	Residents of Swillington unable to access services currently provided locally.

	Supports practice population by maintaining workforce and capacity to deliver services Allows the practice to invest additional funds into development of staff and improvement of services due to financial savings Patients continue to access GP services at Oulton and Marsh Street, in keeping with the arrangements that have been in place since 2020	The mitigations put in place by the practice fail to address the issues raised through the engagement

7. RECOMMENDATIONS FROM PRIMARY CARE OPERATIONAL GROUP

7.1 The findings of the engagement report were presented to the Primary Care Operational Group (PCOG) on 20 March 2025 with a recommendation to approve the application to close Swillington Health Practice.

7.2 PCOG noted the engagement findings and mitigating actions proposed by the practice and, considering all elements of the report, were in support of approving Oulton Medical Centre's application to transfer existing services from SHP and close the branch site.

7.3 The recommendation from PCOG came following in-depth discussions regarding the financial viability of the site and the significant financial challenge this brings to the practice, alongside the consideration given to the long-term viability of the premises to provide healthcare services.

7.4 The main feedback from the engagement was the community's sense of loss on closing the premises and a strong desire for clinical services to remain in Swillington. Members of PCOG recognised the need to assess whether other local practices would be interested in taking on the premises as part of their current estate portfolio and therefore an additional recommendation was made to invite other local practices to submit expressions of interest in the branch site.

7.5 Local practices within the PCN were invited to submit an expression of interest in developing a branch practice by the 14 April. Practices were encouraged to speak to the Primary Care Team to get more detail or to formally write to express their interest. For transparency a copy of the Annual Charging

Schedule for 2024/25 was included to ensure practices received all the information to aid their decision making.

7.6 The ICB received no expressions of interest from practices regarding the branch at Swillington by the 14 April and no further interest has been raised to date.

7.7 Following the PCOG meeting, the final engagement report has been made publicly available via the practice website and to date no further feedback has been received by the ICB or the practice.

8. FINANCIAL IMPLICATIONS AND RISK

8.1 There is currently a significant financial risk to the practice due to the costs of Swillington Health Practice

8.2 The practice has stated that it has become financially unviable to sustain the branch site at Swillington due to the rise in estates costs.

8.3 Closing Swillington Health practice in the interim will have no financial impact on the ICB as the void costs for the premises will continue to be paid for until the future of the building has been decided.

9. STATUTORY / LEGAL / REGULATORY / CONTRACTUAL

9.1 The PGM summarises in Section 8.15.13 what should be considered by the commissioner when deciding on closure:

Contractor and commissioner discussions resulting ultimately in a decision about a branch closure will often include consideration of (but not be limited to):

- *financial viability*
- *registered list size and patient demographics*
- *condition, accessibility and compliance to required standards of the premises*
- *accessibility of the main surgery premises including transport implications*
- *the commissioner's strategic plans for the area*
- *other primary health care provision within the locality (including other providers and their current list provision, accessibility, dispensaries and rural issues)*
- *dispensing implications (if a dispensing practice)*
- *whether the contractor is currently in receipt of premises costs for the relevant premises*
- *other payment amendments*
- *possible co-location of services*
- *rurality issues*
- *patient feedback*

- *any impact on groups protected by the Equality Act 2010 (for further detail see chapter 4: general duties of NHS England)*
- *the impact on health and health inequalities*
- *any other relevant duties under part 2 of the NHS Act (for further detail see chapter 4: general duties of NHS England)*

10. EQUALITY IMPACT ASSESSMENT

10.1 An Equality Impact Assessment (EIA) 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)

11. RECOMMENDATIONS

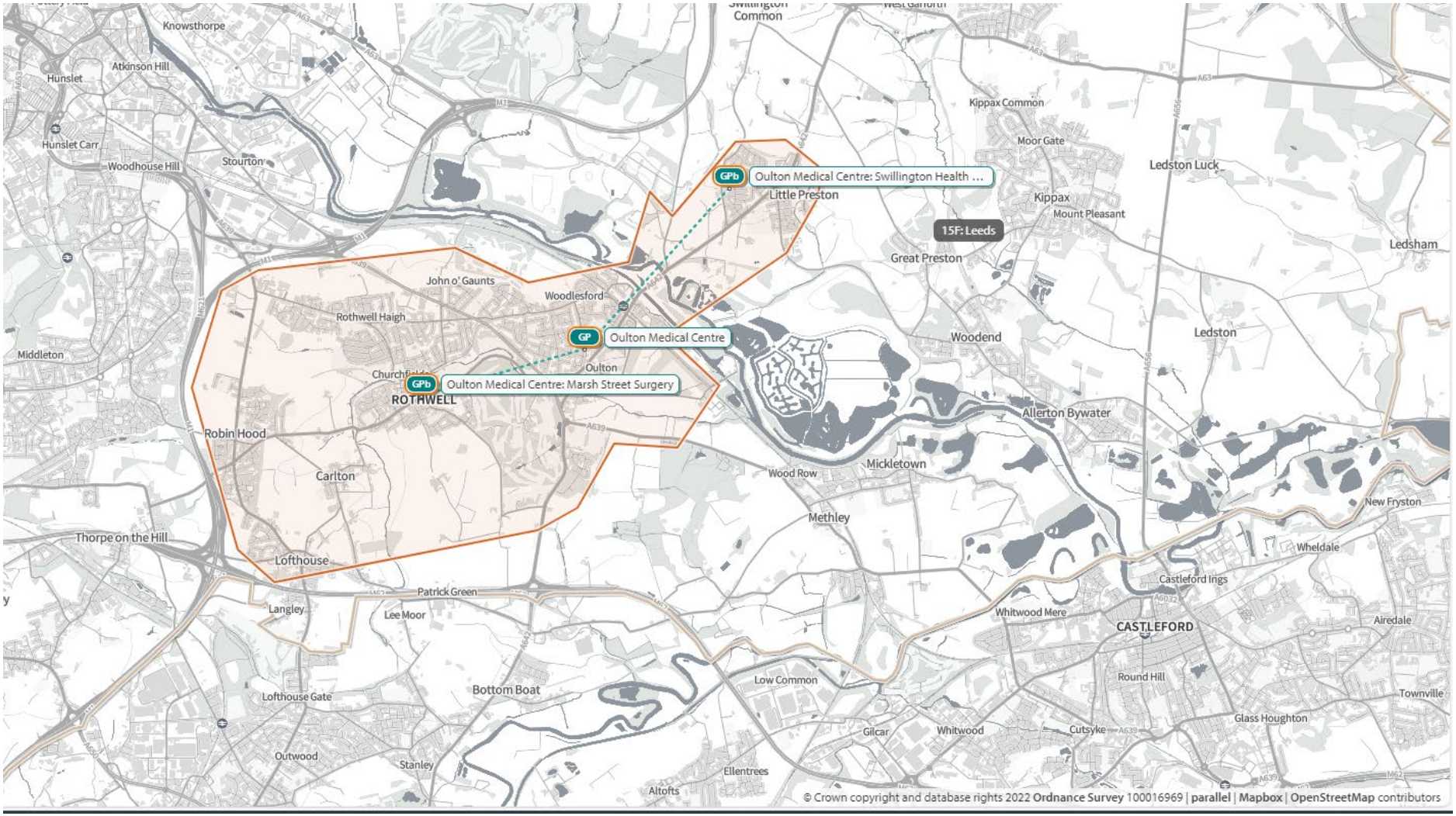
The Leeds Committee of the West Yorkshire Integrated Care Board is asked to:

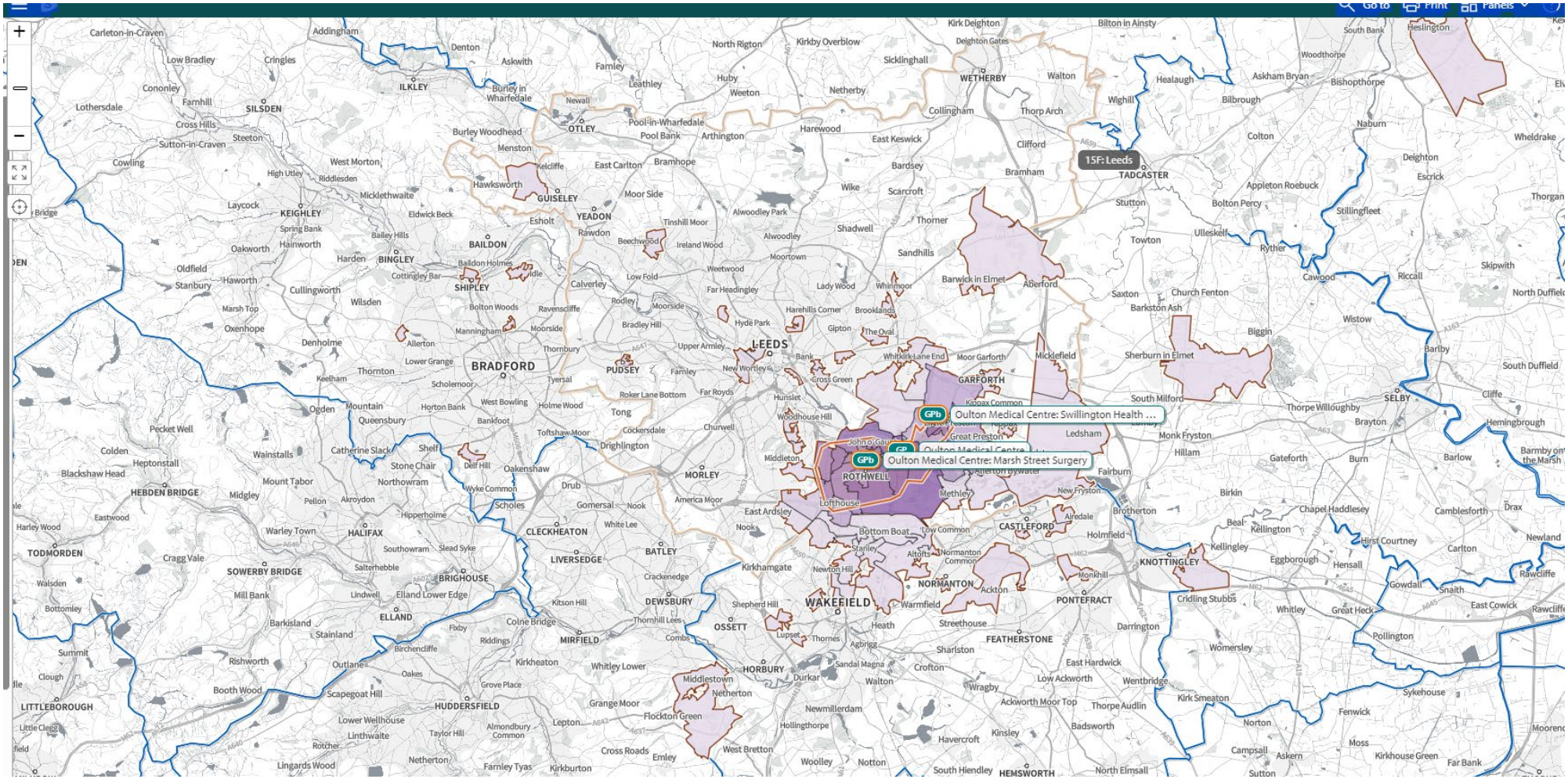
1. **NOTE** the feedback from patients and local stakeholders around the impact of the branch closure
2. **NOTE** the recommendations and additional actions implemented by the Primary Care Operational Group
3. **APPROVE** the application from Oulton Medical Centre to transfer services from Swillington Health Practice and close the branch site by the end of August 2025

12. APPENDICES

1. Practice Site and Boundary Map
2. Engagement Report
3. Equality Impact Assessment

Appendix 1


Knowsthorpe
Hunslet
Atkinson Hill
Hunslet Carr
Woodhouse Hill
Stourton
Middleton
Common
Kippax Common
Moor Gate
Ledston Luck
GPb
Oulton Medical Centre: Swillington Health ...
Little Preston
Kippax
Mount Pleasant
15F: Leeds
Great Preston
Ledsham
John o' Gaunts
Woodlesford
Rothwell Haigh
GP
Oulton Medical Centre
Woodend
Ledston
Oulton
GPb
Oulton Medical Centre: Marsh Street Surgery
ROTHWELL
Allerton Bywater
Robin Hood
Carlton
Wood Row
Mickletown
New Fryston
Methley
Thorpe on the Hill
Lofthouse
Wheldale
Castleford Ings
Patrick Green
Langley
Lee Moor
Whitwood Mere
CASTLEFORD
Airedale
Round Hill
Low Common
Bottom Boat
Lofthouse Gate
Townville
Glass Houghton
Gilcar
Whitwood
Cutsyke
Outwood
Stanley
Ellentrees
Altofts
© Crown copyright and database rights 2022 Ordnance Survey 100016969 | parallel | Mapbox | OpenStreetMap contributors


15F: Leeds
GPb
Oulton Medical Centre: Swillington Health ...
GPb
Oulton Medical Centre: Marsh Street Surgery
LEEDS
BRADFORD
WAKEFIELD
HUDDERSFIELD
HALIFAX
CASTLEFORD
NORMANTON
PONTEFRACT
KNOTTINGLEY
TADCASTER
SELBY
GARFORTH
ROTHWELL
MORLEY
PUDSEY
BAILDON
SHIPLEY
GUISELEY
YEADON
OTLEY
ILKLEY
KEIGHLEY
BINGLEY
SILSDEN
HEBDEN BRIDGE
TODMORDEN
SOWERBY BRIDGE
BRIGHOUSE
ELLAND
LITTLEBOROUGH
MIRFIELD
DEWSBURY
OSSETT
HORBURY
BATLEY
LIVERSEDGE
CLECKHEATON
FEATHERSTONE
WETHERBY

Appendix 2

Leeds Health & Care Partnership

Oulton Medical Centre
Marsh Street Surgery
Swillington Health Practice

NHS West Yorkshire Integrated Care Board

Transfer of services from Swillington Health Practice

Engagement Report

Engagement dates: 6 January – 14 February 2025

Publication date: February 2025
Oulton Medical Centre

Executive Summary

Swillington Health Practice is a branch surgery of Oulton Medical Centre.

The partners at Oulton Medical Centre applied to NHS West Yorkshire Integrated Care Board (ICB), which organises the delivery of NHS services in the Leeds area (the ICB in Leeds), to transfer services currently provided at Swillington Health Practice to our two other sites, and to carry out an engagement with our registered patients about these plans to transfer services, which would result in the closure of the Swillington branch.

The ICB in Leeds agreed to the request to engage with our registered patients, and this report provides a background to the request to transfer services from Swillington Health Practice, and outlines how we engaged with patients and local people about these plans. The report details what people told us during the engagement and outlines how we are responding to their feedback.

The engagement ran from 6 January to 14 February 2025, and aimed to:

- Inform people about the proposed change, and
- Give people an opportunity to share their views on the change, voice any concerns, and tell us what was important to them about GP services.

We sent letters to 800 Swillington households and text messages to all people over the age of 18 years registered at Oulton Medical Centre informing them of the proposal and to advise of the engagement meetings. Over 80 people attending face-to-face events to find out more and to have their say.

This report gives a background to the change and outlines how people were involved in the engagement activity. It details what people told us, and outlines how we are responding to their feedback.

This report will be shared with those involved in the involvement and will be made available on the practice website and the Leeds Health and Care Partnership website. It will also support the general development of local health and care services in Leeds.

Contents

Background

Oulton Medical Centre provides care to over 15,400 people in southwest Leeds and is made up of three surgeries – the main site at Oulton Medical Centre, and two branch surgeries: Marsh Street Surgery in Rothwell, and Swillington Health Practice.

Oulton Medical Centre, including the Marsh Street Surgery, took over Swillington Health Practice in November 2018. Since acquiring the premises, the costs associated with leasing the building have continued to increase significantly.

Numerous meetings and conversations with the Integrated Care Board (ICB) in Leeds (which organises the delivery of NHS services in the Leeds area) and with National Health Service Property Services (NHSPS), which owns the premises, have taken place since the start of the lease on the site, but these have failed to result in a solution.

The practice has been struggling to manage the rising costs associated with Swillington Health Practice, and these costs have now become financially unsustainable.

Due to financial uncertainty surrounding the site, and from the beginning of the COVID-19 pandemic, there has been no GP based at Swillington since early 2020. However, the practice has continued to offer nursing, physiotherapy, and midwifery sessions from the premises.

As a result, at the end of 2024, the practice applied to NHS West Yorkshire Integrated Care Board (the ICB in Leeds) to:

- transfer the services currently provided at Swillington Health Practice to the two other sites, which would result in the closure of the Swillington branch.
- engage with the practice's patients about the plans to transfer the services.

Patients living in the Swillington area have, since early 2020, been travelling to one of the other sites for GP appointments. Patients who are housebound have been receiving, and would continue to receive, home visits and would be unaffected by the change.

The main change would be to the services still running at Swillington Health Practice, nursing, midwifery and physiotherapy appointments. The intention is that, after the end of July 2025, Swillington Health Practice would close, and these sessions would relocate to Oulton Medical Centre and the branch site at Marsh Street Surgery.

Involving patients and wider stakeholders

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

- We have held meetings with the practice's Patient Participation Group and kept them informed about the engagement meetings and invited them to attend the engagement meetings. One member attended the Swillington parish Hall meeting and a further 3 attended the meeting held at Oulton Medical Centre.
- Staff engagement – We shared our concerns over the rising cost associated with operating services at our branch site Swillington Health Practice owned by NHS Property Services and our proposal to transfer services to our other two sites back in July 2024 at a whole practice meeting. We reassured staff there would not be any redundancies as a result of the closure and staff would continue to work across the 2 remaining sites.
- We shared our plans with local councillors and MPs and responded to their enquiries and offered to meet with them. One councillor attended a meeting with the senior partner and practice manager. The MP responded to say he was unable to attend but had arranged to meet with the West Yorkshire Integrated Care Board at a later date.
- We have had discussions and exchanged emails with Swillington Pharmacist and agreed to look at ways we can work together to help mitigate against some of the concerns raised around obtaining prescriptions and the possibility of hiring a consultation room at the chemist premises if deemed suitable from a health & Safety as well as Infection Control perspective. An email was circulated to all the six practices in LS25/26 PCN advising them of our proposal to move services from Swillington Health Practice. We emailed the midwifery services to inform them about the plans and to reassure them their services would transfer to one of our other sites.
- We wrote to 798 registered patient households to outline our plans, and to invite them to take part in our engagement activities. We also sent text to all registered patients over the age of 16 years with a message informing of the proposal and to inform them about the public events and to fill out the survey.
- We ran an online survey and shared the survey link with registered patients, on our website and through our social media platforms. The engagement ran from 6 January to 14 February 2025.
- We provided people with paper copies of the survey at each of our three premises, with different formats / translated copies available on request.

- We held two face-to-face public meetings, one at Swillington Village Hall on 13 January, one at Oulton Medical Centre on 14 January and an online meeting on the 16th January. Following feedback from patients, we also offered a further online session on Microsoft Teams at a time when working people would be more able to join 27th January.
- We developed a Frequently Asked Questions (FAQ) document to share and published it on our website.

Who did we hear from?

Altogether, there were 4 engagements with our involvement activities. Some people may have been involved in more than one way:

- We met with 5 members of our Patient Participation Group on 3 occasions.
- We emailed all the local councillors and received correspondence from and met with one of the local councillors and we exchanged emails with the local MP.
- Approximately 60 people attended the face-to-face public meeting at Swillington Village Hall on 13 January.
- Four people attended the face-to-face public meeting at Oulton Medical Centre on 14 January.
- Nobody attended the lunch time online meeting held on 7th January
- 3 people attended the evening online meeting held 14th February
- 79 people completed the survey, including 6 paper copies.

The Survey

We asked the people completing the survey to tell us who they were:

Option	Total	%
I used to be a patient at Swillington Health Practice	9	11.39%
I am a relative, friend or carer or someone who used to be a patient at Swillington Health Practice	1	1.27%
I currently use one of the services at Swillington Health Practice	36	45.57%
I am a relative, friend or carer of someone who currently uses one of the services at Swillington Health Practice	6	7.59%
I am a patient at Oulton Medical Centre	39	49.37%
I am a relative, friend or carer of someone who is a patient at Oulton Medical Centre	3	3.8%

I am a patient at Marsh Street Surgery	16	20.25%
I am a relative, friend or carer of someone who is a patient at Marsh Street Surgery	1	1.52%
Other	1	1.27%
Answered	79	100%

As it has not been possible for patients to see a GP at Swillington Health Practice since early 2020, we asked people where they have been attending GP appointments since then:

Option	**Total**	**%**
Oulton Medical Centre	46	58.23%
Marsh Street Surgery	20	25.32%
I / they have not been to the GP since early 2020	1	1.27%
Not applicable	26	32.91%
Other	3	3.8%
Answered	73	92.41%
Not Answered	6	7.59%

We asked people who were still attending at Swillington Health Practice what sessions they were attending for:

Option	**Total**	**%**
Nursing sessions	37	46.84%
Physiotherapy sessions	12	15.19%
Midwifery sessions	2	2.53%
Answered	41	51.9%
Not Answered	38	48.1%

Equality monitoring data from the survey

The survey included a standard section on equality monitoring, and those who completed this section provided the following detail:

Age range

Four people were between 26 – 35 years old
Seven people were between 36 – 45 years old
Nine people were between 46 – 55 years old
21 people were between 56 – 65 years old
18 people were between 66 – 75 years old
Five people were between 76 – 85 years old

Gender

39 people stated they were Female
20 people stated they were Male
Two people preferred not to say
One person stated they were Non-binary

Disability

28 people answered Yes, they had a disability

Carers

13 people stated that they provide unpaid care or support for someone who is older, disabled or has a long-term condition

Ethnicity

All those who provided an answer (60 respondents) stated their ethnicity was White - English, Welsh, Scottish, Northern Irish or British.

Employment

18 people stated they were in full-time employment
11 people stated they were employed part-time
Two people stated they were in receipt of state benefits
Two people stated they were not in employment
27 people stated they were retired
One person stated they were self-employed

What did people tell us?

The survey was divided into two sections. The first section asked people to tell us their thoughts about the planned change to Swillington Health Practice. The second section asked them more general questions about their experiences of general practice.

Section One

We asked people who were still using services provided at Swillington Health Practice how the sessions moving to Oulton Medical Centre or to Marsh Street Surgery might affect them:

Option	Total	%
It wouldn't really affect me / them	22	27.85%
It would affect me / them	29	36.71%
Other	7	8.86%
Answered	56	70.89%
Not Answered	23	29.11%

What do we need to consider when thinking about this change?

We asked people if there was anything they thought we should take into account as we are planning to make this change?

(Responses to this question have been analysed using ChatGPT – asked to summarise the responses and pull out the main themes).

There were 54 responses received for this question. A full transcript of all responses is available on request.

Responses primarily focus on concerns and objections related to the potential closure of the Swillington health centre. Here are the key themes and main points raised:

1. Impact on Access and Transport

Inconvenience of Travel: Many residents are concerned about the difficulty of accessing other surgeries (Oulton, Rothwell, and Marsh Street) due to long travel times, unreliable public transport, and the lack of personal transport options.

Elderly and Vulnerable Groups: A significant number of people in Swillington are elderly or have mobility issues. Many do not drive, and public transportation is seen as

inadequate or expensive. Losing the local health centre would force them to rely on others for transportation, impacting their independence and health.

Financial Burden: Some residents highlighted the cost of taxis for appointments, which can be prohibitive, especially for those on fixed or low incomes.

2. Quality of Life and Independence

Elderly and Independent Living: Many individuals rely on the Swillington centre for basic healthcare services, such as blood tests, injections, vaccinations, and nurse appointments. Without a local centre, they would struggle to maintain independence, and family members would have to take time off work to assist with transport.

Stress and Anxiety: Some residents, particularly those with mental health issues, expressed concerns that traveling to a distant surgery would exacerbate anxiety and stress.

3. Local Demographics and Needs

Swillington's Growth: Swillington's population has grown, and it is now home to both elderly individuals and young families with children. The lack of a local GP would significantly impact these groups, especially those without access to cars or reliable transport.

Population Size and Demand: Many residents feel the closure would disproportionately affect those who already face difficulties in accessing healthcare. There is a call for services to be made more accessible rather than reduced, given the size and demographic of the village.

4. Concerns About Service Availability

Impact on Other Surgeries: People are concerned about whether Oulton and Rothwell surgeries can handle the increased patient load if Swillington closes. Many have experienced difficulty getting timely appointments, and there are fears that the situation will worsen with the closure.

Staffing and Space: There are questions about whether the remaining surgeries have the capacity to absorb additional patients and provide the same level of service (e.g., nurse appointments, blood tests).

5. Communication and Consultation Issues

Inadequate Engagement: Many residents feel that the engagement process regarding the closure has been insufficient, with poor notice given and few opportunities for in-person consultation, especially for working-age people. There is also criticism of the timing of the consultations (during winter months).

Lack of Information: Some individuals were unaware that GP services had already been removed from Swillington in 2020 and feel misled by the lack of clear communication from the NHS about changes.

6. Alternative Solutions and Suggestions

Shuttle Services: Some residents propose a shuttle service to transport people between Swillington and the other surgeries, especially for those with mobility issues or no access to transport.

Maintaining Services at Swillington: There are calls for at least some level of GP services to remain in Swillington, with suggestions such as having a GP available one day a week.

Better Infrastructure: Some feel that, if the closure goes ahead, better parking and transport infrastructure at Oulton and Rothwell should be a priority to accommodate the influx of additional patients.

7. Overall Sentiment

Opposition to Closure: A significant portion of the text expresses strong opposition to the closure of Swillington's health centre. Many feel that local medical services should remain local, especially considering the challenges Swillington residents face in terms of transport and mobility.

Financial Concerns vs. Patient Care: Some residents questioned whether the closure was financially motivated and argued that patient health should take precedence over cost-saving measures. Many are worried about the long-term effects on their ability to access necessary healthcare services.

In summary

The main concerns include the lack of transport, the impact on vulnerable groups (especially the elderly), the strain on other surgeries, and the inadequate communication and consultation process. There are also calls for more consideration of local needs and suggestions for alternative solutions like shuttle services or retaining some services at Swillington.

Finally, we asked if people had any further thoughts on the plans for the change.

(Responses to this question have been analysed using ChatGPT – asked to summarise the responses and pull out the main themes).

There were 58 responses received for this question. A full transcript of all responses is available on request.

The responses reflect several recurring themes related to the closure of the Swillington Health Practice:

Access and Convenience: Many residents express concerns about the difficulty of traveling to Oulton or Rothwell, especially for elderly, young, or vulnerable individuals who may struggle with public transport or mobility. The Swillington surgery is seen as essential due to its proximity.

Impact on the Community: Several comments highlight that Swillington has a large population, including elderly and young families, making access to a local medical centre crucial. The closure is seen as detrimental to the community's well-being, with some citing the inconvenience and potential harm to patients' health outcomes, particularly for those unable to drive.

Financial and Operational Concerns: Many respondents understand that financial sustainability is a factor in the closure decision, but some feel that cost-cutting is being prioritized over patient care. There are also questions about the high rent for the Swillington building and whether alternative funding solutions could be found.

Quality of Services and Facilities: The quality of facilities at alternative locations (e.g., Marsh Street) is criticized, especially the waiting room environment and overcrowding at other surgeries like Oulton. Concerns are raised that the remaining surgeries may become overwhelmed with the additional patient load.

Support for Local Services: There is a clear desire for local healthcare services to be maintained or expanded. Many feel that the Swillington surgery should be used more effectively, with suggestions for reinstating GP appointments or expanding nursing services.

Frustration with Decision-Making: Some respondents believe the closure decision is being pushed through without sufficient consultation or regard for public opinion, and that the elderly, in particular, are not being properly considered. There are accusations that patient care is being sacrificed in favour of financial considerations.

Alternatives and Solutions: A few responses propose solutions, such as providing limited GP services at the Swillington premises, offering transport for those unable to access other locations, or negotiating better contracts for the building.

Overall, the main concerns revolve around accessibility, patient care, and the potential negative impact of the closure on the local community, with many asking for more consideration of the needs of Swillington residents before making such a decision.

Section Two

We asked people which three things are most important to them when making an appointment with their GP practice:

Option	Total	%
Getting an appointment quickly	67	84.08%
Same day appointments	19	24.05%
Seeing a specific person at the practice	15	18.99%
The quality of care I receive	57	72.15%
Feeling that it is a safe environment	4	5.06%
Good communication	21	26.58%
The opening times of the practice	13	16.46%
Being able to access a range of different services locally	31	39.24%
Other	3	3.8%
Answered	74	93.67%
Not Answered	5	6.33%

We asked if people knew that every GP practice has a Patient Participation Group (PPG):

Option	Total	%
Yes	34	43.04%
No	41	51.9%
Answered	74	93.67%
Not Answered	5	6.33%

Nine people said they would like to find out more about getting involved with the PPG at Oulton Medical Centre.

We asked if people had heard of, or are signed up to use, the NHS App:

Option	Total	%
I haven't heard of it	1	1.27%
I have heard of it, but I haven't signed up to it	8	10.13%
I have signed up to it but don't really use it	20	25.32%
I have signed up to it and find it helpful	39	49.37%
Other	5	6.33%
Answered	72	91.14%
Not Answered	7	8.86%

Practice response to feedback received

We are grateful to everyone who has taken part in this engagement and provided us with their views and concerns about the transfer of services from Swillington Health Practice.

We understand that people may have concerns about the closure of the premises at Swillington, and how this may affect them, and we have listened to the feedback at the engagement meetings, and to the concerns raised in the survey responses.

We have been able to reassure patients that they will continue to be registered with Oulton Medical Centre, unless they choose to register with an alternative provider. Oulton Medical Centre remains the nearest practice to Swillington, and there are other surgeries in Garforth and Allerton Bywater.

The biggest concern we have heard from patients through the engagement is about accessing our other two sites, which would involve a car journey or a bus journey.

Buses operate through Swillington, linking with Oulton, and we have looked into the current provision of this service, requiring one bus ride to complete the journey between the sites.

Buses currently operating along this route (174 and 175) operate hourly. The 168 runs every 30 minutes and the 9C operates hourly. Bus number 22 operates approximately every 120 minutes.

During this engagement, patients have informed us that the buses, although frequent, can be unreliable, and patients were concerned this may make them late for appointments. The practice is happy to support raising this issue with local councillors and / or bus companies and will continue to review patient feedback to understand any impact this may cause.

For those travelling by car, both our other sites have a car park with off street parking available.

Comments were made during the meetings and in the surveys about maintaining some services at Swillington:

There are calls for at least some level of GP services to remain in Swillington, with suggestions such as having a GP available one day a week.

During COVID-19, five years ago, we moved all GP services to our Oulton site to comply with strict infection control procedures that were in place and, in the main, patients were dealt with remotely or in a designated room at our Oulton site.

As things started to open and social distancing measures were relaxed, we continued to see patients at our other two sites at Oulton Medical Centre and Marsh St Surgery in Rothwell. We used our Swillington site for planned care appointments such as nursing activities including blood tests, blood pressure checks and long-term condition reviews including diabetes and heart disease as well as respiratory conditions.

There has not been a GP based at Swillington for five years now and patients have been travelling to one of our 2 other sites for appointments with a doctor during this time. A recent audit of our planned care appointments demonstrated that only 30% of appointments at Swillington Health Practice were utilised by patients residing in Swillington area. Swillington has a population of 3,513, out of which only 1,434 people are registered with our practice. Due to the relatively small number of patients registered at Swillington we found that approximately 70% of our planned care clinics were filled with patients who had travelled from Oulton or Rothwell.

This alongside our on-going dispute with NHS Property Services was undermining our ability to form a long-term plan for the site.

We have reassured patients that there would be no reduction in appointments and that all services currently operating from Swillington would transfer to our other two sites.

The practice has had discussions with Swillington Pharmacy about potentially utilising a consultation room at the chemist for a couple of sessions a week for possible blood tests and health checks. The pharmacist has said he would like to extend his premises to include further consultation rooms in the future. We are also keen to utilise the Parish Hall for large vaccination campaigns if available.

Next steps

The feedback received through the engagement has been brought together in this final report. The report will be posted on our practice website and the link shared with our patients by text.

We will also provide updates about the next steps, and decisions taken, on our website, to ensure everyone is kept fully informed about important information and timescales.

You can keep up to date with developments at our practice website:

https://www.oultonmedicalcentre.co.uk/

Appendix 3

West Yorkshire Health and Care Partnership

NHS West Yorkshire Integrated Care Board

Equality Impact Assessment (EIA)

1. Project Summary Information

Project name	Transfer of services (and closure of branch site) of Oulton Medical Centre (Swillington Health Practice)
Organisation/s	Oulton Medical Centre NHS West Yorkshire Integrated Care Board (ICB) In Leeds
Date	Start date: 01.06.25

Project Lead	Hilary Farrar (Practice Manager at Oulton Medical Centre)
Clinical Lead	Ben Gatenby (GP Partner Oulton Medical Centre)
Equality Lead	Senior Equality, Diversity and Inclusion Manager NHS Integrated Care Board in Leeds
Senior Responsible Owner (SRO)	Ben Gatenby (GP Partner Oulton Medical Centre

Project proposal / objectives
1. To engage with stakeholders around the potential closure of one site (Swillington Health Practice (SHP)). The practice took over Swillington Health Practice in November 2018 as part of a managed allocation. Our boundary throughout remained unchanged apart from extending to incorporate Waterloo Manor Independent Hospital, Selby Road, Garforth. We had around 400 patients residing at Swillington prior to taking over the surgery. The costs of operating from Swillington Health Practice have become financially unviable due to incremental increase in costs imposed by National Health Service Property Services (NHSPS).

Project proposal / objectives
We have worked closely with the NHS West Yorkshire ICB (WYICB) and held several meetings jointly with NHSPS over the last 3 years to try to reach a solution. Despite numerous meetings we have been unable to negotiate a reduction in costs. Our most recent Annual Charging Schedule 2024-25 show our non-reimbursable costs to be £52,552.17. Swillington Health Practice currently hosts nursing, physiotherapy, and midwifery sessions. Since the start of COVID we haven't had a GP based at the surgery. Patients from Swillington have become accustomed to travelling to our main site at Oulton. To reduce the financial burden associated with SHP we have had to look at new models of working. We propose to move services currently at SHP to Oulton Medical Centre and our branch site at Marsh Street Surgery. There will be no reduction in patient services resulting from the branch closure. Patients residing near Swillington health practice may oppose the closure due to the convenience of having services on their doorstep. We will collect these views and opinion during our engagement period and would hope to be able to address any concerns. Feedback from this engagement will feed into our plans and help us to consider necessary mitigations to any issues that people may face as a result of the transfer of these services. Patients will continue to be seen at either our main site Oulton Medical Centre 1.9 miles away or our branch site Marsh Street Surgery 3.3 miles away. Those patients who are unable to get out of their homes or are receiving palliative care will continue to receive home visits. Seasonal influenza and COVID vaccination clinics will be delivered from Swillington Parish Village Hall to ensure we continue to vaccinate at the earliest opportunity and reach maximum number of patients. We will continue to offer telephone appointments where suitable and also have the capability to offer video consultation. We are looking into the option of funded transport i.e., taxis or minibus for those patients who are unable to travel to our main site by public transport and don't have access to a car. There is a regular bus service operating between Swillington and Oulton - numbers 9C and 168 that run throughout the day.

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.

National and local research

Local demographics / Census data Provide in this section local demographic and or Census data
Swillington has a population of 3,513 (2021 Census) Males 1,678 Females 1,829 **Age Groups:** 0-17 years - 651 18-64 years - 2,033 65+ years - 823 **Ethnicity groups:** White - 3,366 Asian – 65 Black – 12 Arab – 1 Mixed/multiple – 71 Other ethnicity group – 3 **Religion or belief:** Christian – 1,840 Muslim – 25 Hindu – 6 Sikh – 1 Buddhist – 11 Jewish – 2 Other religion – 21 No religion – 1,429

Service user equality monitoring data:

Provide in this section analysis of service user data by protected groups

Total Patients including Male/Female split:

Swillington

1449 - Total

767 - Female

682 – Male

Oulton

7553 – Total

3885 – Female

3667 – Male

Marsh Street

6251 – Total

3255 – Female

2996 – Male

Breakdown of age of population:

Swillington

0-15 = 234

16-18 = 49

19-65 = 809

66-75 = 132

76+ = 225

Oulton

0-15 = 1319

16-18 = 252

19-65 = 4612

66-75 = 672

76+ = 698

Marsh Street

0-15 = 1004

16-18 = 201

19-65 = 3804

66-75 = 647

76+ = 595

Top 10 Ethnicities within the practice:

Swillington

Bangladesh – 2
British Bangladesh – 2
Caribbean - 3
Pakistani or British Pakistani - 4
Indian or British Indian - 7
Other Black - 8
Other Asian - 9
White & Asian - 10
White & Black Caribbean - 11
African -11
White & Black African - 12
Other Mixed Other -14
Irish -15
Other White- 70
British or Mixed British – 1395

Oulton

British or Mixed British – 2208
British – 2220
White British – 1351
Other White – 61
African – 23
Indian/British Indian – 21
Chinese – 19
Polish – 19
Other Mixed 19
White & Asian - 12

Marsh Street

British or Mixed British – 5974
Other White – 385
Other mixed – 53
Irish – 46
African – 39
Indian or British Indian – 37
White & Asian – 32
Other Asian – 28
White & Black African – 25
Caribbean - 19

Top 10 first Languages within the practice:

Swillington

Main spoken language English – 1391

Main Spoken Language French – 3
Main Spoken language Punjabi -1
Main Spoken Language Hungarian – 6
Main Spoken Language Urdu – 2
Using British Sign – 2
Main Spoken language Spanish – 1
Main Spoken Language Lithuanian – 1
Main Spoken language Russian – 1

Oulton

Main Spoken Language English – 6708
Main Spoken Language Polish – 39
Main Spoken Language Romanian -18
Main Spoken Language Pashto – 10
Main Spoken Language Farsi – 10
Main Spoken Language Spanish – 10
Main Spoken Language Russian – 8
Main Spoken Language Cantonese – 8
Main Spoken Language French – 7
Main Spoken Language Chinese - 7

Marsh Street

Main Spoken Language English – 5686
Main Spoken Language Polish – 25
Main Spoken Language Farsi-8
Main Spoken Language Romanian – 8
Main Spoken Language Spanish – 7
Main Spoken Language Mandarin - 6
Main Spoken Language Lithuanian – 6
Main Spoken Language Italian – 5
Main Spoken Language Greek – 5
Main Spoken Language French - 5

Patients documented with have a disability/Reasonable adjustment:

Mental Health SMI (Severe Mental Illness)

Swillington = 30
Oulton = 56
Marsh Street = 43

Learning Disability

Swillington = 8
Oulton = 35
Marsh Street = 42

Accessible Information Standard – Recorded information

Swillington = 450
Oulton = 1458
Marsh Street = 1428

Reasonable Adjustment:
There are 475 patients requiring reasonable adjustments registered at Swillington Health Practice according to the Leeds Data Quality reports. This figure includes those requiring a quieter environment when being seen at the practice, hearing impaired or deaf patients and blind or sight impaired patients requiring larger print or braille.

Swillington = 475
Oulton = 1639
Marsh Street = 1549

Other demographic information:

People with long term conditions:
Diabetes
Swillington = 125
Oulton = 432
Marsh Street = 417

Asthma
Swillington = 112
Oulton = 456
Marsh Street = 460

COPD
Swillington = 61
Oulton = 163
Marsh Street = 179

Heart Failure
Swillington = 38
Oulton = 115
Marsh Street = 84

Coronary heart Disease
Swillington = 71
Oulton = 225
Marsh Street = 198

People over the age of 65
Swillington = 126
Oulton = 436
Marsh Street = 418

Patient experience data:
Covering Patient experience, Patient safety

Patient experience data:

Friends and Family Test:

Reporting period 23/10/2023 – 23/10/2024

Total Amount of feedback = 3097

Rated Very Poor (2%) 62

Rated Poor (3%) 97

Rated Neither (13%) 409

Rated Good (28%) 857

Rated Very Good (48%) 1487

Rated Don't Know (6%) 185

Care Opinion - 0 stories found in the last 6 years.

Care Quality Commission – Rated the GP practice as Good in 2018

GP Patient Survey – 2024 - 77%- Good overall experience at the practice

Top 3 areas on the GP Patient Survey:

- 93% Felt their needs were met during their last general practice appointment.
- 96% Knew what the next step would be within two days of contacting this GP practice.
- 96% Had confidence and trust in the healthcare professional they saw or spoke to during their last general practice appointment.

Three areas for improvement:

- 38% Find it easy to get through to this GP practice by phone.
- 31% Usually get to see or speak to their preferred healthcare professional when they would like to
- 25% were offered a choice of location when they tried to make a general practice appointment.

Complaints

We have received three complaints from patients regarding there being no GP at SHP.

The majority of complaints are regarding long waits on the telephone and dislike of PATCHS system in the last 3 years. We have recently upgraded our phone system as part of a response to this feedback.

We have received 1 verbal complaint regarding the accessible parking space at SHP being unsuitable as it is situated on a slope

Datix (If available)- None specifically relating to SHP.

Engagement and Consultation activity

A paper requesting to go out to engage was presented to the Primary Care Operational Group (PCOG) on the 21.11.24 and was agreed.

Engagement and Consultation activity

A draft Involvement plan was developed outlining the proposed activities:
• Survey (online and paper copies) open from 6 Jan to 14 Feb
• Two face-to-face public events:
  ○ Monday 13 January 4:30-5:30pm at Swillington Parish Hall
  ○ Tuesday 14 January 4:30-5:30pm at Oulton Medical Centre
• Online public Microsoft Teams meeting on Thursday 16 January 9:00-10:00am
• A second online session following feedback re working people, on Monday 27 January at 6pm.
• Engagement report due March 2025
 	
As a priority the practice is scheduling initial (confidential) meetings with local Councillors and MPs and a session with the Patient Participation Group following the PCOG meeting, in anticipation of sign off, to discuss the approach to the engagement / involvement.

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.
We have no further any information from local community groups/ third sector organisations at this time as we have not had permission to commence engagement/involvement.

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 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.

Group	Impact and evidence used	Actions / Mitigation
General Issues	Poor transport infrastructure around Swillington	Buses operate through Swillington linking with Oulton. It would require one bus ride to complete the journey between the sites. Buses currently operating along this route 174, 175 operate hourly. 168 runs every 30 minutes and 9C operates hourly. Bus

Group	Impact and evidence used	Actions / Mitigation
		number 22 operates approximately every 120 minutes. The practice is not aware of any reliability issues.
	Continuity of care for people 65+/ those with Long Term Conditions	Long term conditions will continue to be monitored by our very experienced health care team comprising of Health Care Assistants, Practice Nurses and Advanced Care Practitioner. 4 of our nurses have completed the Independent Prescribing course and 2 are about to commence training. All are trained in Long Term Conditions. Patients will be able to attend appointments at our 2 other sites and we will continue to offer visits to those who are unable to get out of their homes.
	Availability of accessible parking	The practice will look into the option of delivering Seasonal influenza and COVID vaccination clinics from Swillington Parish Village Hall to ensure we continue to vaccinate at the earliest opportunity and reach maximum number of patients. Swillington Parish Hall is accessible and can accommodate wheelchair users.
	Other service provision	We will continue to offer telephone appointments where suitable and also have the capability to offer video consultation

Group	Impact and evidence used	Actions / Mitigation
	Increased travel time	Our two other surgeries have designated parking along with accessible parking spaces. The distance from Swillington to our main site is 1.9 miles. Travelling to our main site by car would take approximately 6 minutes. A bus journey would take approximately 15 minutes.
Age	Patient over 65 years who are unable to get out of their homes	If are unable to get out of their homes, we will continue to offer home visits for clinical care
Disability	Availability of accessible parking Our main site Oulton Medical Centre and Branch site at Marsh Street Surgery meet all requirements in relation to physical access, requested reasonable adjustments and are complaint in respect of the Accessible Information Standard	As above – please see general issues Patients who are physically disabled and unable to get out of their homes/ places of residence will continue to receive home visits. Both our main site and our branch site have accessible parking. For those unable to use public transport there are several taxi companies in the local area that can accommodate a wheelchair.
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
Pregnancy and maternity	Our midwife service will move to Oulton Medical Centre	Patients may travel by public transport from Swillington, as listed previously, by bus, taxi or car.

Group	Impact and evidence used	Actions / Mitigation
		The majority of our patients reside in Oulton or Rothwell so moving the service to Oulton will benefit more patients who are currently having to travel to Swillington Health Practice. Patients who are pregnant or have recently delivered a baby and are unable to attend the surgery will be offered a visit if clinically appropriate.
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	No impacts have been identified in relation to sex	No actions/ mitigation required
Sexual orientation	No impacts have been identified in relation to sexual orientation	No actions/ mitigation required
Carers	Carers Health Checks will continue from both our other sites. This could potentially impact on carers who would usually attend Swillington Health Practice.	Carers health Checks will be offered at either of our other two sites. Patients can travel via car, taxi or use the bus services listed above. A carer who is unable to attend the surgery due to caring responsibilities would be offered a visit from one of the nursing team.
Any other groups e.g., people from low-income backgrounds, rural communities, homeless	No impacts have been identified in relation to any other groups	No actions/ mitigation required

Group	Impact and evidence used	Actions / Mitigation
people, asylum seekers and refugees		
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 Joint Strategic Needs Assessment (JSNA)	No impacts have been identified in relation to Health Inequalities	No actions/ mitigation required

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

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 and will always consider new patients for this service on a case-by-case basis.	Ongoing	Oulton Medical Centre
Patients who find the bus services unreliable, meaning they may not be able to make their	The practice responded to these queries through the public engagement and will continue to encourage patients to feedback about their experience with, for	Ongoing	Oulton Medical Centre

Impact	Action	Timescale	Lead
appointments on time.	example, the buses. The practice, and the ICB, will continue to flag and raise this as a concern with local councillors where necessary.		
Patients who need to rearrange their planned appointments to other premises.	The practice will continue to work with patients to accommodate their needs and preference for times and location.	Ongoing	Oulton Medical Centre

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.

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 – monthly area leads meeting. Will include reviews of patient feedback.	Review	Monthly
How will these actions be embedded into mainstream activity?	The practice – included in monthly area leads meeting. Regular review of patient feedback.	Review	Monthly
Who will review the outcome of the proposed changes and when?	The practice will review at monthly area leads meeting.	Review	Monthly

6. For Equality Lead Only

Equality Lead to sign off in table below

Equality Lead	Senior Equality, Diversity and Inclusion Manager
Recommendations	The mitigating actions and activities identified in this impact assessment should be robustly monitored

Sign off date	31 March 2025

7. For SRO Only

SRO to sign off in table below

SRO	
Recommendations	
Sign off date	

West Yorkshire Health and Care Partnership

NHS West Yorkshire Integrated Care Board

Meeting name:	Leeds Committee of the West Yorkshire Integrated Care Board
Agenda item no.	14a/25
Meeting date:	21 May 2025
Report title:	Consolidating VCSE Mental Health Contracts – Community Support and Social Recovery – Leeds Health and Care Partnership
Report presented by:	Helen Lewis, Director of Pathway and System Integration
Report approved by:	Helen Lewis, Director of Pathway and System Integration
Report prepared by:	Wendy Stanley, Senior Procurement Officer

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

Previous considerations:

27 November 2024 - Leeds Committee of the West Yorkshire Integrated Care Board – Provided approval to proceed with Provider Selection Regime (PSR) Most Suitable Provider (MSP) process.

Executive summary and points for discussion:

The purpose of this report is to:

- Provide assurance in respect of the robust procurement and evaluation undertaken and the recommendation for the appointment of the provider for Voluntary, Community, and Social Enterprise (VCSE) Mental Health – Community Support and Social Recovery service.
- To provide details of the next steps in terms of contract award and mobilisation of the service.

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

☒ Improve healthcare outcomes for residents in their system

☒ Tackle inequalities in access, experience and outcomes

☒ Enhance productivity and value for money

☒ Support broader social and economic development

Recommendation(s)

The Leeds Committee of the WY ICB is asked to:

1. **Note** the process undertaken and to confirm their acceptance that a fair and robust procurement process has been followed for selecting a provider for VCSE Mental Health – Community Support and Social Recovery service.

2. **Confirm** that a contract can be awarded under the Most Suitable Provider Process.
3. **Approve** the award of a contract to the identified bidder.

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

N/A

Appendices

1. Service Specific Questions
2. Consensus Submission Scores

Acronyms and Abbreviations explained

1. VCSE - Voluntary, Community, and Social Enterprise
2. PSR – Provider Selection Regime
3. MSP – Most Suitable Provider
4. PQQ – Pre-Qualifying Questionnaire

What are the implications for?

Residents and Communities	Social value section of the accreditation includes consideration of value for residents and communities
Quality and Safety	Procurement process has included consideration of quality and safety in delivery models
Equality, Diversity and Inclusion	Procurement process has included consideration of EDI in delivery of these services
Finances and Use of Resources	Procurement process has provided additional assurance on the use of resources
Regulation and Legal Requirements	Procurement process meets the legal and regulatory requirements for the ICB
Conflicts of Interest	Any interests were managed in line with the policy for managing Conflicts of Interest.
Data Protection	None Identified in respect of the procurement and award process
Transformation and Innovation	None Identified in respect of the procurement and award process
Environmental and Climate Change	Procurement included consideration of environmental impacts in the delivery model and provider
Future Decisions and Policy Making	None Identified in respect of the procurement and award process

Citizen and Stakeholder Engagement	Evaluation includes consideration of this area.

1 Main Report Detail

1.1 NHS West Yorkshire Integrated Care Board, Leeds Health and Care Partnership intends to consolidate nine current separate ICB held contracts/grant awards with VCSE provider partners, into two lead provider led contract lots.

1.2 This paper sets out the processes that have been followed in line with the Provider Selection Regime to award a contract for the lead provider led contract lot VCSE Mental Health – Community Support and Social Recovery service.

1.3 The Health Care Services (Provider Selection Regime) Regulations 2023, Most Suitable Provider Process is being used to commission this service.

1.4 This service is to be delivered under an NHS Standard Contract, which will have a term of 5 years (3 + 2) from 1 July 2025.

1.5 The value of the contract is £6,103,325 over the 5 years.

1.6 Following approval to proceed, the Most Suitable Provider (MSP) Process was undertaken. The MSP documents were issued in accordance with the timeline.

1.7 The procurement was managed through Atamis, the e-tendering system used by the West Yorkshire Integrated Care Board. The timetable as agreed was:

Stage	**Timescale**
Approval to follow PSR route and Commitment to Expenditure And Investment Control Panel	December to 22 January
Consider Basic Selection Criteria and Prepare PQQ	10 January to 4 March
Consider Key Criteria and Prepare Assessment	4 March to 31 March
Prepare Prior Information Notice (PIN)	10 January to 22 January
Notify Provider to be considered and confirm their intention to proceed Obtain TUPE information (if relevant)	14 January to 21 January
Publish PIN (F01)– Intention to Follow the MSP Process Notice	5 February to 18 February
Publish PQQ (Basic Selection Criteria questions)	12 March
PQQ Closes	26 March at 12pm

Evaluation of PQQ	27 March to 2 April
Providers Complete Key Criteria Assessment Opens – 3 April Clarification Deadline – 17 April at 12pm Closes – 28 April at 12pm	3 April to 28 April
Evaluation of Key Criteria Assessment	29 April to 13 May
Governance Approval	14 May to 30 May
Contract Award Notice (F03) and standstill period	2 June to 12 June
Contract Award	13 June
Intention to Award Notice (F14)	(within 30 days of contract award)
Mobilisation	14 June to 30 June
Contract Start Date	1 July

1.8 As per the timeline above, a prior information notice was published on Find a Tender Service for the required 14 days to set out the ICB's intention to follow the most suitable provider process.

1.9 The ICB received one further expression of interest in response to the notice.

1.10 The ICB's selected most suitable provider and the provider that had expressed an interest were invited to complete a pre-qualification questionnaire via Atamis covering the basic selection criteria.

1.11 The ICB's selected most suitable provider submitted a response to the PQQ within the designated timeframe. The provider that had expressed an interest declined to provide a response. The PQQ was subject to evaluation and passed this step.

1.12 Subsequent to a successful outcome of the PQQ evaluation, the ICB's selected most suitable provider was invited to complete scored service specific questions based on the key criteria, via Atamis.

1.13 The Provider submitted a response by the deadline date. The response received was subject to evaluation. Details of the service specific questions are attached as Appendix 1.

1.14 In accordance with the commissioning procedures and the Memorandum of Information that was shared with provider, the evaluation was undertaken by a suitably qualified and experienced panel. The response was evaluated in accordance with the predetermined percentage weighted criteria.

1.15 Scoring Rationale used for the technical section of the Most Suitable Provider Process was:

Grade Label	Definition of Graded Questions	Grade
Excellent	The response supports an excellent degree of confidence in the Bidder's ability to deliver and/or exceed the Contracting Authority's specified requirements and/or expectations. Where appropriate, the response is well evidenced, and/or of a quality and/or level of detail, and understanding that provides either a remarkably high certainty of delivery or is considered likely to offer innovation, added value, likely to result in improved: • quality and/or. • performance and/or; • efficiency and/or; • outcomes. There are no issues, weaknesses, or omissions. The response includes a high level of relevant and detailed information and is backed up with clear evidence and examples.	100
Comprehensive	A comprehensive response submitted in terms of relevance, detail, and evidence; and able to meet in full the requirements of the Contracting Authority. A high degree of confidence in the Bidder's ability to do what is being requested. This grade differs from an Excellent response in terms of: • the level of evidence given (i.e. lacking innovation, added value, evidence and examples) and/or • whether the Bidder has fully outlined how they will bring together the various components listed above and/or	80

	• whether the Bidder has fully addressed all the local needs outlined in the service specification.	
Acceptable	An acceptable response submitted in terms of the level of detail and relevance. Meets the standard in most aspects but fails in some areas. There is reasonable confidence that the Bidder will be able to deliver in line with expectations and the requirements of the Contracting Authority as detailed in the Service Specification.	60
Limited	Limited information provided and/or a response that is inadequate. Fails to meet expectations/requirements in many ways and provides insufficient confidence of delivery. Does not include sufficient evidence, clarity, or information in support.	40
Inadequate	Significantly fails to meet the standard Inadequate detail provided / questions not answered / answers not directly relevant to the question.	20
Deficient	Completely fails to meet the standard. Response significantly deficient / no response.	0

1.16 The provider was informed that a score of at least 60% for each response at the assessment stage is required to be successful.

1.17 The e-tendering system Atamis was used by evaluators to input their score and rationale/comments on the bid received to ensure a full audit trail and to aid feedback following the award of the contract. Following evaluation, moderation of scoring took place i.e., a consensus meeting was held to ensure consistency of scoring and to agree the final scores.

1.18 The summary of the consensus (moderated) scores is detailed below. An example of a consensus extract from the evaluation is included as Appendix 2. The e-tendering system provides a full audit trail to demonstrate the robustness of the process and to provide appropriate detail for feedback to bidders.

	Total Mark (100%)

Provider 1	90%

1.19 The provider achieved the required threshold at consensus, with a total score of 90% out of 100%. Given the outcome of the Most Suitable Provider process it is recommended that the provider is awarded the contract.

2 Next Steps

2.1 If the proposed contract award is approved, the provider will be notified of the outcome.

2.2 A Contract Award Notice will be published which will commence the standstill period. Following the 8 working day standstill period, a contract award will be made to the provider. Mobilisation will then commence, with a start date for the new contract to begin on the 1st of July 2025.

3 Recommendations

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

- Note the process undertaken and to confirm their acceptance that a fair and robust procurement process has been followed for selecting a new provider for the VCSE Mental Health – Community Support and Social Recovery service.
- Confirm that a contract can be awarded under the Most Suitable Provider Process.
- Approve the award of a contract to the identified bidder.

4 Appendices

1. Service Specific Questions
2. Consensus Submission Scores

Appendix 1 – Service Specific Questions

Value	
Q1. How will you ensure that the service maximises value for public money and optimise the ICB's financial allocation of resource?	A good answer will include/ describe: • Collaboration and system integration • A commitment to working flexibly / focussing on areas of greatest need • A commitment to working in partnership with the ICB to plan for, monitor and manage service activity and the cost of this. • An approach that maximises a streamlined and cohesive management structure and operational model. • Maximising opportunities to embed a joined up approach to service development. • An approach that maximises standardised ways of working across services and teams. • Identified efficiencies around joining up functions such as contract management, training, reflective practice and reporting (performance, safeguarding, incident and complaint). • Proactively help manage unplanned demand and pressures, notably to acute and crisis mental health provision, through a focus on prevention, enabling people to function better within their own communities.
Quality & Innovation	
Q2 Please describe how you will implement and evidence continuous improvement to the quality of service, always ensuring safe delivery of care and positive patient experience. Please explain how you demonstrate	In regards to Patient Safety & Quality Improvement A good answer will include/ describe: • What systems and process you follow for reporting, recording, managing and investigating, incidents and complaints?

compliance with the elements included in the service specification	• What you have in place to promote an open reporting culture. • How you ensure compliance with duty of candour guidance. • How you ensure patients and families feel comfortable raising concerns or complaints? And how do you assure them that complaints have been dealt with, and lessons have been learned. • How and where you track and report themes and trends from complaints or incidents? • How you use themes and trends from incidents and complaints to learn and improve practice and experience of care. • Where appropriate and necessary, how your organisation shares learning form patient safety incidents with the wider health care system. • How and where you collect and use positive feedback and patient experience (compliments) to improve service quality. In regards to Governance, a good answer will include/ describe • Systems in place to ensure a safe and appropriate clinical environment for service provision • An overview of the risk management process including identification, monitoring and resolving risk • An overview of policies and procedures in place to support the organisation and staff in raising concerns

Q3 Please describe how your service model will meet the requirements of the specification by providing an offer that is person centred and focussed on delivering better health outcomes.	A good answer will include/describe: ● A person centred care approach, with service users actively contributing to their support planning ● An innovative approach focusing on delivering better health outcomes. ● Embedded within local Community Mental Health Hub Joint Management Arrangements, and working in line with Transformation arrangements. ● The service offer and the services that you will put in place to identify, assess and meet need ● How you will deliver and report outputs and outcomes into the national Mental Health Service Data Set. ● Robust and timely reporting processes ● How you will use information to monitor, review and make improvements to the service
Integration, collaboration and service sustainability	
Q4 Please describe how your service model will meet the requirements of the specification by providing an offer that is fully integrated with **a) Leeds Community Mental Health Transformed Services (CMHT), to include design, delivery, hubs and anchor days.** **b) The wider Leeds Health and Care partnership to include secondary, community and primary care mental health**	A good answer will include/describe: • Integration with local Community Mental Health joint management arrangements, hubs, anchor days, design and delivery.

services, Local Authority and third sector.	
Q5 Please describe how your organisation is committed to improving and advancing services for people with complex and enduring mental health needs.	A good answer will include/describe: • Integration in the complex and enduring mental health space • Experience and participation in appropriate networks • Innovation and creativity • Evidence of delivery
Improving Access, Reducing Health Inequalities and Facilitating Choice	
Q6 Please describe how you would ensure accessibility to services and treatments for all eligible individuals, proactively working with people from all communities with a focus on harder to reach communities.	A good answer will include/describe: • Evidence of active in-reach • Systems and policies for protected groups, including equality monitoring approaches, reporting and action plans for service users and staff. Provide real examples of improvement/activity. • How your service will be tailored or adapted to meet service user needs, inc reference to model (timings, face to face / virtual offer) and reasonable adjustments for those who have additional needs for example deaf, don't speak English well or neurodivergent etc. • How will you address underrepresentation within the service, including protected groups and other health inclusion groups. • Demonstrate how you will gather and use service user feedback, and how this will inform service delivery improving patient satisfaction for all groups.

Q7 Please evidence your work and experience in delivering services for people with complex and enduring mental health needs. Describe how you would enable the provision of choice to people on how they achieve their goals.	A good answer will include/describe: • The service offer and the services that you will put in place to identify, assess and meet need • How choice can be encouraged and facilitated
Social Value	
Q8 Fighting Climate Change Please document your effective stewardship of the environment and commitment to reducing your environmental impact.	A good answer will include/describe activities that: • Deliver additional environmental benefits in the performance of the contract including working towards net zero greenhouse gas emissions. • Influence staff, suppliers, customers and communities through the delivery of the contract to support environmental protection and improvement. • Delivery optimisation and use of low/zero carbon vehicles. • Support biodiversity initiatives developed or supported in the local area
Q9 Under the Public Services (Social Value) Act 2012, all public bodies in England and Wales are required to consider how the services they commission and procure might improve the economic, social and environmental wellbeing of the area. Please explain how Leeds will benefit if you were awarded the contract.	A good answer will include/describe: • What you will do over the life of the contract in support of the identified outcomes (improve the economic, social and environmental wellbeing of the area) • Evidence of local recruitment • Local opportunities. Grow staff. • Plans of workforce representative of local population to include ethnic mix, disability and other diversity

Appendix 2 – Consensus Submission Scores

Question No	Description	Weighting	Score	Weighted Score
1	Value	20	100	20
2	Quality & Innovation	10	80	8
3	Quality & Innovation	10	60	6
4	Integration, collaboration and service sustainability	10	100	10
5	Integration, collaboration and service sustainability	10	80	8
6	Improving Access, Reducing Health Inequalities and Facilitating Choice	10	100	10
7	Improving Access, Reducing Health Inequalities and Facilitating Choice	10	80	8
8	Social Value	10	100	10
9	Social Value	10	100	10

West Yorkshire Health and Care Partnership

NHS West Yorkshire Integrated Care Board

Meeting name:	Leeds Committee of the West Yorkshire Integrated Care Board
Agenda item no.	14b/25
Meeting date:	21 May 2025
Report title:	Consolidating VCSE Mental Health Contracts – Employment and Peer Support – Leeds Health and Care Partnership
Report presented by:	Helen Lewis, Director of Pathway and System Integration
Report approved by:	Helen Lewis, Director of Pathway and System Integration
Report prepared by:	Wendy Stanley, Senior Procurement Officer

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

Previous considerations:

27 November 2024 - Leeds Committee of the West Yorkshire Integrated Care Board – Provided approval to proceed with Provider Selection Regime (PSR) Most Suitable Provider (MSP) process.

Executive summary and points for discussion:

The purpose of this report is to:

- Provide assurance in respect of the robust procurement and evaluation undertaken and the recommendation for the appointment of the provider for VCSE Mental Health – Employment and Peer Support service.
- To provide details of the next steps in terms of contract award and mobilisation of the service.

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

☒ Improve healthcare outcomes for residents in their system

☒ Tackle inequalities in access, experience and outcomes

☒ Enhance productivity and value for money

☒ Support broader social and economic development

Recommendation(s)

The Leeds Committee of the WY ICB is asked to:

1. **Note** the process undertaken and to confirm their acceptance that a fair and robust procurement process has been followed for selecting a provider for VCSE Mental Health – Employment and Peer Support service.
2. **Confirm** that a contract can be awarded under the Most Suitable Provider Process.

3. **Approve** the award of a contract to the identified bidder.
Does the report provide assurance or mitigate any of the strategic threats or significant risks on the Corporate Risk Register or Board Assurance Framework? If yes, please detail which:
N/A
Appendices
Appendix 1 – Service and Provider Assessment
Acronyms and Abbreviations explained
1. VCSE - Voluntary, Community, and Social Enterprise 2. PSR – Provider Selection Regime 3. MSP – Most Suitable Provider

What are the implications for?

Residents and Communities	Social value section of the accreditation includes consideration of value for residents and communities
Quality and Safety	Procurement process has included consideration of quality and safety in delivery models
Equality, Diversity and Inclusion	Procurement process has included consideration of EDI in delivery of these services
Finances and Use of Resources	Procurement process has provided additional assurance on the use of resources
Regulation and Legal Requirements	Procurement process meets the legal and regulatory requirements for the ICB
Conflicts of Interest	Any interests were managed in line with the policy for managing Conflicts of Interest
Data Protection	None Identified in respect of the procurement and award process
Transformation and Innovation	None Identified in respect of the procurement and award process
Environmental and Climate Change	Procurement included consideration of environmental impacts in the delivery model and provider
Future Decisions and Policy Making	None Identified in respect of the procurement and award process
Citizen and Stakeholder Engagement	Evaluation includes consideration of this area

1 Main Report Detail

1.1 NHS West Yorkshire integrated Care Board, Leeds Health and Care Partnership intends to consolidate nine current separate ICB held contracts/grant awards with VCSE provider partners, into two lead provider led contract lots.

1.2 This paper sets out the processes that have been followed in line with the Provider Selection Regime to award a contract for the lead provider led contract lot VCSE Mental Health – Employment and Peer Support service.

1.3 The Health Care Services (Provider Selection Regime) Regulations 2023, Most Suitable Provider Process is being used to commission this service.

1.4 This service is to be delivered under an NHS Standard Contract, which will have a term of 5 years (3 + 2) from 1 July 2025.

1.5 The value of the contract is £5,652,189.

1.6 Following approval to proceed, the Most Suitable Provider (MSP) Process was undertaken. The MSP documents were issued in accordance with the timeline.

1.7 The procurement was partially managed through Atamis, the e-tendering system used by the West Yorkshire Integrated Care Board. The timetable as agreed was:

Stage	Key Dates
Approval to follow PSR route and Commitment to Expenditure And Investment Control Panel	1 December 2024 to 22 January 2024
Consider Basic Selection Criteria and Prepare PQQ	10 January to 4 March 2025
Consider Key Criteria and Prepare Assessment	4 March to 27 March 2025
Prepare Prior Information Notice (PIN)	10 January to 22 January 2025
Notify Provider to be considered and confirm their intention to proceed Obtain TUPE information (if relevant)	14 January to 21 January 2025
Publish PIN – Intention to Follow the MSP Process Notice	5 February to 18 February 2025
Publish PQQ (Basic Selection Criteria questions)	12 March 2025
PQQ Closes	26 March 2025

Evaluation of Basic Criteria and Key Criteria Assessment	27 March to 30 April 2025
Governance Approval	6 May to 30 May 2025
Contract Award Notice and standstill period	2 June to 12 June 2025
Contract Award	13 June 2025
Intention to Award Notice (Corrigendum)	(within 30 days of contract award)
Mobilisation	14 June to 30 June 2025
Contract Start Date	1 July 2025

1.8 As per the timeline above, a prior information notice was published on Find a Tender Service for the required 14 days to set out the ICB's intention to follow the most suitable provider process.

1.9 The ICB did not receive any expressions of interest in response to the notice.

1.10 The most suitable provider was assessed against the key criteria and basic criteria. A pre-qualification questionnaire was completed via Atamis covering the basic selection criteria and a social value requirement question covering the social value key question. The response received was subject to evaluation.

1.11 A narrative based assessment based on the providers existing performance records was undertaken by the assessment panel to assess the remaining key criteria. See the attached appendix 1 – Service and Provider Assessment.

2 Next Steps

2.1 If the proposed contract award is approved, the provider will be notified of the outcome.

2.2 A Contract Award Notice will be published which will commence the standstill period. Following the 8 working day standstill period, a contract award will be made to the provider. Mobilisation will then commence, with a start date for the new contract to begin on the 1st of July 2025.

3 Recommendations

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

- Note the process undertaken and to confirm their acceptance that a fair and robust procurement process has been followed for selecting a new provider for the VCSE Mental Health – Employment and Peer Support service.
- Confirm that a contract can be awarded under the Most Suitable Provider Process.
- Approve the award of a contract to the identified bidder.

4 Appendices

Appendix 1 – Service and Provider Assessment

NHS West Yorkshire
Integrated Care Board

Appendix 1

The Most Suitable Provider Process

Service and Provider Assessment

Date Record Created	28th April 2025
Assessment Panel Details	Ryan Turnbull - Senior Contracts Manager, MH and LD, West Yorkshire ICB Jenny Baines - Senior Programme Manager, Pathway and System Integration, West Yorkshire ICB
Service Description	Workplace Leeds & Individual Placement Support plus the Peer Support Workers offer
Provider Name	Leeds MIND

Basic Selection Criteria
The Provider completed a Pre-Qualifying Questionnaire (PQQ) via ATAMIS contracting portal, which covered the basic selection criteria. *Using contract monitoring data and information the Key Criteria have been assessed on a narrative basis, against the service currently being delivered. For the Social Value section, the Provider was asked, via ATAMIS to provide evidence of how they already demonstrate/plan to build elements of economic, social and environmental well-being into the service delivery, to create additional benefits for the communities and residents of Leeds. Their response has been included below.*

Key Criteria 1. Quality and Innovation

Relative authorities must give due consideration to how well providers are able to deliver high quality care when deciding who to arrange services with. The ICB must ensure they assess the extent to which an arrangement with a provider could generate new and significant improvements in the promotion and adoption of proven innovations in care delivery.	
Criterion	**Assessment of the Providers Performance for the Criterion**
Evidence that the service is of good quality and supports the potential for the development and implementation of new or significantly improved services or processes that will improve the delivery of health care and health outcomes.	**<u>Peer Support</u>** Due to new waiting list management systems, specifically an improved tracking system and offered group work, the wait time for Peer Support has dropped from three months back down to two months. Referrals remain very high, 68 in quarter 4 (2024/25) with 18 people on the waiting list. The service continues to develop projects, workshops and courses designed to improve outcomes for people. • Managing anxiety and building self-esteem • Art project to create a booklet to showcase talent and recovery through creativity • Coping with isolation Although one 12-week support group and one 7-week course were not able to run their duration as attendances dropped despite strong initial bookings. The service is looking to refine and improve its booking arrangements and feedback processes to reduce client drop-off. Furthermore, the service reduced the number of planned group work over this quarter to help manage a large influx of referrals that had increased the 1-1 waiting list time. Peer support has redesigned its offer for reflective practice which will be offered to staff next quarter. **Feedback:** **How would you describe your experience?** Positive, helpful, comforting

What have you got out of using our service? It's helped me a bit with moving on from past traumas and just having someone to talk to made me feel less lonely (as someone who lives alone).
Has the service made a difference to your life? How can you tell? I have noticed that i do feel a bit happier and more able to live in the present moment.
What will you do with what you have learned? I will do as many of the things that were suggested to me to help me to keep moving forwards with my life, such as getting a job.
Service development focus demonstrating awareness of system and city priorities:

- To continue to develop the groupwork offer.
    - To continue the development of the groupwork offer to include groups that tackle inequalities such as LGBTQIA+, diverse communities, pain and mental health.
- To develop a new evaluations process to better evaluate the clients journey through the service and demonstrate the value of peer support.
- To gather feedback from our older people's peer support worker position and seek further funding opportunities.
- To develop existing roles through the city-wide rollout.

Individual Placement Support

Summary of 24-25
• Performance: Four (4) out of nine (9) of our contractual KPIs were exceeded, with an additional four within the 75% threshold. The remaining 1 that was not successful was linked to Digital / IT Support group, which by mutual agreement was closed on 31st March 25
• Demand: Service demand is consistent, with referral targets being exceed by 2%.
• Evaluations: Client service evaluations consistently report a quality rating of 4 or higher out of 5.
• Quality Assurance: Next Fidelity review is projected for Nov 25, with plans being implemented from May 25 to support preparation.
• Access – the Landscape of IPS and mental health transformation, requires the implementation of plans to move into the Primary Care Sector. Plans are already underway, with mobilisation set for June 25.

The IPS service report that they continue to see a bigger percentage of service users accessing for 'new employment' rather than 'job retention' – now sitting at 17%, 8% lower than projections.

This trend (23% across the full year) will be monitored, with the intention of providing an alternative, but more responsive approach to job retention.

This service has a wait time at approx. 6 months, despite the increase in capacity utilisation, due to the increased referrals. This has been a stable position and they predict a continued wait time of 6 months for the next quarter, with the potential of a slight increase due to the introduction of the transformation roll out. Contract monitoring states next steps will be to***:***

- Focus on aligning with the transformation roll out
- analyse and plan for seasonal trends in data analyse to ensure a strategic approach in future target setting
- continue to fill staff caseloads to maximum (20 active cases)
- prioritise a review of triage processes to support reduction of wait time

Fidelity is an assessment against standards. Based on recent upward trends and growth rates the service is projected to achieve 'Good' fidelity by Summer 2025. A recent fidelity review identified a need to invest in the later stages of the service user journey (action planning and user support). Current rates for new employment are below the 30% target. Leeds Mind have created a training schedule that includes these topics, as well as an 'away day' for upskilling staff and a collaborative visit from a neighbouring IPS service (Bradford) who show a strength in these areas.

The Outcome rate has increased from 69% last quarter to 73% (71% ave. across year) placing us significantly above our target (by 11% across the year). This meets expectations as **staff began to learn new techniques to support job retention cases, see seeing their confidence and competence increasing**, thereby impacting outcome rates positively.

Feedback: "*My greatest fear was that my mental illness would stop me being employable. and not be capable of finding work. I really didn't, know how to discuss this in a positive way with prospective employers. Richard gave me the skills on how to discuss this with any future employer in a positive way."*

Although not linked to contractual measures, Leeds MIND also recorded over 951 job applications created with clients across this year, with 210 interviews being offered to its clients

Peer Support Workers Job Description / Workplace Leeds and IPS Service Spec	Documents can be accessed as supplementary information.
Summary of any service and/or quality issues	Caseload and Capacity: Throughout the year, significant efforts have been made to help employment specialists reach their maximum caseload numbers, including training on effective caseload management and regular audits and reviews. Currently, the average caseload is 17 out of 20, indicating room for improvement to meet attachment targets. However, specialists may struggle with increased workload expectations, especially with additional non-client facing tasks like employer engagement and fidelity review preparation. Further time, support, and policy reviews are needed to ensure sustainable work at maximum capacity. However, it is important to note that the service has reached 88% of the annual target, with is within the agreed threshold of this KPI. Transformation – City-wide roll out. The impact of the city-wide roll-out on both this and other transformation projects will be monitored closely to understand any impacts on service delivery.
Data Sources that Aided the Assessment	*CMHTr Dashboard and Provider submits regular Contract monitoring information*

Key Criteria 2. Value	
The ICB must give due consideration to the value offered by a service, in terms of the balance of costs, overall benefits and the financial implications of an arrangement.	
Criterion	**Assessment of the Providers Performance for the Criterion**
Annual Contract Value & Associated Expenditure	Annual Contract Value for £1,106,645 **(£825,921 Employment Wellbeing Support/IPS** + **£280,724 Peer Support**) for a 1 year contract. Uplifted by 2.15% in April 2025 for an extension period (via Contract Modification) of 3 months to the end of June for an additional £282,609.47.

Evidence that the service is of good value in terms of the balance of costs, overall benefits and the financial implications of a proposed contracting arrangement.	Peer support workforce 6.85wte. Two new starters have been recently inducted and making good progress with shadowing, training and integrating into transformation. There are currently 102 active clients receiving 1:1 peer support and 29 clients receiving group work. IPS workforce 9.1wte operational Employment Specialists in service, with 3.81 completing their induction (with an assumed slower turnover speed), and 2wte on long term sickness (requiring their caseloads to be reallocated). There are currently 177 active cases, with space for around 1 per operational ES (down from 5 – showing better utilisation of caseloads). Q3 24/25 saw the IPS service's highest attachment rate yet (137), representing an 47% increase from last quarter, and 69% over target – peaking in Oct and returning to average levels in Nov/Dec. Across the year the service saw a steady increase in their rate, as a response to reducing wait times and allowing the service to operate within IPS's 'zero exclusion' ethos. Job Retention rates consistently meet targets (with an ave. sustainment of 71% across the year – 11% more than targeted), reflecting effective job retention support for those accessing it.

Key Criteria 3. Integration, Collaboration and Service Sustainability	
The ICB must consider the extent to which their decisions are consistent with local and national NHS plans and the importance of services being provided in an integrated and collaborative way, and in a way that improves health outcomes and in a way that seeks to secure the stability of good quality health care services or service continuity of health care services.	
Criterion	**Assessment of the Providers Performance for the Criterion**
Evidence the extent to which services can be provided in:	Referrals to the Peer Support service are received from a range of services and organisations, for example GP, CMHT, other Leeds Mind service), and refers onto a number, demonstrating that the

a) An integrated way (including with other health care services, health-related services or social care services) *b) A collaborative way (including with providers and with persons providing health-related services or social care services)* c) *A sustainable way (which includes the stability of good quality health care services or service continuity of health care services)*	service is well embedded and integrated within the system. The service has reported that the overall quality of referrals has improved. Quarterly Peer Support monitoring information states there is continued success within the MDTs across the three implementer CMHT hubs where staff have been able to bring clients to discuss and have achieved successful outcomes. General feedback is that the new format of partnership working works well and is providing positive outcomes for clients. There were some difficulties with raising people that were being supported at MDTs that do not fall under the three transformation hubs. Transformation rolling out city wide should help with this. CMHT dominates as the key referrer into the IPS service (47% of the referrals). This underscores the importance of integration into those teams, as well as strengthening partnerships with additional sources to diversify intake – which the service believes will be a key aim of the work with the transformation hubs and the city wide roll out. The Transformation also prompts a need to review the services ability to integrate with Primary Care, as they will become embedded within the hubs. 1,445 employers are engaged with the service, with 1,350 operating locally and 95 nationally. A strong local employer base suggests a well-developed regional network. All Employment support staff have attended the transformation hub induction days, with a follow up staff handbook being released shortly afterwards, aiming to prepare the team for full integration into the hubs. At least 1 FTE are allocated to each hub.

Key Criteria 4. Improving Access, Reducing Health Inequalities and Facilitating Choice	
The ICB must consider the importance of accessibility to services and treatments for all eligible patients, the need to tackle health inequalities and the importance of ensuring that patients have choice in respect of their health care.	
Criterion	**Assessment of the Providers Performance for the Criterion**

Evidence the accessibility to services and treatments for all eligible patients, improving health inequalities and ensuring that patients have choice in respect of their health care. Examples of reasonable adjustments made by the service to service its population.	An influx of referrals for Peer Support recently meant that a wait list built up. The offer is 8 sessions or 4 months, whichever comes first, and adhering to this has meant that the wait list has been addressed. The city wide roll out of Peer Support to all CMHT hubs is challenging on current workforce capacity and is likely to not expand fully beyond the three implementer sites/hubs. Commissioners and ICB teams are aware, escalating any risks, and preparing to assess and mitigate. Peer Support Groups reach a mix of existing clients and new clients. Groups are open to the wider public, although targeted at CMHTr clients. These offer a continuation of support from people moving from 1-1s and represents a chance to do preventative work in groups. Contract monitoring information confirms that the IPS service has engaged a more culturally diverse client base this quarter, particularly among Black, Asian, and Mixed ethnic groups. • White (British) individuals remain the majority (60%), but this is a notable 10.37% decrease compared to the previous quarter (70.37%). • Asian (14%) and Black (16%) groups have increased slightly (from 11.11% and 9.88%, respectively). • Mixed ethnicity representation has nearly doubled from 3.7% to 7%. • White (Culturally Diverse, 3%), slightly decreased, but is similar (from 3.7% in last quarter) The increased engagement with Black, Asian, and Mixed groups is positive. The service are committed to ensuring continued outreach to maintain and build upon this trend.

Key Criteria 5. Social Value	
The ICB must consider whether what is proposed might improve economic, social, and environmental well-being of the area relevant to an arrangement.	
Criterion	**Assessment of the Providers Performance for the Criterion**

Please provide evidence of how Leeds MIND already demonstrates or will build elements of economic, social and environmental well-being into the service delivery wherever possible to create additional benefits for the communities and residents of Leeds	Leeds Mind is committed to modelling an inclusive culture within our services and staff and volunteer teams. This commitment is key to supporting our colleagues to succeed. We have achieved “Great Place to Work” accreditation and are a disability-aware employer. Our recruitment approach emphasises lived experience, ensuring that staff not only live locally but also include individuals who have been clients of our services (such as WPL). Our recruitment is locally focused and uses established links with local partners, including Voluntary Action Leeds and local job centres. We share service employment opportunities with former beneficiaries and volunteers, all local people, ensuring our recruitment strategy is inclusive and community focused. We offer comprehensive training for employees and volunteers, including in-person and online sessions. Ongoing supervision and 1:1s identify development needs. Quarterly reviews set objectives. Where available, we use apprenticeship levy transfers to support staff in gaining recognised qualifications (e.g.: management). As an Investor in Volunteering accredited charity, we ensure volunteer opportunities support volunteers to build new skills relevant to their goals. Workplace Leeds, for instance, volunteer facilitators (former clients) lead pre-employment skills sessions around e.g.: maintaining wellness in work. We prioritise engaging local suppliers to maximize benefits to the Leeds economy such as our gas and security services. This approach supports local businesses and reduces our carbon footprint by minimising transportation distances. We maintain strong relationships with local suppliers and regularly review our supply chain to ensure it aligns with our sustainability goals. Leeds Mind has an environmental working group whose work is underpinned by our environmental policy. We are dedicated to using sustainable resources and limiting the environmental impact of our services. We implement eco-friendly practices such as recycling, energy conservation. Our commitment to sustainability is reflected in our policies and day-to-day operations. We support workforce diversity across the organisation through our Equality Diversity, Inclusion & Belonging (EDIB) steering group. This staff-led group coordinates peer-led EDIB groups, working with our specialist Inclusion Coordinator to contribute lived experiences and professional skills to the progression of inclusion and belonging across Leeds Mind. We ensure that every member of staff, volunteer, and client feels able to contribute to the running of Leeds Mind. Our approach to management creates a culture where people feel safe to disclose their needs, confident that they will be supported by their peers and managers. Inclusion training is mandatory for all staff and refreshed every two years. We offer flexible working arrangements, reasonable adjustments, occupational health assessments, and wellness action plans, revisited at every supervision to check progress. We continually improve our practice through maintaining an EDI dashboard measuring representation

	of protected characteristics in recruitment and the workforce. The People Director reports against this at monthly SLT meetings, Board, and People subcommittees, producing action plans to improve any underrepresentation. We undertake quarterly reviews with disabled and neurodivergent staff, for instance, to understand their progress, ensuring no unforeseen barriers to progression and encouraging ambition.

Meeting name:	Leeds Committee of the WY ICB
Agenda item no.	LC 15/25
Meeting date:	21 May 2025
Report title:	Leeds Health and Care Partnership Memorandum of Understanding (MoU) Review
Report presented by:	Sam Ramsey, Senior Partnership Development Lead
Report approved by:	Tim Ryley, Accountable Officer
Report prepared by:	Sam Ramsey, Senior Partnership Development Lead

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

Previous considerations:

A Memorandum of Understanding (MoU) was agreed on the establishment of the West Yorkshire Integrated Care Board (ICB) between the partners that make up the Leeds Health and Care Partnership.
This was discussed and approved through each partner Board in June 2022.

Executive summary and points for discussion:

The Leeds Health and Care Partnership Memorandum of Understanding (MoU) sets out the vision, objectives and shared principles of its signatories. The MoU describes the approach to developing place-based health and care provision for the people of Leeds using a population health management approach, building on the progress achieved by the Partners.

The MoU also sets out how Partners will work together, including the governance arrangements and how they will discharge delegated functions from the WY ICB and allocate resources for the benefit of the population of Leeds.

Each of the five places that make up West Yorkshire, as well as the West Yorkshire Integrated Care System, have a form of MoU or partnership agreement in place. However, a recent review of the partnership agreements found that review dates had passed for four of the places including the one covering the Leeds Health and Care Partnership. Given the significant changes to place governance arrangements and the way we work as a partnership that are due to take place over the next year, it does not seem a good use of capacity to review the document strategically at this stage. The Leeds Place Accountable Officer has agreed to review and make necessary minor changes to ensure the MoU reflects current arrangements.

The Leeds Health and Care Partnership MoU forms part of NHS West Yorkshire Integrated Care Board's (ICB) governance arrangements and is complimentary to governance arrangements of the ICB and should be read alongside the NHS West Yorkshire Integrated Care Board's Constitution and Governance Handbook.

Minor changes have been made to the MoU, which include:

- Reference to the Health and Care Act 2022;
- Signal a comprehensive review through 2025/26 and subsequently a move to a longer review period on a 3-yearly cycle at section 14;
- Update to the governance structure to make reference to the dissolving of the Delivery Subcommittee and to move from three to two assurance subcommittees;
- Amendments to change the governance arrangements from Partnership Executive Group (PEG) to the Partnership Leadership Team (PLT).

Any future changes to the MoU will take account of the updated NHS England guidance arrangements for delegation and joint exercise of statutory functions (19 February 2024 updated 24 March 2024). This guidance for ICBs, NHS Trusts and Foundations Trusts provides an overview of new collaborative working arrangements that the Health and Care Act 2022 introduced to the NHS Act 2006. Building on this guidance and in line with the future direction of greater autonomy for places changes to the ICB's constitution have been made, and were approved by the ICB Board on 17 December 2024. These changes are subject to an NHS England application for approval before becoming live and provide for:

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

As described in the changes outlined above, through 2025/26 material changes are expected to the MoU and will give due consideration to the recent findings and recommendations of the review of place partnership arrangements led by Antony Kealy and the work towards strengthening our Provider Collaborative approach within the Leeds Health and Care Partnership. Following 2025/26, subsequent review cycles are recommended at 3 yearly intervals.

Given the revisions to the MoU are minor, members of the Leeds Committee are asked to approve the minor amendments on behalf of their partner organisations and once approved, an updated version will be saved on the West Yorkshire ICB website.

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

☐ Improve healthcare outcomes for residents in their system

☐ Tackle inequalities in access, experience and outcomes

☐ Enhance productivity and value for money

☐ Support broader social and economic development

Recommendation(s)

The Leeds Committee of the WY ICB is asked to:

1. **NOTE** and **APPROVE** the changes to the Leeds Health and Care Partnership MoU, on behalf of the partner represented;

2. **NOTE** the material changes that are expected to the Leeds Health and Care Partnership MoU during 2025/26, and the subsequent move to 3-yearly cycle of review; and
3. **AGREE** to ensure that partner organisations receive and are made aware of the changes to the MoU; and
4. **NOTE** the proposal to change the signatory of the Partnership MoU on behalf of the ICB from the ICB Chief Executive to the Place Accountable Officer, in-line with the delegation set out in the ICB Scheme of Reservation and Delegation (subject to NHS England approval of NHS West Yorkshire ICB's constitution changes agreed by the ICB Board on the 17 December 2024).

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
1. Leeds Health and Care Partnership Memorandum of Understanding V1.1

Acronyms and Abbreviations explained
1. MoU – Memorandum of Understanding
2. ICB – Integrated Care Board

What are the implications for?

Residents and Communities	Delegation arrangements support our commitment to meet the health needs of our residents and communities.
Quality and Safety	There are no specific quality and safety implications arising from this report.
Equality, Diversity and Inclusion	The Board and 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	There are no specific financial implications arising from this report.
Regulation and Legal Requirements	Arrangements are designed to comply with regulation and legal requirements
Conflicts of Interest	The approach to conflicts of interest are 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	The Partnership MoU is designed to support agile decision making
Citizen and Stakeholder Engagement	Approach set in the ICB involvement framework

LEEDS HEALTH AND CARE PARTNERSHIP

MEMORANDUM OF UNDERSTANDING

No	Date	Version Number	Author
1	21.05.21	0.1	Hill Dickinson
2	08.10.21	0.2	Hill Dickinson
3	02.11.21	0.3	Amends and Comments from Governance Network
4	05.05.22	0.4	Amends for 1 July Establishment Date
5	16.05.22	0.5	Hill Dickinson
	02.04.25	1.1	Updated in line with review (Sam Ramsey, Senior Partnership Development Lead)

BACKGROUND

(A) Leeds has a long history of successful partnership working with people at the heart and with a breadth of assets to enable genuine whole system change. There are many examples of how, by working together as a partnership, we have achieved successes and improvements to lives of people who live and work in Leeds. Building on this success, we want to proactively continue to create the conditions that enable and support our health and care staff who come from all professions to continue to work together, and with people and communities, to deliver measurable progress towards our ambition to improve outcomes and reduce inequalities for our population. Whereas Leeds has predominantly led with a values and behaviours culture, working together on a shared ambition of the Health and Wellbeing Strategy and developing strong relationships, and mutual accountability, partners have agreed that Leeds would benefit from having an agreement which captures and formalises health and care partnership arrangements in Leeds.

(B) This Memorandum of Understanding ("**MoU**") sets out the vision, objectives and shared principles of the signatories to this MoU ("**Partners**") in establishing a place-based partnership for Leeds (the "**Partnership**") and further developing place-based health and care provision for the people of Leeds using a population health management approach, building on the progress achieved by the Partners to date. The MoU also sets out how the Partners will work together as participants in the Partnership, including the governance arrangements.

(C) The Partners will focus on the Priority Areas within the 'Healthy Leeds – Our Plan to Improve Health and Wellbeing in Leeds', Healthy Leeds Plan ("**HLP**") set out in this MoU to work towards specific outcomes over the term. Further Priority Areas, or changes to existing Priority Areas, may be agreed by the Partners during the term of this MoU as required to further the

collaborative work of the Partners for the benefit of the population of Leeds.

(D) Partners recognise that from the passing of the Health and Care Act 2022, there is a continued need, through the Partnership governance arrangements set out in this MoU, to further develop the Partnership to become a thriving place-based partnership and discharge delegated functions from the NHS West Yorkshire Integrated Care Board ("**ICB**") and allocate resources for the benefit of the Leeds population.

(E) The Partners acknowledge that the success of the Partnership will rely on the Partners working collaboratively rather than separately to plan financially sustainable methods of delivering integrated, population-focused services in furtherance of the Priority Areas.

(F) This MoU is intended to supplement and work alongside the Partners' respective governance arrangements and, in the case of provider Partners, their existing and future services contracts with the ICB, NHS England and the Council, whilst respecting their individual sovereignty. It is also intended to work alongside the section 75 agreement in relation to the Better Care Fund between the ICB and the Council.

1. DEFINITIONS AND INTERPRETATION

1.1 In this MoU, capitalised words and expressions shall have the meanings given to them in Schedule 1.

1.2 In this MoU, unless the context requires otherwise, the following rules of construction shall apply:

1.2.1 a person includes a natural person, corporate or unincorporated body (whether or not having separate legal personality);

1.2.2 unless the context otherwise requires, words in the singular shall include the plural and in the plural shall include the singular;

1.2.3 a reference to a Partner includes its personal representatives, successors or permitted assigns;

1.2.4 a reference to a statute or statutory provision is a reference to such statute or provision as amended or re-enacted. A reference to a statute or statutory provision includes any subordinate legislation made under that statute or statutory provision, as amended or re-enacted;

1.2.5 any phrase introduced by the terms "**including**", "**include**", "**in particular**" or any similar expression shall be construed as illustrative and shall not limit the sense of the words preceding those terms; and

1.2.6 a reference to writing or written includes emails.

2. STATUS AND PURPOSE

2.1 The Partners have agreed to work together on behalf of the people of Leeds to establish the Partnership through which to identify and respond to the health and care needs of the Leeds population, and deliver integrated health, support and community care to develop and ultimately deliver improved health and care outcomes for the people of Leeds.

2.2 This MoU sets out the key terms that the Partners have agreed, including:

2.2.1 the vision of the Partners, and key objectives for the development and delivery of integrated services in Leeds and the Priority Areas;

2.2.2 the key principles that the Partners will comply with in working together through the Partnership;

2.2.3 the updated governance structures underpinning the Partnership

2.3 Notwithstanding the good faith consideration that each Partner has afforded the terms set out in this MoU, the Partners agree that, save as provided in Clause 2.4 below, this MoU shall not be legally binding. The Partners each enter into this MoU intending to honour all of their respective obligations.

2.4 Each of the Partners agrees to work together in a collaborative and integrated way on a Best for Leeds basis. This MoU is not intended to conflict with or take precedence over the terms of the Services Contracts or the Section 75 Agreement unless expressly agreed by the Partners.

3. APPROVALS

Each Partner acknowledges and confirms that as at the date of this MoU, it has obtained all necessary authorisations to enter into this MoU and that its own organisational leadership body has approved the terms of this MoU.

4. DURATION AND REVIEW

4.1 This MoU will take effect on the Commencement Date and will expire on 31 March 2023 (the "**Initial Term**"), unless and until terminated in accordance with the terms of this MoU.

4.2 At the expiry of the Initial Term this MoU will expire automatically without notice unless, no later than 3 months before the end of the Initial Term, the Partners agree in writing that the term of the MoU shall be extended for a further term to be agreed between the Partners.

4.3 The Partners may agree to vary the MoU to reflect developments as appropriate in accordance with Clause 18 (*Variations*).

SECTION A: VISION, OBJECTIVES AND PRINCIPLES

5. THE VISION

5.1 The Partners have agreed to work towards a common vision for the Partnership as follows:

Leeds, a healthy and caring city for all ages, where people who are the poorest will improve their health the fastest.

6. THE OBJECTIVES

6.1 The Partners have agreed to work together and to perform their duties under this MoU in order to achieve the following Objectives:

6.1.1 Living our Partnership Principles: we start with people; we deliver; we are Team Leeds;

6.1.2 Working with people and staff and hearing all of their voices;

6.1.3 Rethinking how we deliver better person-centred outcomes, drive a seamless experience of care and reduce inequalities;

6.1.4 A relentless focus on our shared three key city ambitions combined to make Leeds a healthy, compassionate, climate conscious city with a strong economy, where people who are the poorest improve their health the fastest;

6.1.5 Creating a culture that encourages system leadership – 'Leeds £', 'city first, organisational second', 'working as if we are one organisation';

6.1.6 Collectively owning and unblocking performance, intelligence, efficiency, quality and financial issues facing health and care;

6.1.7 Unblocking intra-organisational system issues, maximising opportunities, eliminating duplication;

6.1.8 A shared transformation plan which creates meaningful change, ensuring the short-term is managed in the context of the long-term;

6.1.9 'One city voice' – shared understanding and ownership of unified positions and messages; and

6.1.10 Maximise the leverage from our collective influence regionally and nationally.

6.2 Through the Objectives, the Partners will aim to achieve the following Outcomes identified in the Leeds Health & Wellbeing Strategy:

6.2.1 People will live longer and have healthier lives;

6.2.2 People will live full, active and independent lives;

6.2.3 People's quality of life will be improved by access to quality services;

6.2.4 People will be actively involved in their health and their care; and

6.2.5 People will live in healthy, safe and sustainable communities.

6.3 The Partners acknowledge that they will have to make decisions together in order for the Partnership arrangements to work effectively. The Partners agree that they will work together and make decisions on a Best for Leeds basis in order to achieve the Objectives, subject to Clause 9.

7. THE PRINCIPLES

7.1 The Principles set out below underpin the delivery of the Partners' obligations under this MoU and set out key factors for a successful relationship between the Partners for the delivery of the Partnership.

7.2 The Partners agree that the successful delivery of the Partnership operating model will depend on their ability to effectively co-ordinate and combine their expertise and resources in order to deliver an integrated approach to the planning, provision and use of community assets and services across the Partners.

7.3 The Partners will work together in good faith and, unless the provisions in this MoU state otherwise, the Partners will ensure:

7.3.1 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;

7.3.2 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;

7.3.3 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;

7.3.4 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;

7.3.5 Act in the best interests of the population of Leeds;

7.3.6 Resolve differences between members and present a united front in the best interests of the people of Leeds;

7.3.7 Openness and transparency in discussions;

7.3.8 Actively work to remove barriers that prevent Team Leeds working;

7.3.9 Hold each other to account;

7.3.10 Be clear in language used to reduce any confusion between Partners;

7.3.11 Seek clarity from other Partners if unsure of terminology/language used;

7.3.12 Offer constructive challenge to improve service delivery and ensure financial balance;

7.3.13 Openness and transparency in decision making, being explicit of when not agreeing/supporting a decision;

7.3.14 Stick to decisions that are made;

7.3.15 Follow through on actions agreed,

and together with the principles set out in Clause 7.2 these are the "Principles".

8. PROBLEM RESOLUTION AND ESCALATION

8.1 The Partners agree to adopt a systematic approach to problem resolution which recognises the Objectives and the Principles set out in Clauses 6 and 7 above and which:

8.1.1 seeks solutions without apportioning blame;

8.1.2 is based on mutually beneficial outcomes;

8.1.3 treats each Partner as an equal party in the dispute resolution process; and

8.1.4 contains a mutual acceptance that adversarial attitudes waste time and money.

8.2 If a problem, issue, concern or complaint comes to the attention of a Partner in relation to the Priority Areas, Objectives, Principles or any matter in this MoU such Partner shall notify the other Partners. The Partners shall then try to resolve the issue in a proportionate manner by a process of discussion within 20 Operational Days of notification. If they are not able to do this, the matter will be resolved in accordance with Schedule 5 (*Dispute Resolution Procedure*).

8.3 If any Partner receives any formal enquiry, complaint, claim or threat of action from a third party relating to this MoU (including, but not limited to, claims made by a supplier or requests for information made under the FOIA relating to this MoU) the receiving Partner will liaise with the Leeds Health and Care Partnership Executive Group as to the contents of any response before a response is issued.

SECTION B: OPERATION OF AND ROLES IN THE PARTNERSHIP

9. RESERVED MATTERS

9.1 The Partners agree and acknowledge that nothing in this MoU shall operate as to require them to make any decision or act in anyway which shall place any Partner in breach of:

9.1.1 Law;

9.1.2 any Services Contract or the Section 75 Agreement;

9.1.3 any specific Department of Health and Social Care or NHS England policies;

9.1.4 if applicable its Constitution (including for the ICB and the Council), any terms of its provider licence from NHS Improvement or its registration with the CQC;

9.1.5 the terms of reference for the Leeds Committee of the WY ICB;

9.1.6 any legislative requirements including the NHS Act 2006 (as amended); or

9.1.7 any term of a non-NHS party's legal constitution or other legally binding agreement or governance document of which specific written notice has been given to the Partners,

and the Leeds Health and Care Partnership Leadership Team will not make a final recommendation which requires any Partner to act as such.

10. TRANSPARENCY

10.1 Subject to compliance with the Law and contractual obligations of confidentiality, the Partners will provide to each other all information that is reasonably required in order to deliver the Priority Areas and implement the Partnership Development Plan in line with the Objectives.

10.2 The Partners have responsibilities to comply with the Law (including where applicable Competition Law). The Partners will make sure that they share information, and particular Competition Sensitive Information, in such a way that is compliant with Competition Law. The ICB will ensure that the Leeds Committee of the West Yorkshire ICB and corresponding sub Leeds place Committees establish appropriate information barriers between and within the Providers so as to ensure that Competition Sensitive Information and Confidential Information are only available to those Providers who need to see it to achieve the Objectives and for no other purpose whatsoever so that the Partners do not breach Competition Law.

10.3 It is accepted by the Partners that the involvement of the Providers in the governance arrangements for the Partnership is likely to give rise to situations where information will be generated and made available to the Providers which could give the Providers an unfair advantage in competitive procurements or which may be capable of distorting such procurements (for example, disclosure of pricing information or approach to risk may provide one Provider with a commercial advantage over a separate Provider).

10.4 Any Provider will have the opportunity to demonstrate to the reasonable satisfaction of the ICB and/or the Council (where acting as a commissioner) in relation to any competitive procurements that the information it has acquired as a result of its participation in the Partnership, other than as a result of a breach of this MoU, does not preclude the ICB and/or the Council (where acting as a commissioner) from running a fair competitive procurement in accordance with their legal obligations.

10.5 Notwithstanding Clause 10.4 above, the ICB and the Council may take such measures as they consider necessary in relation to competitive procurements in order to comply with their obligations under Law which may include excluding any potential bidder from the competitive procurement in accordance with the Law governing that competitive procurement.

SECTION C: GOVERNANCE ARRANGEMENTS

11. LEEDS HEALTH AND CARE (PLACE-BASED) PARTNERSHIP GOVERNANCE

11.1 The governance structure for the Place Partnership is set out in the diagram in Schedule 3 (*Governance*) and includes the following:

11.1.1 the Leeds Health and Wellbeing Board;

11.1.2 the Leeds Committee of the WY ICB;

11.1.3 the Leeds Health and Care Partnership Leadership Team; and

11.1.4 two Leeds Sub-Committees.

Leeds Health and Wellbeing Board

11.2 The Leeds Health and Wellbeing Board is a committee of the Council, charged with promoting greater health and social care integration in Leeds. The Health and Wellbeing Board will receive reports from the Leeds Health and Care Partnership Executive Group as to the development of the Partnership arrangements under this MoU and progress against the Health & Wellbeing Strategy and the Partnership Development Plan.

*Leeds Committee of the WY ICB (the "Leeds ICB **Committee**")*

11.3 The Leeds ICB Committee is established as a formal committee of the West Yorkshire ICB Board, in accordance with the ICB's constitution. The Leeds ICB Committee has delegated authority from the ICB Board to make decisions about the use of ICB resources in Leeds in line with its remit, and otherwise support the ICB as set out in its terms of reference at Schedule 3 Part 1 (current as at the Commencement Date). The decisions reached by the Leeds ICB Committee are decisions of the ICB, in line with the ICB's Scheme of Reservation and Delegation. Members of the Leeds ICB Committee must comply with ICB policies and procedures.

11.4 The Leeds ICB Committee reports to the ICB Board and will:

11.4.1 together with Partner organisations, oversee the Partnership arrangements under this MoU;

11.4.2 act in accordance with its terms of reference at Schedule 3 Part 1;

11.4.3 provide updates to the Health and Wellbeing Board on progress against the Joint Health and Wellbeing Strategy (JHWS) for Leeds;

11.4.4 report to Partner organisations on progress against the Objectives;

11.4.5 liaise where appropriate with:

(a) national stakeholders (including NHS England and NHS Improvement); and

(b) the West Yorkshire Integrated Care Partnership,

to communicate the views of the Partnership on matters relating to integrated care in Leeds.

11.5 The Partners acknowledge that their employees may be appointed as members of the Leeds ICB Committee. The Partners agree to support their employees in doing so in line with the aims and objectives of the Leeds ICB Committee. The Partners acknowledge that any individual who is nominated as a member of the Leeds ICB Committee or sub-committee of the Leeds ICB Committee understands and agrees to bring knowledge and perspective from their sector but not be a delegate or carry agreed mandates from that sector or from their Partner organisation.

11.6 Each Partner must ensure that its appointed members or attendees of the Leeds ICB Committee (or their appointed deputies/alternatives) attend all of the meetings of the relevant group and participate fully and exercise their rights on a Best for Leeds basis and in accordance with Clause 5 (*Objectives*) and Clause 7 (*Principles*).

Leeds Health and Care Partnership Leadership Team (PLT)

11.7 PLT is a consultative and collaborative team to inform and support the work of the Leeds ICB Committee and the Health and Wellbeing Board. PLT is not a committee of any Partner or any combination of Partners and will operate as a collaborative forum.

11.8 PLT will support system development by establishing a shared culture where Partner staff adopt common sets of values and behaviours. It will help to oversee and support the development of shared partnership infrastructure that may be required to support the work of the Partnership. PLT will act in accordance with its terms of reference.

Leeds Sub Committees

11.9 The Leeds Sub Committees are Quality and People's Experience and Finance and Best Value.. The Sub Committees are established by, and will each report and provide assurance to, the Leeds ICB Committee [as formal sub-committees of the Leeds ICB Committee]. Their terms of reference can be requested.

11.10 The Partners will review and develop the governance arrangements for the Partnership during 2022/23 to strengthen joint decision-making between the Partners, such review to include consideration of developing a joint committee structure between the Partners in line with the relevant provisions of the Health and Care Act 2022.

Place Lead role

11.11 Following a nomination from the Partnership, the ICB has appointed a 'Place Lead' who has responsibility for strategic leadership of the Partnership. The Place Lead is the 'convenor' of the Partnership, bringing Partners together and leading collaborative work and integration

across the Partnership. The Place Lead is a member of the WY Integrated Care Board, the Leeds ICB Committee, the Leeds Health and Wellbeing Board and the PLT.

12. CONFLICTS OF INTEREST

12.1 Subject to compliance with Law (including without limitation Competition Law) and contractual obligations of confidentiality, the Partners agree to share all information relevant to the achievement of the Objectives in an honest, open and timely manner.

12.2 The Partners will:

12.2.1 disclose to each other the full particulars of any real or apparent conflict of interest which arises or may arise in connection with this MoU or the operation of the Partnership governance immediately upon becoming aware of the conflict of interest whether that conflict concerns the Partner or any person employed or retained by them for or in connection with the performance of this MoU;

12.2.2 not allow themselves to be placed in a position of conflict of interest in regard to any of their rights or obligations under this MoU (without the prior consent of the other Partners) before they participate in any decision in respect of that matter; and

12.2.3 use best endeavours to ensure that their representatives on the Leeds ICB Committee also comply with the requirements of this Clause 12 when acting in connection with this MoU.

12.3 If there is:

12.3.1 any uncertainty or a lack of consensus between the Partners regarding the existence of a conflict of interest under Clause 12.2.1 or 12.2.2; or

12.3.2 any query or Dispute as to whether any Partner is put in a position (or will be) of conflict under Clause 12.2.2,

any Partner may refer the matter for resolution under Clause 8 (Problem Resolution and Escalation).

12.4 The Partners will each comply with the ICB conflicts of interest policy when participating in the Leeds ICB Committee or any other Governance Group undertaking ICB Business, otherwise the conflicts of interest policy and procedures of its Partner organisation will apply.

12.5 The ICB has made arrangements to manage any actual and potential conflicts of interest to ensure that decisions made by committees or sub-committees of the ICB will be taken and seen to be taken without being unduly influenced by external or private interest and do not, (and do not risk appearing to) affect the integrity of the ICB's decision-making processes. These arrangements apply to the Leeds ICB Committee and any sub-committees of the Leeds ICB Committee.

12.6 The ICB has agreed policies and procedures for the identification and management of conflicts of interest which are published on the ICB website.

12.7 The Partners shall ensure that all Leeds ICB Committee and sub-committee members nominated by them comply with the ICB policy on conflicts of interest in line with their terms of office. This will include but not be limited to declaring all interests on a register that will be maintained by the ICB.

12.8 The Partners shall ensure that all Leeds ICB Committee and sub-committee members comply with the ICB Standards of Business Conduct policy.

SECTION D: FINANCIAL PLANNING

13. FINANCIAL PRINCIPLES

13.1 The Partners will continue to be paid in accordance with the mechanism set out in their respective Services Contracts.

13.2 The Partners commit to developing and agreeing system financial principles during the initial term for the allocation of resources within Leeds.

13.3 Any future introduction of a risk / reward sharing mechanism would require additional provisions to be agreed between the Partners and incorporated into this MoU in accordance with Clause 18 (Variations).

SECTION E: FUTURE DEVELOPMENT OF THE PARTNERSHIP

14. PARTNERSHIP DEVELOPMENT

14.1 Throughout 2025/26 material changes are expected to the MoU and will give due consideration to the recommendations of the review of place partnership arrangements. The West Yorkshire Integrated Care Board is reviewing its leadership and organisational arrangements to strengthen and support the collective approach to the planning and delivery of health services in place.

14.2 Work will be undertaken through 2025/26 across the Leeds Health and Care Partnership relating to the development of a formal 'provider partnership, in line with our local strategy and as a response to the national direction of travel set be the government, which sees ICBs becoming strategic commissioners and delegating more functions and responsibilities to provider organisations working at place-level.

SECTION F: GENERAL PROVISIONS

15. EXCLUSION AND TERMINATION

15.1 A Partner may be excluded from this MoU on notice from the other Partners (acting in consensus) in the event of:

15.1.1 the termination of their Services Contract; or

15.1.2 an event of Insolvency affecting them.

15.2 A Partner may withdraw from this MoU by giving not less than 6 months' written notice to each of the other Partners' representatives.

15.3 A Partner may be excluded from this MoU on written notice from all of the remaining Partners in the event of a material or a persistent breach of the terms of this MoU by the relevant Partner which has not been rectified within 30 days of notification issued by the remaining Partners (acting in consensus) or which is not reasonably capable of remedy. In such circumstances this MoU shall be partially terminated in respect of the excluded Partner.

15.4 The PPB may resolve to terminate this MoU in whole where:

15.4.1 a Dispute cannot be resolved pursuant to the Dispute Resolution Procedure; or

15.4.2 where the Partners agree for this MoU to be replaced by a formal legally binding agreement between them.

15.5 Where a Partner is excluded from this MoU, or withdraws from it, the excluded or withdrawing (as relevant) Partner shall procure that all data and other material belonging to any other Partner shall be delivered back to the relevant Partner or deleted or destroyed (as instructed by the relevant Partner) as soon as reasonably practicable.

16. INTRODUCING NEW PROVIDERS

16.1 Additional parties may become parties to this MoU on such terms as the Partners shall jointly agree in writing, acting at all times on a Best for Leeds basis. Any new Partner will be required to agree in writing to the terms of this MoU before admission.

17. LIABILITY

17.1 The Partners' respective responsibilities and liabilities in the event that things go wrong with the Services will be allocated under their respective Services Contracts and not this MoU.

18. VARIATIONS

18.1 Save as set out in Clause 19, any amendment, waiver or variation of this SPA will not be binding unless set out in writing, expressed to amend, waiver or vary this SPA and signed by or on behalf of each of the Partners.

19. ASSIGNMENT AND NOVATION

19.1 Unless the Partners agree otherwise in writing, none of the Partners will novate, assign, delegate, sub-contract, transfer, charge or otherwise dispose of all or any of their rights and responsibilities under this MoU.

20. CONFIDENTIALITY AND FOIA

20.1 Each Partner shall keep confidential all Confidential Information that it receives from the other Partners except to extent such Confidential Information is required by Law to be disclosed or is already in the public domain or comes into the public domain otherwise than through an unauthorised disclosure by a Partner to this MoU.

20.2 To the extent that any Confidential Information is covered or protected by legal privilege, then disclosing such Confidential Information to any Partner or otherwise permitting disclosure of such Confidential Information does not constitute a waiver of privilege or of any other rights which a Partner may have in respect of such Confidential Information.

20.3 The Partners agree to procure, as far as is reasonably practicable, that the terms of this Clause 20 (*Confidentiality and FOIA*) are observed by any of their respective successors, assigns or transferees of respective businesses or interests or any part thereof as if they had been party to this MoU.

20.4 Nothing in this Clause 20 (*Confidentiality and FOIA*) will affect any of the Partners' regulatory or statutory obligations, including but not limited to competition law of any applicable jurisdiction.

20.5 The Partners acknowledge that some of them are subject to the requirements of the FOIA and will facilitate each other's compliance with their information disclosure requirements, including the submission of requests for information and handling any such requests in a prompt manner and so as to ensure that any Partner which is subject to FOIA is able to comply with their statutory obligations.

21. GENERAL

21.1 Any notice or other communication given to a Partner under or in connection with this MoU shall be in writing, addressed to that Partner at its principal place of business or such other address as that Partner may have specified to the other Partner in writing in accordance with this Clause, and shall be delivered personally, or sent by pre-paid first class post, recorded delivery or commercial courier or email.

21.2 A notice or other communication shall be deemed to have been received: if delivered personally, when left at the address referred to in Clause 21.1 above; if sent by pre-paid first class post or recorded delivery, at 9.00 am on the second Operational Day after posting; if delivered by commercial courier, on the date and at the time that the courier's delivery receipt is signed; or if sent by email, one (1) Operational Day after transmission.

21.3 Nothing in this MoU is intended to, or shall be deemed to, establish any partnership between any of the Partners, constitute any Partner the agent of another Partner, nor authorise any Partner to make or enter into any commitments for or on behalf of any other Partner except as expressly provided in this MoU.

21.4 This MoU may be executed in any number of counterparts, each of which when executed and delivered shall constitute an original of this MoU, but all the counterparts shall together constitute the same agreement. The expression "counterpart" shall include any executed copy of this MoU scanned into printable PDF, JPEG, or other agreed digital format and transmitted as an e-mail attachment. No counterpart shall be effective until each Partner has executed at least one counterpart.

21.5 This MoU, and any dispute or claim arising out of or in connection with it or its subject matter or formation (including non-contractual disputes or claims), shall be governed by, and construed in accordance with, English law, and where applicable, the Partners irrevocably submit to the exclusive jurisdiction of the courts of England and Wales.

21.6 A person who is not a Partner to this MoU shall not have any rights under or in connection with it.

This MoU has been entered into on the date stated at the beginning of it.

Signed by [insert] .....

for and on behalf of **NHS WEST YORKSHIRE INTEGRATED CARE BOARD** [ ]

Signed by [insert] .....

for and on behalf of **LEEDS CITY COUNCIL** [ ]

Signed by [insert] .....

for and on behalf of **LEEDS COMMUNITY HEALTHCARE NHS TRUST** [ ]

Signed by [insert] .....

for and on behalf of **LEEDS TEACHING HOSPITAL NHS TRUST** [ ]

Signed by [insert]

for and on behalf of **LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST** .....

[ ]

Signed by [insert] .....

for and on behalf of **GENERAL PRACTICE** [ ]

Signed by [insert]

for and on behalf of **THIRD SECTOR**

.....

[ ]

FORUM CENTRAL LEAD - VOLITION

.....

[ ]

FORUM CENTRAL PARTNER - LEEDS OLDER PEOPLES FORUM

SCHEDULE 1

Definitions and Interpretation

1. The following words and phrases have the following meanings:

Best for Leeds	best for the achievement of the Vision, Objectives and Outcomes for the Leeds population on the basis of the Principles.
Commencement Date	the date entered on page one (1) of this MoU.
Commercially Sensitive Information	Confidential Information which is of a commercially sensitive nature relating to a Partner, its intellectual property rights or its business or which a Partner has indicated would cause that Partner significant commercial disadvantage or material financial loss.
Commissioner	a Partner who is also a commissioner of Services, being the ICB and the Council as at the Commencement Date.
Competition Law	the Competition Act 1998 and the Enterprise Act 2002, as amended by the Enterprise and Regulatory Reform Act 2013.
Competition Sensitive Information	Confidential information which is owned, produced and marked as Competition Sensitive Information by one of the Partners and which that Partner properly considers is of such a nature that it cannot be exchanged with the other Partners without a breach or potential breach of Competition Law. Competition Sensitive Information may include, by way of illustration, trade secrets, confidential financial information and confidential commercial information, including without limitation, information relating to the terms of actual or proposed contracts or sub-contract arrangements (including bids received under competitive tendering), future pricing, business strategy and costs data, as may be utilised, produced or recorded by any Partner, the publication of which an organisation in the same business would reasonably be able to expect to protect by virtue of business confidentiality provisions.
Confidential Information	the provisions of this MoU and all information which is secret or otherwise not publicly available (in both cases in its entirety or in part) including commercial, financial, marketing or technical information, know-how, trade secrets or business methods, in all

	cases whether disclosed orally or in writing before or after the date of this MoU, including Commercially Sensitive Information and Competition Sensitive Information.
Dispute	any dispute arising between two or more of the Partners in connection with this MoU or their respective rights and obligations under it.
Dispute Resolution Procedure	the procedure set out in Schedule 5 for the resolution of disputes which are not capable of resolution under Clause 8 (*Problem Resolution and Escalation*).
FOIA	the Freedom of Information Act 2000 and any subordinate legislation (as defined in section 84 of the Freedom of Information Act 2000) from time to time together with any guidance and/or codes of practice issued by the Information Commissioner or relevant Government department in relation to such Act.
Good Practice	Good Clinical Practice and/or Good Health and/or Social Care Practice (each as defined in the Services Contracts), as appropriate.
Governance Group	any group referred to in this MoU or set up pursuant to the various terms of reference referred to in this MoU to further the work of the Partnership.
ICB	NHS West Yorkshire Integrated Care Board.
Initial Term	the initial term of this MoU as set out in Clause 4.1.
Insolvency	(as may be applicable to each Partner) a Partner taking any step or action in connection with its entering administration, provisional liquidation or any composition or arrangement with its creditors (other than in relation to a solvent restructuring), being wound up (whether voluntarily or by order of the court, unless for the purpose of a solvent restructuring), having a receiver appointed to any of its assets or ceasing to carry on business.
Law	a) any applicable statute or proclamation or any delegated or subordinate legislation or regulation; b) any applicable judgment of a relevant court of law which is a binding precedent in England and Wales; c) Guidance (as defined in the NHS Standard Contract); d) National Standards (as defined in the NHS Standard Contract); and e) any applicable code.

Leeds Health and Care Partnership Executive Group	has the meaning set out in Clause 11.7.
Leeds Committee of the WY ICB	the Leeds Place-based Partnership Committee of the ICB, the terms of reference for which are set out in Part 1 of Schedule 4 (Governance).
Leeds ICB Committee	the Leeds Committee of the West Yorkshire Integrated Care Board.
MoU	this memorandum of understanding incorporating the Schedules.
NHS Standard Contract	the NHS Standard Contract for NHS healthcare services as published by NHS England from time to time.
Objectives	the objectives for the Partnership set out in Clause 6.1.
Operational Days	a day other than a Saturday, Sunday or bank holiday in England.
Outcomes	the outcomes for the Partnership set out in Clause 6.2.
Partnership Development Plan	the initial Partnership Development Plan set out in Schedule 3 (*Partnership Development Plan*).
PLT	the Leeds Health and Care Partnership Leadership Team has the meaning set out in Clause 11.7.
Population	the population of Leeds, who reside in Leeds or are registered with a Leeds GP.
Principles	the principles for the Partnership set out in Clause 7.
Priority Areas	the priority areas identified by the Partners as set out in Schedule 2 (*Priority Areas*).
Provider	a Partner who is also a provider of Services under a Services Contract.
Section 75 Agreement	the agreement entered into by the Commissioners under section 75 of the National Health Service Act 2006 to commission the services listed in the Schedules to that agreement.
Service Users	people within the Leeds population, who reside in Leeds or are registered with a Leeds GP.
Services	the services provided, or to be provided, by each Provider to Service Users pursuant to its respective Services Contract.

Services Contract	a contract entered into by one of the ICB or the Council and a Provider for the provision of Services, and references to a Services Contract include all or any one of those contracts as the context requires.
Vision	the vision of the Partnership, as set out in Clause 5.

SCHEDULE 2

Priority Areas

The Partners have identified the Priority Areas during the Initial Term (as may be agreed and amended from time to time) as:

'Healthy Leeds – Our Plan to Improve Health and Wellbeing in Leeds (HLP)'

SCHEDULE 3

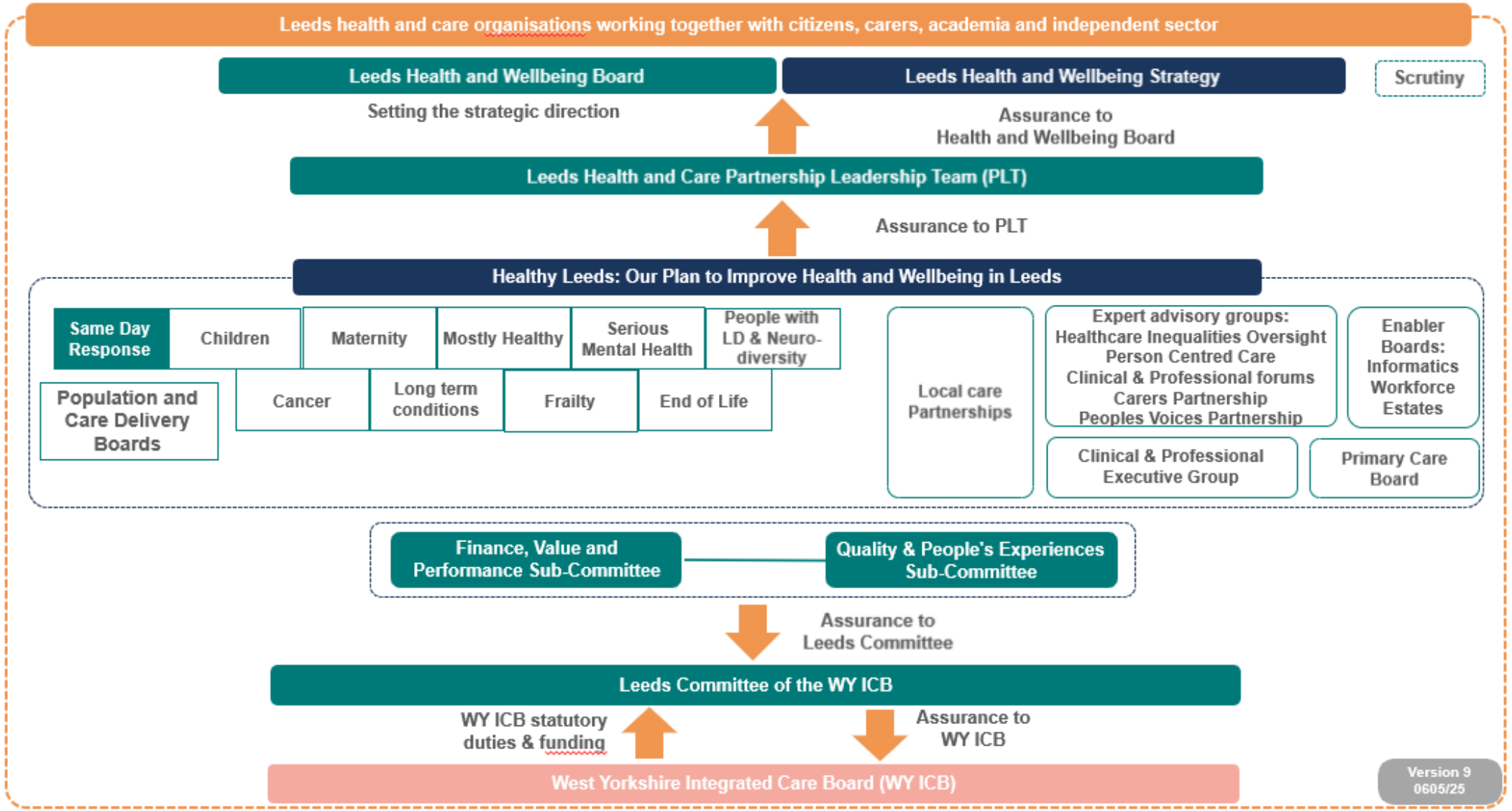
Governance

This Schedule 4 sets out the governance arrangements for the Partnership under this MoU.

The diagram below summarises the updated governance structure which the Partners have agreed to provide oversight of the development and implementation of the Partnership approach and the arrangements under this MoU.

This Schedule also contains the terms of reference for the Leeds Committee of the WY ICB.

Leeds Health & Care Partnership Governance Structure



Part 1 – Leeds Committee of the West Yorkshire Integrated Care Board (ICB) Terms of Reference

Version control

Version: 3.0

Approved by: West Yorkshire Integrated Care Board

Date Approved: 1 July 2022

Responsible Officer: Accountable Officer (Leeds)

Date Issued: 25 June 2024

Date to be reviewed: June 2025

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

1. Introduction

1.1 The Leeds Health and Care 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 Chair
- Independent Member – Finance
- Independent Member – Health Inequalities and Delivery
- Healthwatch Representative
- Executive Members (Leeds Office of the WY ICB)

- ICB Leeds Place Lead
- ICB Leeds Finance Lead
- ICB Leeds Nurse 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.

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 8 individuals. This must include representation from the following as a minimum:

- The Chair or his/her nominated Deputy Chair
- At least one independent member
- ICB Place Lead or ICB Place Finance Lead
- 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 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 meet 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 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

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, 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

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 shall draw to the attention of the ICB Board any significant issues or risks relevant to the ICB.

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.

Meeting name:	Leeds Committee of the West Yorkshire Integrated Care Board
Agenda item no.	LC 16/24
Meeting date:	21 May 2025
Report title:	Annual Governance Review
Report presented by:	Sue Baxter, Head of Partnerships Governance
Report approved by:	Tim Ryley, Place Lead and Accountable Officer
Report prepared by:	Harriet Speight, Corporate Governance Manager

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

Previous considerations:

Quality and People's Experience Sub-Committee – 23 April 2025

Finance, Value and Performance Sub-Committee – 30 April 2025

Executive summary and points for discussion:

The sub-committees of the Leeds Committee of the West Yorkshire Integrated Care Board are reviewed on an annual basis, in line with their terms of reference, to provide assurance that they are fulfilling their duties and remain effective.

The report presents a review of the two sub-committees, Finance & Best Value and Quality & People's Experience, during the period 1 April 2024 to 31 March 2025. Please note that from 1 April 2025, the Finance & Best Value Sub-Committee became the Finance, Value and Performance Sub-Committee and therefore the next annual report will reflect the new remit and body of work undertaken in its first year. Members are asked to receive the annual reports (attached at Appendices 1 and 2) as assurance that the sub-committees have fulfilled their function.

The amended Finance, Value & Performance Sub-Committee and Quality & People's Experience Sub-Committee terms of reference (ToR) are attached at Appendices 3 and 4 for approval.

The Leeds Committee Annual Report and amended ToR are also attached (Appendices 5 and 6) for review and comment, ahead of formal approval at the West Yorkshire Integrated Care Board meeting on 24 June 2025.

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

☒ Improve healthcare outcomes for residents in their system

☒ Tackle inequalities in access, experience and outcomes

☒ Enhance productivity and value for money

☒ Support broader social and economic development

Recommendation(s)
The Leeds Committee of the West Yorkshire Integrated Care Board is asked to: a) **RECEIVE** the sub-committee annual reports and **CONSIDER** if there are any further actions to be taken to improve the effectiveness of the sub-committees b) **APPROVE** the amends to the sub-committee terms of reference. c) **REVIEW** and **COMMENT** on the Leeds Committee Annual Report and terms of reference ahead of formal consideration by the WYICB Board on 24 June 2025.
Does the report provide assurance or mitigate any of the strategic threats or significant risks on the Corporate Risk Register or Board Assurance Framework? If yes, please detail which:
N/A
Appendices
1. Finance & Best Value Sub-Committee Annual Report 2024/25 2. Quality & People's Experience Sub-Committee Annual Report 2024/25 3. Finance, Value & Performance Sub-Committee amended ToR 4. Quality & People's Experience Sub-Committee amended ToR 5. Leeds Committee of the WYICB Annual Report 2024/25 6. Leeds Committee of the WYICB amended ToR
Acronyms and Abbreviations explained
1. WYICB – West Yorkshire Integrated Care Board 2. ToR – Terms of Reference

What are the implications for?

Residents and Communities	The annual reports identify the work undertaken through the sub-committees including people's voice and people's experience.
Quality and Safety	The report highlights the work of the Quality and People's Experience Sub-Committee through the annual report.
Equality, Diversity and Inclusion	The report highlights implications for equality, diversity, and inclusion throughout.
Finances and Use of Resources	The report highlights the work of the Finance Sub-Committee through the annual report.
Regulation and Legal Requirements	None identified.
Conflicts of Interest	None identified.
Data Protection	None identified.
Transformation and Innovation	None identified.

Environmental and Climate Change	None identified.
Future Decisions and Policy Making	The Committee is responsible for approving the ToR of each of its sub-committees. The WYICB Board is responsible for approving the Leeds Committee ToR.
Citizen and Stakeholder Engagement	The annual reports identify the work undertaken through the sub-committees including people's voice and people's experience.

1. Purpose of this report

1.1 The report presents a review of the two sub-committees (Finance & Best Value and Quality & People's Experience) during the period 1 April 2024 to 31 March 2025.

1.2 The annual reports, attached at Appendices 1 & 2 include a review of the sub-committees' activities and assurances provided over the last 12 months, and a summary of the self-assessment survey that was undertaken by members and attendees. Please note that from 1 April 2025, the Finance & Best Value Sub-Committee became the Finance, Value and Performance Sub-Committee and therefore the next annual report will reflect the new remit and body of work undertaken in its first year. As the Delivery Sub-Committee was dissolved following agreement at the Leeds Committee meeting held on 26 February 2025, an annual report has not been completed.

1.3 Each of the sub-committees' terms of reference have been reviewed and are attached at appendices 3 & 4 for approval.

2. Key Points

2.1 Each of the sub-committees met four times during 2024/25 and the sub-committee effectiveness survey has been undertaken in line with the terms of reference.

2.2 Each annual report was discussed at the relevant sub-committee, acknowledging the highlights from the sub-committees work over the last 12 months and potential areas for development in 2025/26.

2.3 Minor amendments are proposed to the sub-committee terms of reference, and all amends are included as tracked changes. The Leeds Committee of the WY ICB is asked to approve these amendments.

2.4 The Leeds Committee Annual Report and amended ToR are also attached (Appendices 5 and 6) for review and comment.

3. Next Steps

3.1 The Leeds Committee of the ICB annual report and ToR will be presented to the WY ICB Board on 24 June 2025.

3.2 In addition to this, work will continue across the WY ICB consolidated governance team to share best practice and learning from Place Committees.

3.3 Any agreed actions in relation to the sub-committee's effectiveness will be taken forward from June 2025.

4. Recommendations

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

1. **RECEIVE** the sub-committee annual reports and **CONSIDER** if there are any further actions to be taken to improve the effectiveness of the sub-committees.
2. **APPROVE** the amends to the sub-committee terms of reference.
3. **REVIEW** and **COMMENT** on the Leeds Committee Annual Report and terms of reference ahead of formal consideration by the WYICB Board on 24 June 2025.

5. Appendices

1. Finance & Best Value Sub-Committee Annual Report 2024/25
2. Quality & People's Experience Sub-Committee Annual Report 2024/25
3. Finance, Value & Performance Sub-Committee amended ToR
4. Quality & People's Experience Sub-Committee amended ToR
5. Leeds Committee of the WYICB Annual Report 2024/25
6. Leeds Committee of the WYICB amended ToR

Leeds Finance and Best Value Sub-Committee ANNUAL REPORT 2024/25

INTRODUCTION

Following a sub-committee governance review at the end of 2024/25, the Leeds Finance and Best Value Sub-Committee will become the Leeds Finance, Value and Performance Sub-Committee from 1 April 2025. This annual report is a reflection on the work and achievements of the Finance and Best Value Sub-Committee throughout 2024/25, and a forward look to areas for consideration for the Finance, Value and Performance Sub-Committee for 2025/26.

The Finance and Best Value Sub-Committee was accountable to the Leeds Committee of the WY ICB for providing assurance on its work. The role of the sub-committee was to alert, advise and assure the Leeds Committee of the WY ICB through performance oversight of key financial and performance plans, indicators and/or targets, including good stewardship of resources, as specified in the Leeds Health and Care Partnership's strategic and operational plans, in order to ensure best value and clinical outcomes.

The sub-committee was responsible for advising and supporting the Leeds Committee of the WY ICB in:

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

MEMBERSHIP

- Cheryl Hobson (Chair), Independent Member – Finance
- Yasmin Khan, Independent Member – Health Inequalities and Delivery
- Tim Ryley, ICB Leeds Place Lead
- Alex Crickmar, ICB Leeds Place Finance Lead
- Dr Keith Miller, ICB Leeds Place Associate Medical Director
- Jenny Ehrhardt, Partner Member - Leeds Teaching Hospitals Trust (LTHT)
- Dawn Hanwell, Partner Member - Leeds & York Partnership Foundation Trust (LYPFT)
- Andrea Osborne, Partner Member - Leeds Community Healthcare Trust (LCH)

- John Crowther, Chief Officer, Resources and Strategy (Adult Social Care and Public Health), Leeds City Council (LCC)
- Helen Kemp, Third Sector Representative

The following Executive Members were invited where required, dependent on the agenda item discussion:

- Nick Earl, Director of Strategy, Planning and Programmes
- Helen Lewis, Director of Pathway Integration

MEETINGS HELD

Meetings of the Finance and Best Value Sub-Committee were held on: 24 April 2024; 31 July 2024; 23 October 2024; and 22 January 2025. All four meetings were held via MS Teams.

ATTENDANCE

Member	**Attendance – number of meetings** **(meetings eligible to attend)**	**Attendance as %**
Cheryl Hobson, Independent Member - Finance	4 (4)	100
Yasmin Khan, Independent Member – Health Inequalities and Delivery	2 (4)	50
Visseh Pejhan-Sykes, Finance Place Lead, ICB in Leeds Alex Crickmar, Finance Place Lead, ICB in Leeds	1 (1) 3 (3)	100
Tim Ryley, Place Lead, ICB in Leeds	3 (4)	75
Keith Miller, Associate Medical Director, ICB in Leeds	4 (4)	100
Simon Worthington, Director of Finance, LTHT Jenny Ehrhardt, Director of Finance, LTHT	1 (1) 0 (2)	25
Andrea Osborne, Interim Director of Finance, LCH *Deputy - Cherrine Hawkins	1 (4) 2 (2)	75
Dawn Hanwell, Chief Financial Officer, LYPFT *Deputy – Jonathan Saxton	2 (4) 1 (4)	75
John Crowther, Chief Officer, Resources and Strategy (Adult Social Care and Public Health), LCC	1 (3)	25

Rebecca Charlwood, Independent Chair, Leeds Committee of the West Yorkshire Integrated Care Board	2 (4)	50
Helen Kemp, Forum Central *Deputy - Francesca Wood *Deputy – Pip Goff	2 (4) 1 (1) 1 (1)	100

HIGHLIGHTS FROM THE COMMITTEE'S WORK IN 2024/25

People's Voice

Every meeting of the sub-committee begins with a People's Voices item which provides a lived experience of healthcare in Leeds, to focus minds and set the tone for the remainder of the meeting. The item is led by the People's Voices Partnership (PVP) and includes videos and reports from the 'How does it feel for me?' series which follows people's experiences of services over a period of time to inform recommendations to health and care partners for service improvements and highlight best practice. This year, a range of experiences have been shared, including those of people with complex mental health needs and older people reflecting on physical and cultural barriers.

Financial Position Update / Financial Plan Reviews

At every meeting, the sub-committee receives a report that provides an update on the financial position for the Leeds Place of the WY ICB and in the context of the wider WY ICB financial position. The report provides details of current and future actions to ensure the city has a sustainable financial position. It also provides an overview of the financial projections for the three NHS Providers across Leeds that form part of the overall WY ICB in terms of financial resources and delivery. Alongside the updates on the financial position, additional reports have been submitted throughout the year providing additional assurance on the financial planning processes undertaken for 2025/26 and beyond including the draft Medium Term Financial Plan.

Towards the end of the financial year, the sub-committee considered the draft Financial Plan for 2025/26 in advance of the Leeds Committee, providing comments and steer ahead of formal approvals.

Population and Care Delivery Board Reports

In the last year, the sub-committee received reports from each of the following Population and Care Delivery Boards: Same Day Response, End of Life, Frailty, Mental Health and Learning Disabilities and Neurodiversity. Where possible, a

representative from the board attended the meetings to present the reports and answer any questions from members.

This item was paused after the first meeting of 2024/25 due to ongoing work to redefine the role of the Population Boards to ensure that they have a tighter focus on a set of agreed partnership transformation programmes and priorities for their specific population and work is ongoing to continue to provide assurance of these areas through various reporting mechanisms. Future reporting will be reviewed as the year progresses.

Risk Management Reporting
The sub-committee seeks assurance that finance related risks are being managed appropriately, by acknowledging the factors that provide assurance, identifying any gaps, noting any mitigating factors and the adequacy of action plans to address these risks. The sub-committee receives and reviews the risks rated as high amber (12) and risks that are scored at 15 or above. Due to changes to the governance and risk arrangements at the WYICB, the format of the risk report changed in 2024/25 whereby all three Leeds sub-committees receive a single report, with an appendix specifically highlighting the risks that are aligned to that sub-committee.

Value-Based Health & Care: The Shift from Activity-Based Systems to Outcomes-Based Systems
The sub-committee considered the potential opportunities and challenges of developing a value-based approach to health and care and the shift from activity-based systems to outcomes-based systems. Members discussed how the increased integration of services, data, financial risk and decision-making could lead to more decisions being made on the basis of value. Challenges to transitioning to a value-based health and care approach were also identified including statutory priorities and current funding arrangements. Going forward, the Finance, Value and Performance Sub-Committee will continue to consider the development of a value-based health and care approach.

Other Reports
This year, the sub-committee scrutinised the proposed route to procurement of a new contract for an integrated provider of short-term community beds

At the end of the year, the sub-committee received a report outlining proposed changes to the governance structure of the Leeds sub-committees from 1 April 2025. Members supported the proposed change from three sub-committees to two sub-committees which would result in financial aspects of the Finance and Best Value Sub-Committee and performance aspects of the Delivery Sub-Committee transferring to the Finance, Value and Performance Sub-Committee. Oversight of health inequalities work would transition to the Leeds Committee of the WY ICB,

however the new membership also includes key roles to ensure that health inequalities continue to be a prominent feature of discussions.

Committee effectiveness survey

The sub-committee undertook a self-assessment following the final meeting of 2024/25, in the form of an anonymous questionnaire. The questionnaire was sent to 13 people who were members or regular attendees of the sub-committee. Eight responses were received, representing a response rate of 61%.

In summary, some key themes emerged as follows:

- There was strong agreement that the meetings are well-chaired, with debate being allowed to flow freely
- It was felt that members could provide more genuine challenge in addition to seeking clarification and reassurance
- Respondents identified the need for more regular and consistent attendance by partners to ensure the sub-committee is representing the wider Leeds system
- There was some disagreement regarding the appropriate level of assurance received by and provided by the sub-committee.

Issues raised in the self-assessment questionnaire will be considered at the Finance, Value and Performance Sub-Committee meeting on 30 April 2025.

AREAS FOR DEVELOPMENT FOR THE FINANCE, VALUE AND PERFORMANCE SUB-COMMITTEE IN 2025/26

- The sub-committee identified areas for development for the Finance, Value and Performance Sub-Committee through the self-assessment undertaken: It was suggested that the sub-committee have a further discussion around priorities for the year and suggest key assurance areas to be added to the forward workplan for 2025/26, with further discussions regarding defining what we mean by ‘best value’,
- Members reflected that continuity of attendance from members would be key to ensuring consistency and effective assurance.
- It was suggested that, where appropriate, continuing to bring additional clinical leadership insight into the sub-committee would enhance value-based discussions in the context of population outcomes and care.
- Members also reflected on the anticipated changes to the finance and performance assurance functions of ICBs and implications for the sub-committee and noted that further areas for development may be identified as the year progresses.

Terms of Reference

The Draft Terms of Reference for the new Finance, Value and Performance Sub-Committee are attached for review ahead of approval by the Leeds Committee.

Appendix 2

Leeds Quality and People's Experience Sub-Committee
ANNUAL REPORT 2024/25

INTRODUCTION

The role of the Quality and People's Experience Sub-Committee (QPEC) is to ensure that quality is at the heart of the place-based partnership in Leeds. The main role of the sub-committee is to seek assurance that quality outcomes are achieved for the population of Leeds, that services are safe, and they provide a good experience for our populations.

The sub-committee brings together system partners from health and social care and the third sector who will be mutually accountable. A key role for the sub-committee is assurance that quality standards are being met, but also where not being delivered, members understand how services are applying improvement approaches to address them. The sub-committee also seeks assurance that where quality challenges span different services and providers of care, a collaborative approach to improvement is taken.

MEMBERSHIP

- Rebecca Charlwood (Chair) - Independent Chair
- Yasmin Khan (Vice-chair)- Independent Member, Health Inequalities and Delivery
- Jo Harding - Executive Member (Leeds Office of the WY ICB)
- Nick Earl – Executive Member (Leeds Office of the WY ICB)
- Dr Ali Best – Executive Member (Leeds Office of the WY ICB)
- Rabina Tindale – Provider representative
- Lynsey Yeomans - Provider representative
- Nichola Sanderson – Provider representative
- Kashif Ahmed - Leeds City Council, Adults Services
- Phil Evans - Leeds City Council, Children and Young Peoples Services
- Kate O'Connell - Director of Leeds Strategic Workforce & Health and Care Academy
- Sarah Sturgeon - Third Sector representative
- Hannah Davies - Healthwatch Leeds
- Dr Jan O'Mahony - Primary Care representative
- Dawn Bailey - Public Health/ Public Health consultant

MEETINGS HELD

Four QPEC Sub-Committee meetings were held in 2024/25: 1 May 2024; 17 July 2024; 16 October 2024; and 15 January 2025. Three meetings were held via MS Teams, with one meeting being held in person.

ATTENDANCE

Member	Attendance – number of meetings (meetings eligible to attend)	Attendance as %
Rebecca Charlwood (Chair), Independent Chair of the Leeds Committee of the WYICB	4 (4)	100
Yasmin Khan, (Vice Chair) Independent Member	2 (4)	50
Jo Harding, Director of Nursing and Quality	4 (4)	100
Nick Earl, Interim Director of Strategy, Planning and Programmes *Deputy - Nicola Nicholson	2 (4) 1 (1)	75
Dr Ali Best, Associate Medical Director	3 (4)	75
Rabina Tindale, LTHT *Deputy – Craig Brigg **Both in attendance on 15/01/2025	2 (4) 3 (4)	100**
Stephanie Lawrence, Executive Director of Nursing and Quality, LCH Lynsey Yeomans, Director of Nursing *Deputy - Sheila Sorby	1 (2) 2 (2) 1 (1)	100
Nichola Sanderson, Director of Nursing, Quality and Professions, LYPFT *Deputy – Alison Quarry	1 (3) 1 (1)	50
Tony Meadows, Interim Director, Adults and Health, Leeds City Council Kashif Ahmed, Director, Adults and Health, LCC *Deputy - Kate Daly	1 (1) 0 (2) 1 (1)	50
Phil Evans, Chief Officer for Transformation and Partnerships, Leeds City Council	1 (4)	25

Kate O'Connell, Director of Leeds Strategic Workforce & Health and Care Academy	4 (4)	100
Dawn Bailey, Chief Officer for Public Health	3 (4)	75
Sarah Sturgeon, Third Sector Representative	4 (4)	100
Hannah Davies, Chief Executive, Healthwatch Leeds *Deputy – Stuart Morrison	1 (4) 1	50
Dr Jan O'Mahony *Deputy – Joanne Evans	2 (3) 1 (1)	75

HIGHLIGHTS FROM THE COMMITTEE'S WORK IN 2024/25

People's Voice

Every meeting of the sub-committee begins with a People's Voices item which provides a lived experience of healthcare in Leeds, to focus minds and set the tone for the remainder of the meeting. The item is led by the People's Voices Partnership (PVP) and includes videos and reports from the 'How does it feel for me?' series which follows people's experiences of services over a period of time to inform recommendations to health and care partners for service improvements and highlight best practice. A wide range of experiences have been shared, including those of families of children with complex needs and older people facing physical and cultural barriers. During discussions of these items, members have reflected on the importance of the 3Cs – communication, coordination and compassion – and their impact on people's experiences of healthcare services.

Population and Care Delivery Board Reporting

In the last year, the sub-committee received reports from the Mental Health Population Board and the Learning Disabilities and Neurodiversity Population Board. A representative from the board attended the meetings to present the reports and answer any questions from members.

This item was paused after the first meeting of 2024/25 due to ongoing work to redefine the role of the Population Boards to ensure that they have a tighter focus on a set of agreed partnership transformation programmes and priorities for their specific population and work is ongoing to continue to provide assurance of these areas through various reporting mechanisms. Future reporting will be reviewed as the year progresses.

Quality Highlight Report

The ICB in Leeds Quality Team present a quality highlight report as a standing item. The report provides a healthcare system overview of key highlights of quality across the Leeds place, including providers' regulatory status. The principles on which items are reported to the QPEC include: national agenda significantly impacting on local systems work; quality performance consistently below standards at a place level; items on a topical issue that may be high profile and/or media sensitive; and current and unmitigated quality and safety risks for the Leeds system. The reporting format and presentation of content continues to be developed using partner and sub-committee member feedback. Partners are regularly invited to contribute intelligence to the report.

Risk Management Report

Members receive and review the red and high amber (12) risks aligned to the QPEC Sub-Committee at every meeting. Due to changes to the governance and risk arrangements at the WYICB, the format of the risk report changed in 2024/25 whereby all three Leeds sub-committees receive a single report with an appendix specifically highlighting the risks that are aligned to that sub-committee.

The sub-committee seeks assurance that quality related risks are being managed appropriately, by acknowledging the factors that provide assurance, identifying any gaps, noting any mitigating factors and the adequacy of action plans to address under-performance. A number of discussions have been focused on emerging risks that have been identified and escalated.

Other Reports and Deep Dives for Assurance

Over the course of the year, QPEC members considered a range of items for assurance and the delivery of joint objectives. Items have included: joint commissioning of care homes; the HomeFirst Programme; preparation for special educational needs and disabilities (SEND) inspection; and quality assurance arrangements at Leeds Place.

The sub-committee received a 'deep dive' report into local system processes and standards relating to do not attempt cardiopulmonary resuscitation (DNA CPR) decisions and end of life planning for people with a learning disability (LD).

The sub-committee receives updates on the action plan to implement a recent independent review's recommendations. Members receive updates for assurance at every sub-committee meeting and will continue to do so until all the actions have been completed.

The sub-committee considered a number of safeguarding items including the 2023-2024 annual reports of the Leeds Safeguarding Children Partnership, Leeds Safeguarding Adults Board and the ICB in Leeds Safeguarding team, as well as

assurance regarding the safeguarding governance arrangements for the Leeds system.

Committee effectiveness survey

The sub-committee undertook a self-assessment following the final meeting of 2024-25, in the form of an anonymous questionnaire. The questionnaire was sent to 23 people who were members or regular attendees of the sub-committee. Ten responses were received (appendix 2), representing a response rate of 43%.

In summary, the responses and comments referred to:

- Respondents felt sufficiently comfortable within the sub-committee environment to be able to express their views, doubts and opinions.
- Respondents felt the sub-committee was maturing well with reports feeling more co-produced and partners increasingly engaged with items that relate to their business.
- Respondents felt the sub-committee is well-chaired.
- There was agreement that the sub-committee receives and provides the appropriate level of assurance.
- Concern was raised regarding attendance at the meetings, both in terms of continuity and whether members were of sufficient seniority within the organisations they represented.
- It was felt that members could provide more genuine challenge in addition to seeking clarification and reassurance.
- There was a request for support and guidance for those leads attending the Sub-Committee to present assurance reports. It was felt that leads should highlight key risks and assurances and provide more time for questions and discussion.

The review of the sub-committee's Terms of Reference will provide opportunity to consider some of the above issues. Issues raised in the self-assessment questionnaire will also be considered at the QPEC Sub-Committee meeting on 23 April 2025.

AREAS FOR DEVELOPMENT IN 2025/26

A key area for development is the need to ensure continuity of attendance at QPEC Sub-Committee meetings to ensure consistency and support effective assurance. This has, in most cases, reflected staff changes within partner organisations.

Members also reflected on the anticipated changes to the quality assurance functions of ICBs and implications for the sub-committee and noted that further areas for development may be identified as the year progresses.

Terms of Reference

The QPEC Sub-Committee's Terms of Reference are attached at appendix 3 for review. The Corporate Governance team have reviewed and included tracked changes within this with minor amendments.

Appendix 3

Terms of Reference

Leeds Committee
of the West Yorkshire Integrated Care Board

Finance, Value and ~~&~~ ~~Best Value~~ Performance Sub-Committee

Version: 43.0

Date approved: ~~22 May 2024~~DRAFT

Approved by: Leeds Committee of the West Yorkshire Integrated Care Board

Review date: ~~April 2025~~January 2025

Change history

Version number	Changes	Editor	Date
0.2	Updated in line with governance requirements	Sam Ramsey	08/02/2022
0.3	Further amends following discussion with Chair	Sam Ramsey	10/06/2022
2.0	Review of terms of reference	Sam Ramsey	09/02/2023
3.0	Review of Terms of Reference	Harriet Speight	25/03/2024
4.0	Reviewed and updated with additional responsibilities following sub-committee structure review	Harriet Speight	13/02/2024

1. Introduction

1.1 The Leeds Health and Care (Place Based) Partnership Integrated Care Board (ICB) Committee is established as a committee of the West Yorkshire ICB (WY ICB), in accordance with the ICB's Constitution, Standing Orders and Scheme of Delegation.

1.2 These terms of reference are for the Finance, Value and ~~Best Value~~ Performance sub-committee of the Leeds Health and Care Committee of the WY ICB. 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. Role of this sub-committee

2.1 The Finance, Value and ~~Best Value~~Performance Sub-Committee is accountable to the Leeds Committee of the WY ICB for providing assurance on its work.

2.2 The remit, responsibilities, membership and reporting arrangements of the sub-committee are set out in these terms of reference. The sub-committee has no executive powers, other than those specifically delegated in these terms of reference. The sub-committee is not a decision-making committee.

2.3 The role of the sub-committee is to alert, assure and advise the Leeds Committee of the WY ICB through performance oversight of key financial and performance plans, indicators and/or targets, including good stewardship of resources, as specified in the Leeds Health and Care Partnership's strategic and operational plans, in order to ensure best value and clinical outcomes.

2.4 The sub-committee is responsible for supporting the Leeds Committee of the WY ICB in:

- Scrutinising and tracking the delivery of key financial and service priorities, outcomes and targets as specified in the Leeds Health and Care Partnership's strategic and operational plans;
- Ensuring that the Leeds Committee of the WY ICB develops and adopts appropriate policies and procedures to support effective governance of financial matters;
- Ensuring health inequalities are taken into account in financial decision-making;
- Overseeing performance of the Leeds Office of the ICB in relation to operational plan delivery, NHS System Oversight Framework requirements and local standards, targets and priorities; and

2.5 **Responsibilities**

2.6 Ensure financial management achieves value for money, efficiency and effectiveness in the use of resources, allowing the partnership to achieve best value and outcomes for its investments, with a continuing focus on cost reduction and achievement of efficiency targets.

2.7 Identify and manage mechanisms put in place by the partnership to drive cost improvements.

2.8 Review the partnership's medium-term financial planning and annual budgets and provide assurance to the Leeds Committee of the WY ICB on appropriateness of investment and efficiency priorities within the plans.

2.9 To ensure appropriate information is available to manage financial issues, risks and opportunities across the place.

2.10 Monitor and review population health management and resource allocation.

2.11 Monitor and review the achievement of the financial plan, including good stewardship of resources and identify risks to achievement of these.

2.12 Provide a forum to evaluate requirements and advise the Leeds Committee of the WY ICB on committing resources to respond to performance issues and potential investments.

2.13 To work with place partners to identify and agree common approaches across the system such as financial reporting, estimates and judgements.

2.14 Ensure that processes for financial management (including reporting) are robust and advise the Leeds Committee of the WY ICB appropriately on the content of the Finance Report.

2.15 Review contractual arrangements and payment mechanisms, ensuring fitness for purpose, best value and clinical outcomes.

2.16 Develop the understanding of 'place-based' financial decision-making to inform the development of the Leeds Health and Care partnership and the West Yorkshire Integrated Care System.

2.17 In fulfilling its role, the sub-committee will seek reasonable assurance relating to the performance and improvement in health outcomes being achieved by service transformation. Reasonable assurance is defined as the sub-committee being provided with evidence that performance is in line with agreed targets or trajectories, and where it is not, evidence of reasonable mitigation and an action plan to rectify any issues. Where the sub-committee receives insufficient assurance, it will challenge, assess risks and escalate to the Leeds Committee of the ICB when necessary.

~~2.16~~2.18 The sub-committee will oversee the continuous development of the scope, format, presentation and mechanisms of the system of performance reporting.

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~~2.17~~2.19 Reviewing risks assigned to the sub-committee by the Leeds Committee of the ICB and ensure that appropriate and effective mitigating actions are in place

3. Membership

3.1 This part of the terms of reference describes the membership of the sub-committee.

3.2 **Core membership**

The membership of the Committee will be as follows:

- ~~Chair – Independent Member – Finance and Governance~~
- ~~Independent Member~~
- ~~ICB Operational Director of Finance (Leeds Facing)~~
- ~~Executive Members (Leeds Office of the WY ICB)~~
  - ~~ICB Place Lead~~
  - ~~Associate Medical Director~~

~~*The following Executive Members will be invited where required, dependent on the agenda item discussion:*~~

- ~~Director of Strategy, Planning and Programmes~~
- ~~Director of Pathway and System Integration~~

- ~~Partner Members, representatives from the following *where relevant dependent on the agenda item discussion* :~~
  - ~~Leeds Teaching Hospitals Trust~~
  - ~~Leeds & York Partnership Foundation Trust~~
  - ~~Leeds Community Healthcare Trust~~
  - ~~Leeds City Council~~
  - ~~Third Sector Representative~~
  - ~~Further Non-Executive representation from partner organisations~~

- Chair – Independent Member – Finance and Governance
- Independent Member - Delivery and Health Inequalities
- Independent Member - Chair of the Leeds Committee of the WYICB
- Leeds Place Director of Finance
- ICB Operational Director of Finance (Leeds Facing)

Executive Members (Leeds Office of the WYICB):

- ICB Place Lead
- Associate Medical Director
- Director of Strategic Programmes and Population Health

Additional representatives from the Leeds Health and Care Partnership:

- Leeds Healthcare Inequalities Oversight Group
- Leeds City Council
- Third Sector
- Non-Executive representation from NHS partner organisations

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3.3 Required attendees

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

3.4 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.

3.5 Any member of the Leeds Committee of the WY ICB can be in attendance subject to agreement with the Chair.

4. Arrangements for the conduct of business

4.1 **Chairing meetings**

4.2 The meetings will be run by the chair. In the event of the chair of the sub-committee being unable to attend all or part of the meeting, the remaining members of the sub-committee should appoint a chair for the meeting.

4.3 **Quoracy**

4.4 No business shall be transacted unless at least 6 individuals are present. The quorum is 6 individuals. This must include representation from the following as a minimum:

- The Chair or his/her nominated Deputy Chair
- ICB Place Finance Lead or ~~his/her nominated deputy~~ICB Operational Director of Finance
- At least one partner member

4.5 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.

4.6 Members of the sub-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.

4.7 Members are normally expected to attend at least 75% of meetings during the year.

4.8 With the permission of the person presiding over the meeting, the Executive Members and the Partner Members of the sub-committee may nominate a deputy to attend a meeting of the sub-committee that they are unable to attend. The deputy may speak and vote on their behalf.

4.9 **Conflict resolution / arbitration**

4.10 The sub-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.

4.11 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. Under exceptional circumstances any substantive difference of views among members will be reported to the Leeds Committee of the WY ICB.

4.12 **Frequency of meetings**

4.13 The sub-committee will meet at least four times in the calendar year either in-person or online via Microsoft Teams. Development sessions may also be held throughout the year.

4.14 **Declarations of interest**

4.15 All sub-committee members will comply with the ICB policy on conflicts of interest. This will include but not be limited to declaring all interests on a register that will be maintained by the ICB. All declarations of interest will be declared at the beginning of each meeting.

4.16 The nature of the role and scope of the Finance sub-committee means that conflicts of interest will be inherent within the business. Conflicts of interest cannot be avoided but should be recognised and mitigated where possible.

4.17 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.

4.18 Members are expected to protect and maintain as confidential any privileged or sensitive information divulged during the work of the committee. Such items should not be disclosed until such time as it has been agreed that this information can be released.

4.19 **Support to the sub-committee**

4.20 Administrative support will be provided to the sub-committee by the Corporate Governance Team of the WYICB. This will include:

- Agreement of the agenda with the Chair in consultation with the Executive Lead, 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.
- An annual work plan to be updated and maintained on a monthly basis.

5. Remit and responsibilities of the committee

5.1 The West Yorkshire Integrated Care Board high level Scheme of Reservation and Delegation (SoRD) outlines those responsibilities that will be delegated to a committee or sub-committee.

6. Authority

6.1 The sub-committee will receive information and intelligence from NHS and social care providers across the city and seek assurance on improvement. Where any concerns are raised that require further investigation or assurance, the sub-committee is authorised to commission more detailed reports on specific areas for assurance and learning.

6.2 The sub-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 sub-committee.

6.3 The sub-committee is authorised to commission any reports or surveys it deems necessary to help it fulfil its obligations.

6.4 The sub-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.

6.5 The sub-committee is authorised to create working groups as are necessary to fulfil its responsibilities within its terms of reference.

7. Reporting

7.1 The sub-committee will report directly into the Leeds Committee of the WY ICB and will present a Chairs Summary to each meeting. The Chair shall draw to the attention of the Leeds Committee of the WY ICB any significant issues or risks relevant.

7.2 The sub-committee will also be supported and advised by the Director of Finance Group.

8. Conduct of the committee

8.1 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.

8.2 Members of the sub-committee will abide by the 'Principles of Public Life' (The Nolan Principles) and the NHS Code of Conduct.

8.3 Information obtained during the business of the sub-committee must only be used for the purpose it is intended. Sensitivity should be applied when considering financial, activity and performance data associated with individual services and institutions.

8.4 Members are expected to protect and maintain as confidential any privileged or sensitive information divulged during the work of the sub-committee. Such items should not be disclosed until such time as it has been agreed that this information can be released.

9. Behaviours and practice all members will demonstrate

- Act across the Leeds health and care system in line with Nolan's Seven Principles of Public Life: Selflessness, Integrity, Objectivity, Accountability, Openness, Honesty, Leadership.
- Act in the best interests of the population of Leeds.
- Resolve differences between members and present a united front in the best interests of the people of Leeds.
- Openness and transparency in discussions.
- 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.

10. Equality

10.1 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.

11. Review of the sub-committee

11.1 The sub-committee will produce an annual work plan in consultation with the Leeds Committee of the WY ICB.

11.2 The sub-committee will undertake an annual self-assessment of its performance against the annual plan, membership and terms of reference. This self-assessment will form the basis of the annual report. Any resulting proposed changes to the terms of reference will be submitted for approval by the Leeds Committee of the WY ICB.

11.3 These terms of reference and membership will be reviewed annually.

Appendix 4

Leeds Health & Care Partnership

NHS West Yorkshire Integrated Care Board

Terms of Reference

Leeds Committee of the West Yorkshire Integrated Care Board

Quality and People's Experience Sub-Committee

Version:	~~4~~3.0
Date approved:	~~22 May 2024~~
Approved by:	Leeds Committee of the West Yorkshire Integrate Care Board
Review date:	**March 2026** ~~March 2025~~

Change history

Version number	Changes	Editor	Date
0.3	Updated in line with governance requirements	Sam Ramsey	08/02/2022
0.6	Updated by Director of Nursing & Quality & Head of Governance	Sam Ramsey	31/05/2022
2.0	Review of Terms of Reference	Sam Ramsey	09/02/2023
3.0	Review of Terms of Reference	Karen Lambe	15/04/2024
4.0	Review of Terms of Reference	Karen Lambe	

1. Introduction

1.1 The Leeds Health and Care (Place Based) Partnership Integrated Care Board (ICB) Committee is established as a committee of the West Yorkshire ICB (WY ICB), in accordance with the ICB's Constitution, Standing Orders and Scheme of Delegation.

1.2 These terms of reference are for the Quality and People's sub-committee of the Leeds Health and Care Committee of the WY ICB. The sub-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 ICB 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. Role of this sub-committee

2.1 The role of the Quality and People's Experience Sub-committee is to ensure that we have quality at the heart of the place-based partnership in Leeds. The main role of the sub-committee will be to seek assurance that quality outcomes are achieved for the population of Leeds, that services are safe, and they provide a good experience for our populations.

2.2 The sub-committee will bring a Leeds-wide lens to quality assurance and improvement, bringing together system partners from health and social care and third sector ~~to~~ who will be mutually accountable. A key role for the sub-committee will be assurance that quality standards are being met, but also where is not being delivered, we understand how services are applying

improvement approaches to address them. The sub-committee will also seek assurance that where quality challenges span different services and providers of care, we have a collaborative approach to improvement.

2.3 It will be the responsibility of the sub-committee to oversee and assure itself of the quality of commissioned health and social care services in Leeds. The sub-committee will need to understand measurements of quality within the system, using metrics and outcome data to assess the situation, along with narrative and assurance from city partners, and feedback from people using the services.

2.4 One of the ways the Quality and People's Experience Sub-committee will have a focus on quality is through the lens of Population Health and will seek to understand how quality outcomes are measured for each population group, how value is delivered, and how the service user experience is being captured and improved. Regular updates from the Population and Care Delivery Boards will feed into the Quality and People's Experience Sub-committee throughout the year.

2.5 The Quality and People's Experience Sub-committee will be required to understand any emerging quality risks in the system and actions being taken to support improvement. This will be through a regular quality reporting mechanism to the sub-committee from the Leeds Office of the ICB Quality team. The sub-committee will also receive the Leeds Office of the ICB risk register as part of its forward plan.

2.6 The sub-committee will receive updates on Patient Safety from the Leeds place, the implementation of the new patient safety framework, and the safety improvement plans that are part of the framework.

2.7 It is envisaged that there will be expert and advisory groups that support the work of the Quality and People's Experience Sub-committee. These groups may already exist within the system. Examples of these groups may be ~~T~~tackling h~~H~~ealth inequalities, Person Centred Care, or 'How does it feel for me' around people's experience.

2.8 The sub-committee will report directly into the Leeds Committee of the WY ICB. The sub-committee will also feed into the West Yorkshire System Quality Group and the West Yorkshire Quality Committee, with the Director of Nursing and Quality attending both West Yorkshire meetings.

2.9 Commitments

2.10 The sub-committee agreed a number of commitments to help guide its work. These are:

~~2.11~~ We will ensure that the fundamental standards of quality are delivered across the Leeds Health and Care system

2.11

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2.12 We will continually improve the quality of the services we deliver and apply Quality Improvement (QI) principles to system quality challenges

2.13 We will listen to people who receive care about their experience and commit to continuously improving this experience

2.14 We will engage our clinical leaders in quality improvement work that spans across organisational boundaries

2.15 We will agree our shared priorities for quality improvement, holding each other mutually accountable for delivery of those improvements

2.16 We will work on the triple aim of delivering high-quality care, improved outcomes and value for money in everything we do

2.17 We are leaders in our organisation but also in our place and we will support each other in partnership around a shared approach to quality

2.18 We act with honesty and integrity and trust each other to do the same

2.19 We challenge constructively when we need to, but always demonstrating respectful behaviours

2.20 We assume good intentions and work collaboratively around this work.

3. Membership

3.1 This part of the terms of reference describes the membership of the sub-committee.

3.2 Core membership

The membership of the sub-committee will be as follows:

- Chair – Independent Chair
- Deputy Chair - Independent Member – Health Inequalities and Delivery
- Director Members of the WYICB (ICB in Leeds)
  - Director of Nursing and Quality
  - Director of Strategic ~~Planning and~~ Programmes and Population Health
  - Medical Director
- Director level representative with responsibility for quality assurance and improvement
  - Leeds Teaching Hospitals Trust
  - Leeds Community Healthcare Trust
  - Leeds & York Partnership Foundation Trust
  - Leeds City Council Adults Services
  - Leeds City Council Children and Young Peoples Services
- Director of Leeds Strategic Workforce & Health and Care Academy
- Public Health/ Public Health consultant
- Third Sector representative

- Healthwatch Leeds
- Primary Care representative

3.3 Required attendees

- ~~Associate Director of Quality and Nursing, ICB in Leeds~~
- Head of Quality, ICB in Leeds
- Head of Safeguarding/Designated professional for Safeguarding, ICB in Leeds
- Office of Data Analytics representative – as required

3.4 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.

Any member of the Leeds Committee of the WY ICB can be in attendance subject to agreement with the Chair.

4. Arrangements for the conduct of business

4.1 Chairing meetings

4.2 The meetings will be run by the chair. In the event of the chair of the sub-committee and the deputy-chair being unable to attend all or part of the meeting, the remaining members of the sub-committee should appoint a chair for the meeting.

4.3 Quoracy

4.4 No business shall be transacted unless at least 50% of the membership is present. The quorum is 8 individuals. This must include representation from the following as a minimum:

- The Chair or his/her nominated Deputy Chair
- Executive member of the Leeds Office of the WY ICB
- At least three other members from the core membership.

4.5 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.

4.6 Members of the sub-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.

4.7 Members are normally expected to attend at least 75% of meetings during the year.

4.8 With the permission of the person presiding over the meeting, the Executive Members and the Partner Members of the sub-committee may nominate a deputy to attend a meeting of the sub-committee that they are unable to attend. The deputy may speak and vote on their behalf.

4.9 Conflict resolution / arbitration

4.10 The sub-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.

4.11 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. Under exceptional circumstances, any substantive difference of views among members will be reported to the Leeds Committee of the WY ICB.

4.12 Frequency of meetings

4.13 The sub-committee will meet quarterly ~~bi-monthly~~ with a minimum of four meetings scheduled each calendar year. Development sessions may also be held throughout the year. Meetings may be held either remotely via MS Teams or in-person.

4.14 Declarations of interest

4.15 All sub-committee members will comply with the ICB policy on conflicts of interest. This will include but not be limited to declaring all interests on a register that will be maintained by the ICB. All declarations of interest will be declared at the beginning of each meeting.

4.16 The nature of the role and scope of the Quality and People's Experience Sub-committee means that conflicts of interest will be inherent within the business. Conflicts of interest cannot be avoided but should be recognised and mitigated where possible.

4.17 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.

4.18 Members are expected to protect and maintain as confidential any privileged or sensitive information divulged during the work of the committee. Such items should not be disclosed until such time as it has been agreed that this information can be released.

4.19 Support to the sub-committee

4.20 Administrative support will be provided to the sub-committee by the WYICB Corporate Governance team. This will include:

- Agreement of the agenda with the chair in consultation with the Executive Lead, 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.
- An annual work plan to be updated and maintained on a monthly basis.

5. Remit and responsibilities of the sub-committee

5.1 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.

6. Authority

6.1 The sub-committee will receive information and intelligence from NHS and social care providers across the city and seek assurance on improvement. Where any concerns are raised that require further investigation or assurance, the sub-committee is authorised to commission more detailed reports on specific areas for assurance and learning.

6.2 The sub-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 sub-committee.

6.3 The sub-committee is authorised to commission any reports or surveys it deems necessary to help it fulfil its obligations.

6.4 The sub-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 sub-committee must follow procedures put in place by the ICB for obtaining legal or professional advice.

6.5 The sub-committee is authorised to create working groups as are necessary to fulfil its responsibilities within its terms of reference.

7. Reporting

7.1 The sub-committee will report directly into the Leeds Committee of the WY ICB and will present a Committee Escalation Report (AAA report) ~~-~~to each meeting. The chair shall draw to the attention of the Leeds Committee of the WY ICB any significant issues or risks relevant.

7.2 The sub-committee will also report into the West Yorkshire System Quality Group and the West Yorkshire Quality Committee.

8. Conduct of the sub-committee

8.1 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.

8.2 Members of the sub-committee will abide by the 'Principles of Public Life' (The Nolan Principles) and the NHS Code of Conduct.

8.3 Information obtained during the business of the sub-committee must only be used for the purpose it is intended. Sensitivity should be applied when considering financial, activity and performance data associated with individual services and institutions.

8.4 Members are expected to protect and maintain as confidential any privileged or sensitive information divulged during the work of the sub-committee. Such items should not be disclosed until such time as it has been agreed that this information can be released.

9. Behaviours and practice all members will demonstrate

- Act across the Leeds health and care system in line with Nolan's Seven Principles of Public Life: Selflessness, Integrity, Objectivity, Accountability, Openness, Honesty, Leadership.
- Act in the best interests of the population of Leeds.
- Resolve differences between members and present a united front in the best interests of the people of Leeds.
- Openness and transparency in discussions.
- 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.

10. Equality

10.1 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.

11. Review of the Sub-committee

11.1 The sub-committee will produce an annual work plan in consultation with the Leeds Committee of the WY ICB.

11.2 The sub-committee will undertake an annual self-assessment of its performance against the annual plan, membership and terms of reference. This self-assessment will form the basis of the annual report. Any resulting proposed changes to the terms of reference will be submitted for approval by the Leeds Committee of the WY ICB.

11.3 Ther~~s~~e terms of reference and membership will be reviewed ~~initially after six months and thereafter~~ at least annually following their approval.

Leeds Committee of the West Yorkshire Integrated Care Board
ANNUAL REPORT 2024/25

INTRODUCTION

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 reservation and delegation. The role of the Committee is to lead the Leeds place-based partnership in accordance with the Leeds memorandum of understanding, and in accordance with the constitution of the West Yorkshire ICB. The Committee 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.

We recognise that changes are expected to take place over the coming year to the way that ICBs operate, and that this is likely to have implications for current governance and assurance arrangements at Place level, so therefore this report reflects a point in time and further iterations to the way we work are to be expected as the year progresses.

MEMBERSHIP

Rebecca Charlwood (Chair), Independent Chair of the Leeds Committee of the WYICB
Caroline Baria, Adults and Health, Leeds City Council (LCC)
Selina Douglas, Leeds Community Healthcare Trust (LCH)
Victoria Eaton, Director of Public Health
Dr Sarah Forbes (ICB Leeds Medical Officer)
Pip Goff, Third Sector representative
Jo Harding (ICB Leeds Place Nurse Lead)
Cheryl Hobson, Independent Member – Finance
Yasmin Khan, Independent Member – Health Inequalities and Delivery
Julie Longworth, Children and Families, Leeds City Council (LCC)
Jane Mischenko/Jonathan Phillips, Co-Chairs of Healthwatch Leeds (Joint member)
Dr Sara Munro, Leeds & York Partnership Foundation Trust (LYPFT)
Visseh Pejhan-Sykes/Alex Crickmar (ICB Leeds Place Finance Lead)
Tim Ryley (ICB Leeds Place Lead)
Dr George Winder, Primary Care representative

Professor Phil Wood, Leeds Teaching Hospitals Trust (LTHT)

MEETINGS HELD

22 May 2024
11 September 2024
27 November 2024
26 February 2025

ATTENDANCE

Member	**Attendance – number of meetings** **(meetings eligible to attend)**	**Attendance as % (including deputies)**
Rebecca Charlwood (Chair), Independent Chair of the Leeds Committee of the WYICB	4 (4)	100%
Cheryl Hobson, Independent Member – Finance and Governance	2 (4)	50%
Yasmin Khan, Independent Member – Health Inequalities and Delivery	3 (4)	75%
Jane Mischenko, Co-Chair - Healthwatch Leeds Jonathan Phillips – Healthwatch Leeds Co-Chair *Deputised– Hannah Davies	2 (2) 1 (2) 1 (1)	75% (100% including deputisation)
Tim Ryley, ICB Leeds Place Lead	4 (4)	100%
Visseh Pejhan-Sykes, ICB Leeds Place Finance Lead (until 11/09/2024) Alex Crickmar, ICB Leeds Place Finance Lead (from 11/09/2024)	1 (1) 3 (3)	100%
Jo Harding, ICB Leeds Place Nurse Lead *Deputy - Penny McSorley	2 (4) 1 (1)	50% (75% including deputisation)
Dr Sarah Forbes, ICB Leeds Medical Officer *Deputy – Dr Jason Broch	2 (4) 1 (1)	50% (75% including deputization)
Professor Phil Wood, Chief Executive – LTHT *Deputy – James Goodyear	1 (4) 1 (1)	25% (50% including deputisation)
Dr Sara Munro, Chief Executive - LYPFT	3 (4)	75%
Selina Douglas, Chief Executive, LCH *Deputy – Dr Ruth Burnett	1 (4) 1 (1)	25% (50% including deputisation)

Caroline Baria, Director of Adults & Health – LCC *Deputy – Kashif Ahmed *Deputy – Shona MacFarlane	1 (4) 2 (2) 1 (1)	25% (100% including deputisation)
Dr George Winder, Chair – Leeds GP Confederation	4 (4)	100%
Pip Goff, Third Sector Representative	4 (4)	100%
Victoria Eaton, Director of Public Health	4 (4)	100%

HIGHLIGHTS FROM THE COMMITTEE'S WORK IN 2024/25

Standing agenda items

The Leeds Committee has further developed some of the standing items on the agenda for each meeting this year. Every meeting of the Committee begins with a People's Voices item, which provides a lived experience of integrated care in Leeds, to focus minds and set the tone for the remainder of the meeting. This item is led by the People's Voices Partnership (PVP) and over the year has focused on Healthwatch Leeds content, where possible linked to another item on the agenda, including videos and reports from the 'How does it feel for me?' series, which follow people's experiences of services over a period of time to inform recommendations to health and care partners for service improvements and highlight best practice. During discussions of these items throughout the year, members have reflected on the partnerships' role in addressing health inequalities, how to further embed co-production and early engagement into processes across the partnership, and the importance of progressing neighbourhood health approaches to support person-centred care. The Committee has also recognised the positive experiences of care identified and celebrated the services mentioned, including the Leeds BID Services, Feel Good Factor and North Leeds Medical Practice.

The Committee has continued to receive other well-established standing items such as the Place Lead Update Report, which provides an overview of any local, regional and national policy or organisational changes for members to be aware of, along with a summary of service delivery and performance in Leeds.

The Committee also receives a risk management report, to provide assurance that risks are being managed appropriately at Leeds Place; and a financial update report, which provides an update of the financial position for Leeds Place in the context of the wider WY ICB financial position.

The Committee has also received Alert Assure and Advise (AAA) reports from each of the three sub-committees – Delivery, Quality and People's Experiences, and

Finance and Best Value – which summarise the outputs of recent meetings in respect to progress being made with Leeds plans to improve outcomes, tackle health inequalities and improve the effectiveness and efficiency of services. At its meeting on 26 February 2025, the Committee agreed to move from three to two assurance sub-committees from 1st April 2025, to bring together finance, performance and outcomes under the remit of one sub-committee – the Finance, Value and Performance Sub-Committee - to enable greater integration of all three aspects. The Delivery Sub-Committee was dissolved as a result, with the oversight of health inequalities transferred directly to the Leeds Committee. This work was in line with the recent review of Place Partnerships, which encouraged the rationalisation of governance within the system to ensure effective assurance mechanisms and support agile decision making.

Decisions taken

The Committee approved the Joint Working Agreement (JWA) with AstraZeneca for Phase 2 of the Leeds MART Project (11 September 2024), which aims to transform asthma management in adults with poorly controlled asthma, and an extension of the previously approved Chronic Kidney Disease JWA for another six months to allow for further data coding and analysis (27 November 2024).

The Committee also approved two Provider Selection Regime (PSR) routes in line with the West Yorkshire Procurement Policy, for a new contract for integrated provider of Short-Term Community Beds (22 May 2024) and for the consolidation of nine separate ICB held mental health contracts/grant awards with Voluntary, Community and Social Enterprise (VCSE) provider partners (27 November 2024).

The Committee did not approve any significant changes to primary care provision this year, however it did receive an update on the change of control of Alternative Provider Medical Services (APMS) contract for GP services provided at Shakespeare Medical Practice (22 May 2024), following previous consideration and approval in 2023.

Strategic updates and items for assurance

Throughout the year, the Committee has maintained oversight over financial planning alongside the standard financial position reports, with a follow-up report on financial planning for 2024/25 titled ‘Assurance and update on our plan for financial sustainability in 24/25’ (22 May 2024), which provided an update on the work undertaken to risk assess, assure and engage on efficiency schemes. This led to a discussion around necessary improvements to future processes and supported the Quality and Equality Impact Assessment (QEIA) assurance panel approach, a now well-established process with Leeds Committee independent member involvement.

At the last meeting of the financial year (26 February 2025), received several presentations and update reports outlining the current planning position in relation to the next financial year and further into the medium-term. In recognition of the challenging timing of the governance cycle in relation to submission dates for 2025/26 plans, members noted and supported the indicated direction of travel and planning principles set out, highlighted the importance of the preventative agenda and reducing health inequalities.

The Committee also received several strategic updates, including an update from the Cancer Population Board on their recent successes and challenges (22 May 2024) and an overview of work undertaken to review the roles and responsibilities of Population Boards to support the reallocation of resources to higher value interventions for their populations (27 November 2024). The Committee also received an update on the 'Fairer, Healthier Leeds' (Marmot City) programme, intended to enable the city to better understand how to maximise opportunities to address health inequalities and the findings and recommendations following whole system review (11 September 2024).

The Committee also received the Director of Public Health Annual Report 2023 titled 'Ageing Well: Our Lives in Leeds' (11 September 2024), which explored how healthy people, places, and communities all contribute to living and ageing well in Leeds. This included actions to create the conditions for healthy ageing and increasing the number of years spent in good health. The Committee supported the recommendations set out within the report for partners.

AREAS FOR DEVELOPMENT IN 2025/26

The Leeds Committee identified some areas for development through the self-assessment undertaken, including:

- Members reflected that the timing of meetings have not always aligned appropriately with national timescales and end-of-year financial submissions. It is noted that the Committee dates are set to lead into the WYICB Board meetings currently, which limits the frequency to once a quarter and dictates when these meetings will be held. Members also noted there is still some duplication of reporting across the Leeds system. It is recognised that there is anticipated significant change to the ways that ICBs operate over the coming year, which may present opportunities to review governance structures, processes and meeting formats.
- Some members felt that the length of some papers submitted make it difficult to identify the key issues and in order to determine the level of assurance required. We will continue to work with report authors to ensure that the executive summary within each cover report is clear and concise.

- Some members disagreed with the statement 'members provide real and genuine challenge – they do not just seek clarification and reassurance' – this will be an area of focus for the development sessions in 2025/26.
- In recognition of the upcoming changes to the ways ICBs operate, members suggested further development sessions to focus on culture shift and team building, as well as how the Committee can drive the change required by the Government in terms of the key areas of focus identified within the NHS 10 Year Plan once published.
- The feedback indicated that the Committee was not clear on the purpose of the Board Assurance Framework (BAF) at Place Committee level. This will form part of a development session in 2025/26.

The following is an extract from the 2023/24 annual report:

The Committee has also identified a number of areas for development in 2024/25:

- Focus on understanding of how NHS financial planning works and the way other more advanced systems with a value-based approach to govern themselves.
- Further work to understand the impact of the financial plans on the public and developing a mechanism to communicate these clearly.
- Further development work to be undertaken to identify any potential gaps in the memberships' collective skill set.

Appendix 6

Leeds Health & Care Partnership

NHS West Yorkshire Integrated Care Board

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

Version control

Version:	43.0
Approved by:	West Yorkshire Integrated Care Board
Date Approved:	1 July 2022
Responsible Officer:	Accountable Officer (Leeds)
Date Issued:	24 July 2024
Date to be reviewed:	June 2025

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

1. Introduction

1.1 The Leeds ~~Health and Care~~ 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.
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- 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 Chair
- Independent Member – Finance
- Independent Member – Health Inequalities and Delivery
- Healthwatch Representative
- Executive Members (Leeds Office of the WY ICB)
    - ICB Leeds Place Lead
    - ICB Leeds Finance Lead
    - ICB Leeds Nurse 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.

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.

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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 8 individuals. This must include representation from the following as a minimum:

- The Chair or his/her nominated Deputy Chair
- At least one independent member
- ICB Place Lead or ICB Place Finance Lead
- 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 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 meet 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 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

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, 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

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 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.

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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.

Meeting name:	Leeds ICB Committee
Agenda item number:	17/25
Meeting date:	21 May 2025
Report title:	High Level Risk Report: Cycle 1 2025/26 (March – June 2025)
Report presented by:	Asma Sacha, Risk Manager (WY ICB)
Report approved by:	Sue Baxter, Head of Partnership Governance (WY ICB)
Report prepared by:	Asma Sacha, Risk Manager (WY ICB)

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

Previous considerations:

Leeds Senior Managers meeting 23 April 2025; Quality and People's Experience Sub-Committee, 23 April 2025; Finance, Value and Performance Sub-Committee, 30 April 2025.

Executive summary and points for discussion:

This report presents the Leeds Place High Level Risk Reports, Risk Log and Risk on a Page Report as at the end of the current risk review cycle (Cycle 1, 2025/26).

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

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

The paper includes the summary of the Board Assurance Framework (BAF) at Appendix 2. The BAF will be reviewed by the Executive Directors of the West Yorkshire Integrated Care Board in the current cycle which will be presented to the ICB Board meeting on 24 June 2025. The BAF provides the ICB with a method for the effective and focused management of the principal risks and assurances to meet its objectives. By using the BAF, the ICB can be confident that the systems, policies, and people in place are operating in a way that is effective in delivering objectives and minimising risks.

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

☒ Improve healthcare outcomes for residents in their system.

☒ Tackle inequalities in access, experience and outcomes.

☒ Enhance productivity and value for money.

☒ Support broader social and economic development

Recommendation(s):

The Leeds ICB Committee is asked to **RECEIVE** and **NOTE** the High-Level Risk Report, Risk Log and Risk on a Page Report as an accurate representation of the Leeds Place risk position, following any recommendations from the relevant sub-committees.

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

The report provides details of all risks on the Leeds Place Risk Register. The various ICB Risk Registers support and underpin the BAF, and relevant links are drawn between risks on each.

Appendices:

Appendix 1: Leeds Place risk register
Appendix 2: Summary of the Board Assurance Framework Cycle 1 2025/26
Appendix 3: Risk on a Page Report Cycle 1 2025/26
Appendix 4: Leeds Health and Care Partnership Top Risks - May 2025

Acronyms and abbreviations explained:

In Appendix 1:

- Static – 'x' archives – risk score has been unchanged for 'x' risk cycles
- Static description – neither the risk score nor its description has changed since the previous cycle
- Reached tolerance – current risk score has reduced to target score so risk may be closed

What are the implications for:

Residents and Communities	Any implications relating to individual risks are outlined in the Risk Registers
Quality and Safety	Any implications relating to individual risks are outlined in the Risk Registers
Equality, Diversity and Inclusion	Any implications relating to individual risks are outlined in the Risk Registers
Finances and Use of Resources	Any implications relating to individual risks are outlined in the Risk Registers
Regulation and Legal Requirements	Any implications relating to individual risks are outlined in the Risk Registers
Conflicts of Interest	None identified.
Data Protection	Any implications relating to individual risks are outlined in the Risk Registers
Transformation and Innovation	Any implications relating to individual risks are outlined in the Risk Registers

Environmental and Climate Change	Any implications relating to individual risks are outlined in the Risk Registers
Future Decisions and Policy Making	Any implications relating to individual risks are outlined in the Risk Registers
Citizen and Stakeholder Engagement	Any implications relating to individual risks are outlined in the Risk Registers

1. **Introduction**

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

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

1.3 The report sets out the process for review of the Leeds Place risks during the current review cycle (Cycle 1 of 2025/26) which commenced on 19 March 2025 and ends after the West Yorkshire ICB Board (WY ICB) meeting on 24 June 2025.

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

1.5 The report includes a summary of the Board Assurance Framework (BAF) which is being reviewed by the West Yorkshire ICB during Cycle 1 2025/26, this is attached at **Appendix 2.**

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

2. **Leeds Place Risk Register**

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

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

2.2 Please see pages 21-36 of item 18b Corporate Risk Report reported to the NHS West Yorkshire ICB Board held on the 18 March 2025 to view the Corporate Risk Register.

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

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

2.5 The Place Risk Register will not capture risks which are owned by ICS System Partners that they are accountable for via their individual statutory organisations.

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

2.7 The Place Risk Register will not capture risks which are owned by Leeds Health and Care Partners that they are accountable for via their individual statutory organisations. However, in order to support triangulation of risks and provide visibility of the risk profile across the Leeds Health and Care Partnership, partners have been requested to provide their highest scoring risks that they want the membership of the Leeds Committee to be sighted on. The approach taken by system partners to identify risks for inclusion has included consideration of risks that require partnership working and a system-based solution and has also involved the senior management / leadership teams within the partners. Common risk areas across the partnership include financial pressures, increased demand for services, imbalance of capacity and demand and workforce issues. The top risks identified by system partners are detailed at **Appendix 4**. Partners are also consulted when populating and managing the Population and Care Board risk registers

2.8 There are currently **19 risks** on the Leeds Place Risk Register of which 16 are open risks. There are eight new risks, no risks have increased or decreased in risk score, and three risks which have been closed.

3. **High scoring Risks**

3.1. There are ten high scoring risks (15+) in Cycle 1 2025/26.

Risk Description	**Sub-Committee Alignment**	**Cycle 4 2024/25**	**Cycle 1 2025/26**	**Update for Cycle 1 2025/26**
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.	Finance and Best Value Sub - Committee		20 (L4xI5)	New risk

Risk Description	Sub-Committee Alignment	Cycle 4 2024/25	Cycle 1 2025/26	Update for Cycle 1 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.	Quality and People's Experience Committee		20 (L4xI5)	New risk
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. 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.	Finance and Best Value Sub - Committee		16 (L4xI4)	New risk.
2529 - There is a risk that the ICB in Leeds will not deliver the 2025/26 financial requirement of breakeven (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,	Finance and Best Value Sub - Committee		16 (L4xI4)	New risk.

Risk Description	Sub-Committee Alignment	Cycle 4 2024/25	Cycle 1 2025/26	Update for Cycle 1 2025/26
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 breakeven 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).				
2480 - There is a risk that our current commissioned Tier 3 weight management service not being sufficient to meet demand due to limited local budget and workforce and the introduction of new drugs for weight management and associated NICE technology appraisals increasing demand and legal obligation. This could result in an increased number of referrals to right to choose providers and associated expenditure and potential detrimental impact on the quality and suitability of services for the population in Leeds.	Quality and People's Experience Committee	16 (L4xI4)	16 (L4xI4)	Static – 1 cycle LCH specialist weight management service to resume to referral on 10 April 2025. New commissioning policy is being prepared for publication in June 2025 for all new drugs.
2415 - There is an increasing risk of widening health inequalities and poorer health outcomes across Leeds due to the reduction or loss of VCSE services and closure of VCSE	Quality and Finance Sub-Committee **and** Leeds Committee	16 (L4xI4)	16 (L4xI4)	Static – 4 cycles West Yorkshire ICB decision for 2.15% uplift to the third sector to help mitigate some of the pressures.

Risk Description	Sub-Committee Alignment	Cycle 4 2024/25	Cycle 1 2025/26	Update for Cycle 1 2025/26
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.				Additional workshops are also taking place between the ICB in Leeds and the third sector. The risk score will remain for this cycle with a view to review in Cycle 2, 2025/26.
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 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.	Finance and Best Value Committee	16 (L4xI4)	16 (L4xI4)	Static – 4 cycles The risk score remains the same, finance teams meet bi-weekly to update the position.
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 People's Experience Committee	16 (L4xI4)	16 (L4xI4)	Static – 8 cycles The risk score remains the same, although small improvements have been made alongside dealing with winter pressures, the occupancy levels, trolley waits in the emergency department

Risk Description	Sub-Committee Alignment	Cycle 4 2024/25	Cycle 1 2025/26	Update for Cycle 1 2025/26
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.				and No Reason to Reside (NR2R) figures have not sufficiently reduced to lower the risk.
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 could lead to poor patient outcome and significant financial impact.	Quality and People's Experience Committee	15 (L5xI3)	15 (L5xI3)	Static – 8 cycles The risk remains at the same rating with significant financial risk to the ICB due to the increase in demand for Neurodevelopmental assessment and treatment. The lack of capacity of local NHS services to meet demand is leading to the increasing number of referrals through right to choose.
2301 - There is a risk of CYP being unable to access a timely diagnostic service for neurodevelopmental conditions (Autism and ADHD) due to rising demand for assessments and capacity of service to deliver this (ICAN for under 5, CAMHS for school age). Delays in access to timely diagnosis may impact upon children's outcomes, access to other support services across health, education and social care, and	Quality and People's Experience Committee	15 (L5xI3)	15 L5xI3)	Static – 9 cycles Workshop with education and health and action plan has been agreed. The waiting list data will shape a limited needs led offer by June 2025.

Risk Description	Sub-Committee Alignment	Cycle 4 2024/25	Cycle 1 2025/26	Update for Cycle 1 2025/26
also compliance with NICE standards for assessment within 3 months from referral.				

4. **New Risks this Cycle**

4.1. There are eight new risks added to the Leeds place Risk Register in Cycle 1 2025/26, the new risks include the four risk descriptions outlined above - Risk IDs 2508, 2494, 2530, 2529 and:

ID	Risk Score	Risk Description	Sub – Committee
2511	12 (L3xI4)	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. 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.	Quality and People's Experience Committee
2510	12 (L3xI4)	There is a risk of an inability to deliver all of the statutory functions of the ICB in regard to All Age Continuing Care (AACC) in Leeds due to challenging workforce pressures which could result in reputational damage, financial inefficiency, complaints, challenges and appeals, and staff burnout.	Quality and People's Experience Committee
2509	12 (L3xI4)	There is a risk of the ICB not being able to source high quality and cost-effective care for individuals eligible for NHS Continuing Health Care (CHC) in Leeds due to gaps in cost for care and affordable	Quality and People's Experience Committee

ID	Risk Score	Risk Description	Sub – Committee
		budgets resulting in higher costs to the ICB or individuals presenting with unnecessary deterioration due to unmet needs.	
2531	9 (L3xI3)	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 This could result in: - non-delivery of one of the financial statutory targets - reduction in the expected capital allocation in the next financial year- - increases in backlog maintenance requirements, detrimental impacts on NHS infrastructure, and lost funding as capital money cannot be carried into future years.	Finance and Best Value Sub-Committee

5. **Emerging Risks this Cycle**

Risks will be developed with place leads as part of the West Yorkshire ICB organisational change programme in Q2, 2025/26.

6. **Change to risk score**

6.1 There are no changes to risk scores during Cycle 1 2025/26.

7. **Risks Marked for Closure**

7.1 There are three risks that are marked for closure during Cycle 1 2025/26.

Risk ID	Risk Rating	Risk Description	Risk Status
2024	12	There is a risk of not meeting legislative responsibilities in relation to community deprivation of liberty for fully funded CHC cases; due to assessor capacity and availability of court of protection time;	Closed – a new risk has been developed - Risk ID 2511

Risk ID	Risk Rating	Risk Description	Risk Status
		resulting in deprivation of liberty in breach of legislation. There is a significant additional risk that patients will not have the advocacy they need to go through the process due to a lack of commissioned resource. Family members can act as the RPR if they are objective, however in the majority of cases that is difficult.	
2016	12	There is a risk that as a result of the longer waits being faced by patients and limited capacity for treatments, there is a risk of harm, due to failure to successfully target patients at greatest risk of deterioration and irreversible harm, resulting in potentially increased morbidity, mortality and widening of health inequalities.	Closed - Waiting times have increased nationally due to growing demand, resource challenges which are all consistent across the NHS. The waiting times in Leeds are not an outlier compared with other places/nationally. Under national mandate it is clear that waiting time performance is a key priority that all providers are working to manage with support from partners like the Cancer Alliance, WYAAT, etc. Leeds continues to work to optimise the use of the Independent Sector to support provider waiting times.

Risk ID	Risk Rating	Risk Description	Risk Status
2413	6	There is a risk that the financial position across the Leeds system will not achieve financial balance due to the combination of undelivered QIPP and new cost pressures in 2024 – 25. This could result in the system as a whole not meeting its statutory duties to break even.	Closed – a new finance risk has been developed to reflect the 2025/26 financial position. Risk ID 2529

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

8.1 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.

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

8.3 As at the date of this report, there were no changes that had been made to the BAF in places during Cycle 1, 2025/26.

9. **Next steps**

9.1 The risks will be carried forward to the next risk review cycle which will commence after the WY ICB Board meeting on 24 June 2025. The next risk cycle will be Cycle 2, 2025/26.

10. **Recommendations**

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

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

3. **RECEIVE** and **NOTE** the Board Assurance Framework summary for Cycle 1 2025/26.

Appendix 1

Risk ID	Date Created	Risk Type	Strategic Objective	Risk Rating	Risk Score Components	Target Risk Rating	Target Score Components	Risk Owner	Senior Manager	Principal Risk	Key Controls	Key Control Gaps	Assurance Controls	Positive Assurance	Assurance Gaps	Risk Status
2508	01/04/2025	Finance and Best Value Sub - Committee	Enhance productivity and value for money	20	(I5xL4)	9	(I3xL3)	Andrea Dobson	Jason Broch	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.	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 upon making placements for CHC eligible individuals at standard rates due to 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 AACC 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 AACC 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 AACC financial commitment at a patient level 8. Informed and considered cost and budget setting in place to ensure correct budget in place.	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 exceptionality 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	New - Open
2494	25/03/2025	Quality and People's Experience Committee	Improve healthcare outcomes for residents	20	(I5xL4)	9	(I3xL3)	Karren Leach	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 muti 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 ...	Opportunity for greater connectivity between local controls and pressures including in Health/LA & Provider Collaborative where appropriate	1. Actions agreed and implemented from meetings and escalations 2. When a young person placed is in an inappropriate setting the CQC are informed. Safeguarding colleagues are aware and additional resource and support is put in place for the young person	Regular supervisory/escalation meetings supporting blocks in the system	Timely escalation - without delays	New - Open
2530	14/04/2025	Finance and Best Value Sub - 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	1. Shared understanding / discussion of the risks arising through the prioritisation process for operational capital. 2. Difficult to plan on a strategic basis with single year capital allocations	1. Individual risks flagged through place based risk registers 2. Overview of strategic capital and progress at WY ICB FIPC and the ICS Infrastructure Strategy Oversight Group 3. Expectation that multi-year capital allocations will be announced in 2025/26 for future years	1. Presentation of capital information through WY Capital Working Group, and reporting of capital position including forecast and risk highlighted at WY ICB FIPC. 2. Capital position relating to both operational and other capital reported to WY ICB FIPC and WY ICB System Oversight and Assurance Group 3. Confirmation that Airedale is within national hospitals programme (NHP). 4. 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 FIPC. 2. Announcement to pause development of NHP at Leeds will have material impact on organisational risk	New - Open
2529	14/04/2025	Finance and Best Value Sub - Committee	Enhance productivity and value for money	16	(I4xL4)	12	(I4xL3)	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)	New - Open
2480	14/01/2025	Quality and People's Experience Committee	Improve healthcare outcomes for residents	16	(I4xL4)	9	(I3xL3)	Lindsay Mcfarlane	Helen Lewis	There is a risk that our current commissioned Tier 3 weight management service not being sufficient to meet demand due to limited local budget and workforce and the introduction of new drugs for weight management and associated NICE technology appraisals increasing demand and legal obligation. This could result in an increased number of referrals to right to choose providers and associated expenditure and potential detrimental impact on the quality and suitability of services for	1. Revised contract and specifications to help future planning facilitated by funding (ICB Leeds) 2. Recovery plans and efficiency plans in place 3. Plan to be open to new referrals in July 2024 4. Ongoing work to develop new model delivery 5. NICE TA medicines policy and funding variation 6. Right to choose monitoring	1. Awaiting guidance from NHSE 2. Awaiting guidance and support from WY core team 3. Lack of ability to mitigate referral to Right to Choose 4. Media influence and public demand 5. No local governance contract mechanisms with national right to choose provider(s)	See above	See above	1. Not receiving quality data from right to choose (only referral numbers received) 2. Gaps in data from Leeds data model	Static - 1 Archive(s)
2415	21/03/2024	Quality and Finance Sub-Committee / Leeds Committe	Tackle inequalities in access, experience, outcome	16	(I4xL4)	9	(I3xL3)	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	Need to develop broader partnership overview in Leeds at the moment still too fragmented so assurance is limited.	Static - 4 Archive(s)
2414	20/03/2024	Finance and Best Value Sub - 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 experience by most councils across West Yorkshire and their statutory requirement not to overspend against budgets. This may lead to a potential impact on hospital discharges resulting in higher costs being retained within the Leeds and WY NHS system (additional costs borne by NHS provider organisations for which there may not be mitigations, thereby resulting in adverse variances to plan) and the management of winter pressures	1. Working with Leeds City Council to understand the issues, options being considered and the potential impact on system partners. 2. Review use of intermediate care capacity 3. System leadership oversight and consideration of options to minimise impact	WY councils are separate statutory organisations with no NHS oversight	System oversight of wider health and care financial position	Close working relationships between the NHS and councils in place and representation of councils on system partnership board	Lack of medium term plan to understand how recurrent financial balance position can be achieved.	Static - 4 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 LTHT) and across the system partners, supported by Decision management tool ward based transfer of care model rolled out to all in scope wards in LTHT to help early decision making and identification of need Detailed seasonal surge plans developed and overseen hrough Active System Leadership Structures System Escalation Actions and Processes revised continuously Integrated OPEL Framework 2024/26 published in Oct 24. OPEL & System Pressures Reporting Regime - refreshed in view of the revised OPEL (Nov 23) Communications work with Public to suggest alternatives to ED Investment in HomeFirst services and in assessment capacity through Adult Social Care Discharge Fund Winter capacity plans in place to support discharge capacity Improvements in pathways, processes and in hospital waiting times for social workers and care act assessments have reduced the length of time people wait on pathways 1 & 3 where a care act assessment is required for long-term care. Improved capacity for Same Day Emergency Care at St James's and virtual ward capacity	Key controls in place responding to high levels of demand. Current controls are still not sufficient to reduce the risks when there is exceptionally high demand on the system or where outflow is constrained While occupancy has improved, this isn't always correlated with a reduction in people spending a long time in ED - in part because the bed availability doesn't always match the specialty that is in demand Increased winter demand for acute care coupled with a increase demand for support on discharge has created longer waiting times and backlogs in hospital where capacity has been unable to meet the demand. This is in the context of additional winter capacity in primary care and social work. (Mar 25)	Health & Social Care Command & Control Groups: Active System Leadership,Active System Leadership Executive Group (Silver) Integrated Commissioning Executive Partnership Leadership Group Quality and Performance Committee System Visibility Dashboard is in place to support assurance and decision making	Bi-weekly meeting in place for services to report on capacity /demand (will flex if surge occurs) Reviewed Silver Action cards Revised System Resilience Structure System Visibility dashboard in place and driving change Strong programme of Home First work in place Short Term Assessment pathway in place to support care at home to maintain capacity and ensure focus on home first even if there are constraints in statutory provision Improvements in the waiting times for pathway 3 have been made by process changes Big and sustained improvements in pathway 2 (rehab beds)	OPEL reporting system under development for ASC but not yet finalised or shared. Recruitment and retention remain significantly challenging and limit the ability to create additional capacity, Still too many people over 6 and over 12 hours in ED which we know is linked to risk of harm Patients in LTHT have on occasions been placed in exceptional surge areas including corridors and in day rooms due to the lack of availability for inpatient beds (unsatisfactory environments have been mitigated as far as possible with the provision of call bells and other basic requirements) . Long waits for admission in inappropriate ED environments for mental health beds linked to high MH bed occupancy. Funding to maintain capacity within LTHT and to support Social care assessments is likely to become more difficult in coming months as we transition out of winter SW capacity, recruitment and retention remain a key risk alongside groups such as therapists	Static - 8 Archive(s)
2354	14/08/2023	Quality and People's Experience Committee	Tackle inequalities in access, experience, outcome	15	(I3xL5)	9	(I3xL3)	Philip Chan	Helen Lewis	There is a risk of unsustainable Neurodevelopmental assessment and treatment pathways for adults (autism and ADHD) due to demand for services surpassing the capacity resulting in unmet need of patients, long waiting list and increased right to choose requests which could lead to poor patient outcome and significant financial impact.	ADHD service (LYPFT) has closed to routine referrals temporarily due to the demand for assessment and treatment leading to waiting times of over 10 years. The ICB have commissioned a provider under an urgent award to deliver a support team to proactively contact waiters in IMD1 and/or with other risk characteristics to offer support with the needs that led to seeking referral, and to respond to queries from those on the waiting list who have all been written to. The support team is reporting positive feedback and outcomes for patients. The support team calls are identifying patients who do not need to be on the waiting list and/or providing support/validation so that they no longer need to seek an assessment. From April this team will be offering support to people seeking a diagnosis via their GP, and offering signposting to them as well as discussion of options around seeking a diagnosis. 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 Leeds Autism Diagnostic Service has improved pathway efficiency and waiting times. The increased number of people diagnosed is putting strain on post-diagnostic offer. ICB Place resource is also focussed on supporting the development of a WY accredited provider list to support and manage quality and tariffs associated with RTC referrals. This also aims to improve patient outcomes and experience when seeking treatment and entering shared care in the local area. At place, there will be a focus on: - initial support and guidance for those on the ADHD waiting list - ADHD prescribing capacity/pathways being discussed with primary care provider. WY accredited provider list service specs compliment this approach - pre-diagnostic support to support 'waiting well' including to develop and curate the support offer from third sector organisations. A neurodiversity working group has been established as part of the CMH Transformation programme to improve access to mental health services for people who are neurodivergent. This will help people who are on the diagnostic waiting lists to have their needs met - to 'wait well'. A third sector organisation has been successful in a grant bid for a project to support autistic people to access the new hubs.	Right To Choose referrals for non-urgent assessments will increase due to the local NHS ADHD service pause. Spend in this area needs to be monitored and is an area of unknown/risk. WY accredited provider list will help with the quality assurance oversight of RTC providers and provide consistent tariffs. The WY accredited provider list is awaiting sign off and providers to express interest. An "ADHD front door" is being developed to support patients meet needs before they enter the assessment pathway. Investment and funding to be explored as part of the proposal It is unknown when the Trust ADHD service will reopen to new referrals to non-urgent assessment referrals. The future of the ADHD pathway will be influenced by the NHSE ADHD taskforce however it is unclear how quickly guidance will be shared. Some guidance on clinical prioritisation for assessment is needed. . The WY programme and clinical colleagues are linked in. Leeds system will be exploring options for developing the ADHD pathway for assessment and medication pathways. There is no ring-fenced investment/funding into ADHD development. Autism referral rates to Leeds NHS pathway have reduced, RTC referrals for autism need to be investigated. Seeking funding/grants to support pre- and post diagnostic support offer.	WY ND programme guidance and resources Autism and ADHD diagnostic waiting list times ADHD treatment waiting list times ADHD annual review waiting list times. ND service annual quality report. Service specification reviews Oversight of Right to Choose ND diagnostic pathway referrals and spend Neurodiversity priorities agreed though Learning Disability and Neurodiversity Population Board Leeds Autism Strategy Leeds data model including ADHD and autism data to steer priorities.	Service annual quality board ND programme plan outlining key workstreams and work progressing Learning Disability and Neurodiversity Population Board report.	- Lack of targeted/identified recurrent funding streams provide ongoing challenge for sustainable improvement through non-recurrent mechanisms. - WY Commissioning policy not yet in place but planning for consultation from June - National Task Force set up, but potentially then risks local solution development as people wait for national steer	Static - 8 Archive(s)

2301	16/05/2023	Quality and People's Experience Committee	Tackle inequalities in access, experience, outcome	15	(I3xL5)	6	(I3xL2)	Karren Leach	Helen Lewis	There is a risk of CYP being unable to access a timely diagnostic service for neurodevelopmental conditions (Autism and ADHD) due to rising demand for assessments and capacity of service to deliver this (ICAN for under 5, CAMHS for school age). Delays in access to timely diagnosis may impact upon children's outcomes, access to other support services across health, education and social care, and also compliance with NICE standards for assessment within 3 months from referral.	Development of "ND - thinking differently case" presented to PEG in March and outlining the need to think about a needs based approach to providing support to CYP who are neurodivergent. Further workshop in February 2025 with Education to see how best we can support schools to manage the needs of people who are neurodivergent and reduce dependency on diagnosis. Needs led support needs to be offered earlier in the pathways.Considering options for building this kind of support into Cluster offer Links made to West Yorkshire ND programme of work particularly looking at how we as a WY ICB address the rising demand around the right to choose agenda and ensure a consistent method of delivery across the ICB. ND citywide development workshop undertaken on 19th July 2024. Representatives from across health came together (including Education and parent/carer representation) to understand the current position and challenges facing us both locally, regionally and nationally. Forwards plan for working groups following this and a further education focussed time out in October. Funding has moved to LCH to outsource assessments for our most vulnerable cohorts. 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 Refreshed framework for accreditation of providers to secure face to face capacity about to be published which will help with QA of providers and also aims to increase medication initiation capacity	Escalating increase in choice referrals due constrained local capacity, but long waits for other providers too and not all offer access to medication Available funding and workforce will make rapid improvements difficult. Staff availability with appropriate skills remains a key risk nationally and locally Lack of update from national Task Force	Data from LCH on waiting times Working group established this will report regularly to SEND Partnership board and CYP population board Meeting in place with ICB, LCH and LCC to determine development plan and shared position statement. Engagement with Education underway	Capacity in IS confirmed for highest risk cases ICB establishing a clinical reference group to support model design written to all families on the waiting list to sign post to additional resources that will offer support	Increasing public focus with request from Scrutiny to update Cllrs in September and increasing letters from MPs to service provider (LCH).	Static - 9 Archive(s)
2511	01/04/2025	Quality and People's Experience Committee	Improve healthcare outcomes for residents	12	(I4xL3)	6	(I3xL2)	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. 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 art 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.	1. Updates provided regularly at a number of senior operational meetings 2. Place lead fully involved in WY discussions and updates. 3. AACC database able to record CoPDoL 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.	Gap relates to workforce as identified.	New - Open
2510	01/04/2025	Quality and People's Experience Committee	Improve healthcare outcomes for residents	12	(I4xL3)	6	(I3xL2)	Andrea Dobson	Jason Broch	There is a risk of an inability to deliver all of the statutory functions of the ICB in regard to All Age Continuing Care (AACC) in Leeds due to challenging workforce pressures which could result in reputational damage, financial inefficiency, complaints, challenges and appeals, and staff burnout.	1. Completion of staffing compliment 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	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 demands, 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. 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	1. Increased number of applicants for clinical posts due to reduction in use of agency staffing across the ICB 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.	1. Significant staffing gaps remain, particularly clinical 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	New - Open
2509	01/04/2025	Quality and People's Experience Committee	Improve healthcare outcomes for residents	12	(I4xL3)	6	(I3xL2)	Andrea Dobson	Jason Broch	There is a risk of the ICB not being able to source high quality and cost effective care for individuals eligible for NHS Continuing Health Care (CHC) in Leeds due to gaps in cost for care and affordable budgets resulting in higher costs to the ICB or individuals presenting with unnecessary deterioration due to unmet needs.	1. Market Management and Sustainability activity in place in collaboration with Local Council 2. Direct conversation with Independent Sector Providers relating to gaps in local provision and areas for development 3. 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. 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. Where possible, robust care management arrangements are in place to support reviews of needs. 2. Relationships have been developed with the Market to support ongoing working arrangements 3. Move to a WY ICB is supporting wider discussions regarding costs and uplifts and may support block contract arrangements in the WY area. 4. Contributing to the local Market Position Statement	1. Case Management activity 2. Knowledge of overdue review lists and potential impact 3. Developing standard specifications for AACC care contracts	1. Requirement for a cost setting tool to support standardised cost setting for base fees for all care home providers 2. Risk of not accessing a placement for an individual if cost 'demands' are not met. 3. 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	New - Open
2024	30/06/2022	Quality and People's Experience Committee	Improve healthcare outcomes for residents	12	(I4xL3)	1	(I1xL1)	Andrea Dobson	Jason Broch	There is a risk of not meeting legislative responsibilities in relation to community deprivation of liberty for fully funded CHC cases; due to assessor capacity and availability of court of protection time; resulting in deprivation of liberty in breach of legislation. There is a significant additional risk that patients will not have the advocacy they need to go through the process due to a lack of commissioned resource. Family members can act as the RPR if they are objective, however in the majority of cases that is difficult.	Monthly meetings held with Health Case Management managers to monitor current position, plan LPS and maintain numbers. Prioritise cases based on complexity and risk of challenge Assessments are completed in line with the availability of court time to ensure they do not go out of date. However, delays to court proceedings have meant that a large number of cases have had to be redone as they became 'out of date' whilst awaiting a hearing. This has increased the workload of the HCM team. MCA Lead is working in collaboration with the health case management team and appointed solicitors to minimise delays and maximise performance. More case managers have received relevant training and experience to complete the assessments. Fast track reviewing moved to Continuing Care Service to free up HCM capacity	Please add actions in addition to the controls listed to reduce risk to target - with date for completion- see guidance p4. The following have been copied from Datix: Liberty Protection Safeguards LPS has been delayed in its implementation indefinitely. There is insufficient budget and resource at place to undertake preparatory work for all potential cases of DoL or to engage legal representation in order to progress all cases to the court of protection. The court has raised concerns on a number of occasions about the use of family members as appropriate rule 1.2 representatives, this requires additional legal support and HCM work.	LCH provide performance reports, highlighting the current position. The ICB Mental Capacity Act Lead meets with LCH quality Leads and Beachcroft solicitors quarterly to track progress and unpick any delays or performance issues	Regular meetings with the HCM Managers to ensure issue remains in focus. Mental Capacity Act Lead is working both at the place and ICB level to monitor all associated risks. Adam (CHC System) has been updated to record DoLS, enabling improved monitoring and recording of DoLS	No current gaps identified	Closed - Duplicate (please link to original risk)
2018	29/06/2022	Quality and People's Experience Committee	Tackle inequalities in access, experience, outcome	12	(I4xL3)	9	(I3xL3)	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.	Improving Flow Programme -led by LYPFT in collaboration with system partners- workstreams established to optimise flow through inpatient settings by focusing on maximising our alternative to hospital provision, ensuring that all admissions are purposeful, reducing prolonged length of stay and proactively discharging our service users at the right time to the right place. Remodelling of crisis alternatives provision in Leeds informed by MH crisis pathways to optimize targeting resources to meet the needs of population cohorts most at-risk. This has incorporated focused improvement to strengthen the integrated delivery of Oasis crisis house with LYPFT crisis team and utilisation of a single information system to increase occupancy as an alternative to hospital admission. LYPFT has also recently realigned its crisis offers to be closer to the Area based CMHTs 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 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 work to reduce the waiting list for access to step 3 CBT in NHS talking therapies has impacted significant improvements with many people now able to commence high intensity therapy within 4 months and waiting list greatly improved	Access to urgent crisis assessment within the MH trust within 4hrs whilst improved remains below target. Ongoing queries from patients/Healthwatch around operation of 111 helpline need ongoing work to address, but capacity for handling has been increased Access to housing remains significantly challenging (both for supported and general needs housing), impacting on flow	Waiting and access times to services monitored through performance metrics, Healthy Leeds Plan, and Mental Health Population Board data dashboard (power BI insight hub) Inpatient Flow Oversight Group within LYPFT Integrated Commissioning Oversight Group chaired by Deputy Director at LCC is supporting with the housing challenges, in trying to improve flow through supported housing and reducing barriers to permanent housing, though recognising big waiting lists for housing	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 Work to reduce the waiting list for access to step 3 CBT in NHS talking therapies has maintained improvement- with many people now able to commence high intensity therapy within 4 months and target for waiting list anticipated to be met in Q3 24/25 Improving MH Flow Programme -delivery update presentation to MH Population Board evidences progress on track against the core workstreams-including evidence of positive impacts from the pilot and learning review of focused mini MADE process supported by NHSE, and process improvements including development of barriers to discharge dashboard, and progress made towards system visibility dashboard for mental health. In context of sustained pressures reported through OPEL for LYPFT - this programme of work evidenced some effective progress, achieving a reduction in OOA placements just above the planned trajectory.	Access to urgent crisis assessment within the MH trust within 4hrs whilst improved remains below target. Some early challenges with embedding mobilisation of NHS111 MH into the Leeds system for crisis access-comms plan developed to mitigate. Long delays for those waiting for mental health beds in ED on occasions as balance risk of people at home versus those in ED	Static - 3 Archive(s)
2016	29/06/2022	Quality and People's Experience Committee	Tackle inequalities in access, experience, outcome	12	(I4xL3)	6	(I3xL2)	Lindsay Mcfarlane	Helen Lewis	There is a risk that as a result of the longer waits being faced by patients and limited capacity for treatments, there is a risk of harm, due to failure to successfully target patients at greatest risk of deterioration and irreversible harm, resulting in potentially increased morbidity, mortality and widening of health inequalities.	Joint working between ICB places and WYAAT trusts to maximise access to Independent Sector (IS) provision with a focus on increasing complexity and longest waiters. From October 2023, patients who have waited more than 40 weeks for an appointment or who have a decision to treat but do not have treatment date have been able to request a transfer to another provider with a shorter waiting list (PIDMAS). However, capacity in pressured specialties in limited Consistent messaging to patients re waiting times. Greater use of advice and guidance to help manage patients pre-referral / whilst waiting for appointments Implementation of patient initiated follow up (PIFU) LTHT using methodologies to account for learning disability and deprivation in assessing clinical priority (as part of Healthy Hospitals Network) LTHT implementation of clinical harm reviews of patients awaiting treatment longer than 52 weeks - ICB should be made aware of issues/ concerns as update is shared with ICB post review at the LTHT Quality Assurance Committee on patient harm whilst awaiting treatment. ICB attend weekly LTHT Service Delivery meetings, at which progress on reducing lists of long waiters are shared, risks assessed and appropriately escalated, and mitigating actions agreed (covers cancer and planned care)	Awaiting clarification of process with ICB Quality team and LTHT re quarterly monitoring reports on patient harm whilst awaiting treatment. Capacity gaps in pressured specialties are similar across other regions so the actual opportunities to access care in alternative locations will be limited.	Monthly meetings with Leeds ICB and providers (LTHT/ LCH and community /IS providers) to identify and maximise opportunities to support with waiting lists. Choice Agenda now operational (from October 2023) patients who have waited more than 40 weeks for an appointment or who have a decision to treat but do not have a treatment date will be able to request a transfer to another provider with a shorter waiting list. Advice and guidance and PIFU agreed key components of outpatients strategy/ management of long waiters and fully supported by the Planned Care Delivery Board - January 2024. Monthly Corporate Performance reporting in place / Planned Care Network Board oversight LTHT Harm Review process in place for long waiters Cancer - data driven discussion at WY&H Cancer Alliance Board levels and follow up analysis and actions agreed at place. Cancer Care Delivery Board taking a lead role in developing solutions at a system wide cancer level, through access to SDF monies. Ongoing meetings with ICB at Leeds/ LTHT cancer team and wider partners.	Elective Recovery Funding clarified for 24/25, but against a very significant Cost improvement programme for LTHT	Intermittent industrial action will set back progress due to need to prioritise those patients of greatest clinical need. Size of the overall waiting lists needs to reduce to ensure longer term sustainability and to meet trajectories Initial updates from PIDMAS/ Choice work is that of those patients who initially suggested they would access care outside of Leeds there has been very low levels of actual take up. 2 x funded posts within LTHT (initially funded by city wide HI funding) due to end 24/25 - no alternative funding identified, this is included on LTHT risk register and cost pressures.	Closed - Risk no longer relevant to the CCG
2531	14/04/2025	Finance and Best Value Sub - Committee	Enhance productivity and value for money	9	(I3xL3)	6	(I3xL2)	Matthew Turner	Alex Crickmar	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 This could result in: - 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.	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 ad opportunities 7. Oversight of capital position by WY ICS Finance Forum	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	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	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	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	New - Open

2487	27/01/2025	Quality and People's Experience Committee	Improve healthcare outcomes for residents	9	(I3xL3)	6	(I3xL2)	Lindsay Mcfarlane	Tim Ryley	There is a risk of additional service pressure, across the Leeds place caused through the immediate recovery actions Adult Hospices in Leeds may need to implement, due to the current financial deficit (shortfall in annual funding). This will result in additional service pressures on other health and care partners across Leeds place, including primary care, acute hospitals and community services impacting on hospital admissions, delayed discharges and an increase in social care demands.	1. Funding uplift has been explored by West Yorkshire with £2m agreed recurrently to be spread across the 10 hospices in West Yorkshire awaiting clarity on allocation per hospice and how this may change the score for this risk. 2. Explore funding uplift allocations to all Hospices to mirror NHS statutory organisations 3. Collaboration with stakeholders: Engage with local stakeholders to seek additional funding or support 4. Cost saving measures: Explore efficiency strategies, such as streamlining operations to reduce overhead costs 5. Fundraising campaigns: Support Hospices and local authorities to launch targeted campaigns to increase donations and secure new funding streams 6. Potential government funding for end of life pathways.	1. Limited flexibility in funding reallocation due to existing financial pressures across the system, making it difficult to reallocate funds without compromising essential services 2. Limited opportunity for further efficiency improvements without negatively impacting service quality and staff wellbeing 3. Over-reliance on public donations, which may not bridge the funding gap 4. Potential that the government funding does not materialise and that the allocation is not passed through.	1. Financial audits: Work with finance teams to monitor and evaluate the impact of the tax increase on Hospice finances and assess the effectiveness of mitigation measures 2. Hospice performance reviews: Reviews of service delivery metrics to ensure patient care and service standards are maintained 3. Collect feedback from patients, families, carers and staff 4. End of Life Population Care Board: Regular reporting to ensure governance and accountability in managing the risk 5. Regular reporting to the group Quality sub committee 7. West Yorkshire Palliative End of Life Care Steering Group:	See above	None identified at this stage.	Static - 1 Archive(s)
2413	20/03/2024	Finance and Best Value Sub - Committee	Enhance productivity and value for money	6	(I3xL2)	6	(I3xL2)	Matthew Turner	Alex Crickmar	There is a risk that the financial position across the Leeds system will not achieve financial balance due to the combination of undelivered QIPP and new cost pressures in 2024 – 25. This could result in the system as a whole not meeting its statutory duties to break even.	Budgetary reporting and control meetings with DMT and budget holders/managers. SFI's/SO's Monthly meetings with DoFs and CEOs/AOs through the SFEG. Internal and external audit West Yorkshire finance framework Weekly Leeds DoF meetings Fortnightly meetings with Leeds Council Additional financial controls around all new expenditure - above £50k for healthcare and £10k	There is an active approach adopted across the ICB in Leeds and the wider WY ICB means that all parts of the WY system are actively looking at further opportunities to ensure that the ICB can deliver its agreed financial plan for 2024-25. Development of a medium term strategic financial plan to demonstrate the path to recurrent balance is ongoing across Leeds and West Yorkshire.	Policies and Procedures Financial performance framework Weekly Leeds DoF meetings Fortnightly meetings with Leeds Council Additional financial controls around all new expenditure - above £50k for healthcare and £10k for non-healthcare reviewed by Leeds DTM and WY investments panels.	We are starting the financial year with a £12m planned deficit at the ICB and a total £8m deficit across all NHS partners in Leeds. This is the lowest level of deficit compared to other places in West Yorkshire. There is ongoing benchmarking work across West Yorkshire to identify further potential opportunities to close the financial gap.	Limited further options to close the remaining gap at the ICB at this time, with limited data on benchmarking opportunities. Medium term financial plan yet to be produced to achieve recurrent financial balance.	Closed - Reached tolerance

Appendix 2

Board Assurance Framework Summary, Cycle 1 2025/26

West Yorkshire Integrated Care Board - Board Assurance Framework - Summary						Version: 9	Date: March 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	Anthony Kealy	Finance, Investment and Performance Committee
	2.4	There is a risk that our infrastructure (estates, facilities, digital) hinders our ability to deliver consistently high quality care.	Open	9	16	Jonathan Webb / Shaukat Ali Khan	Finance, Investment and Performance Committee.Transformation Committee for Digital
	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	Anthony Kealy	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	8	Ian Holmes	ICB Board
	4.2	There is a risk that we are unable to achieve our ambitions on equality diversity and inclusion due to ingrained attitudes that persist in society and across our health and care organisations.	Bold	8	12	Ian Holmes	Quality Committee
	4.3	There is a risk that threats to our people and physical and digital infrastructure, e.g. from cyber-attacks, terrorism and other major incidents, prevents us from delivering our key functions and responsibilities.	Averse	9	12	Anthony Kealy / Shaukat Ali Khan	Transformation Committee
	4.4	Due to climate change, there is a risk of increased demand for health and care services and disruption to the provision of services. This will result in health and care services that cannot effectively meet population needs.	Open	12	16	Ian Holmes	Transformation Committee

Board Assurance Framework Summary, Cycle 1 2025/26

West Yorkshire Integrated Care Board - Board Assurance Framework - Heat map			Version 9	Mar - Jun 2025												
Mission		Strategic risk	WYICB and 5 Places	West Yorkshire		Bradford District and Craven		Calderdale		Kirklees		Leeds		Wakefield	
			Risk appetite (All)	Target score (WYICB)	Current score (WYICB)	Target score (BD&C)	Current score (BD&C)	Target score (Cald'e)	Current score (Cald'e)	Target score (Kirk's)	Current score (Kirk's)	Target score (Leeds)	Current score (Leeds)	Target score (Wake'd)	Current score (Wake'd)
Reduce inequalities	1.1	There is a risk that our local priorities to narrow inequalities are not delivered due to the impact of wider economic social and political factors.	Bold	16	20	16	20	16	20	16	20	16	20	16	20
	1.2	There is a risk that operational pressures and priorities impact on our ability to target resources effectively towards improving outcomes and reducing inequalities for children and adults.	Open	9	16	9	12	9	9	6	12	12	16	9	16
	1.3	There is a risk that we fail to join up services in our communities which means that we do not improve outcomes and reduce health inequalities.	Open	8	12	8	12	8	12	8	12	8	12	8	12
Manage unwarranted variation in care	2.1	There is a risk that our inability to collectively recruit and retain staff across health and care impacts on the quality and safety of services.	Open	8	16	6	12	8	12	8	12	9	12	8	12
	2.2	There is a risk that as a system we fail to innovate, learn lessons and share good practice that allows us to respond to service pressures resulting in widening variations across our footprint.	Open	6	8	4	6	4	6	4	8	4	12	4	12
	2.3	There is a risk that we are unable to measure and assess performance across the system in a timely and meaningful way, which impacts on our ability to respond quickly as issues arise.	Open	6	9	2	4	2	6	2	8	2	6	2	6
	2.4	There is a risk that our infrastructure (estates, facilities, digital) hinders our ability to deliver consistently high quality care.	Open	9	16	9	16	9	16	9	16	9	12	9	12
	2.5	There is a risk of an inability to deliver routine health and care services due to the emergence of a future pandemic leading to substantial loss of life and failure to deliver key functions and responsibilities.	Averse	16	16	Not required	Not required	Not required	Not required	Not required	Not required	Not required	Not required	Not required	Not required
Use our collective resources wisely	3.1	There is a risk that we do not invest resources in a way which prioritises community, primary and prevention programmes and so doesn't maximise value for money.	Open	6	12	4	12	4	12	8	12	4	9	4	9
	3.2	There is a risk that we don't operate within our available system and organisational resources (revenue and capital) and so breach our statutory duties.	Cautious	9	20	6	20	6	20	6	20	6	20	6	20
	3.3	There is a risk that ICB capacity and infrastructure is not sufficient nor targeted effectively towards key priorities.	Open	9	12	4	12	4	16	4	12	4	16	4	12
Secure benefits of investing in health and care	4.1	There is a risk that partnership working on wider societal issues is deprioritised in order to meet current operational pressures.	Open	8	8	8	8	8	12	8	12	8	12	8	8
	4.2	There is a risk that we are unable to achieve our ambitions on equality diversity and inclusion due to ingrained attitudes that persist in society and across our health and care organisations.	Bold	8	12	8	12	8	12	8	12	4	9	8	12
	4.3	There is a risk that threats to our people and physical and digital infrastructure, e.g. from cyber-attacks, terrorism and other major incidents, prevents us from delivering our key functions and responsibilities.	Averse	9	12	Not required	Not required	Not required	Not required	Not required	Not required	Not required	Not required	Not required	Not required
	4.4	Due to climate change, there is a risk of increased demand for health and care services and disruption to the provision of services. This will result in health and care services that cannot effectively meet population needs	Open	12	16	Not required	Not required	Not required	Not required	Not required	Not required	Not required	Not required	Not required	Not required

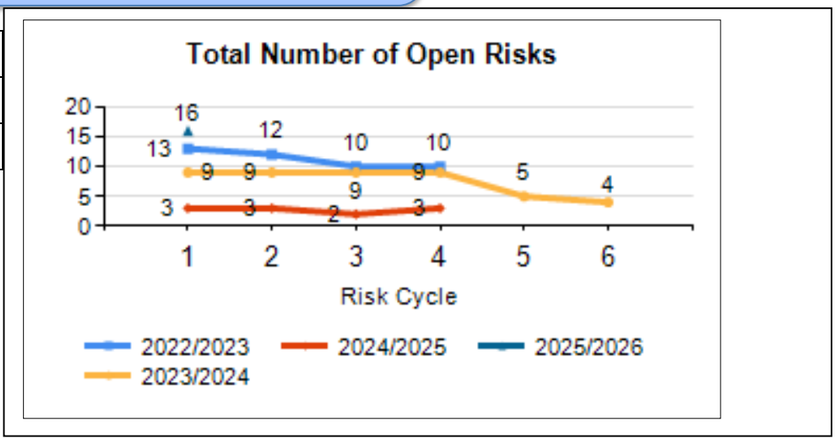
WY ICB Leeds Place, Cycle 1 2025/26
Risk on a Page Report

Leeds Health & Care Partnership

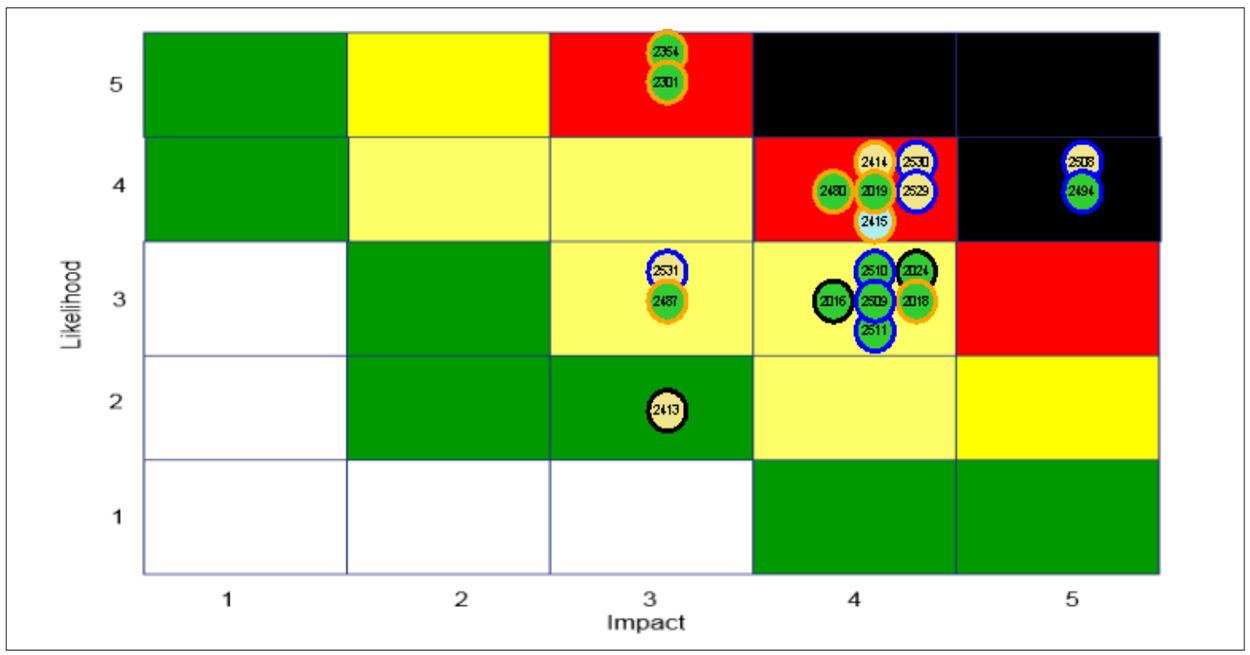
NHS West Yorkshire Integrated Care Board

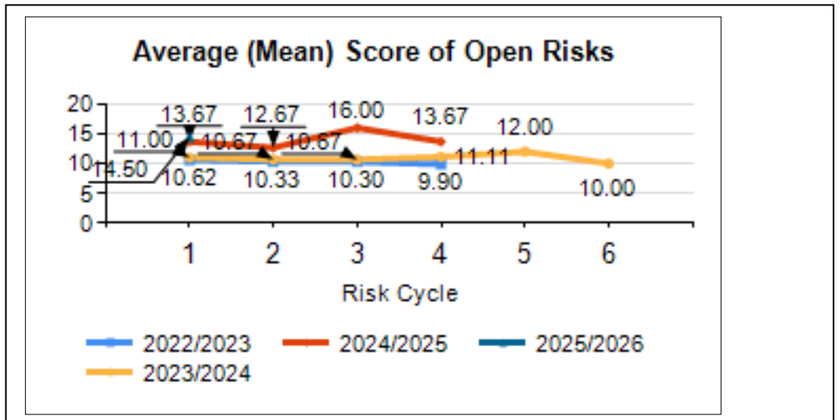
Total Risks	19 (16 open risks)
Finance	6 (5 open risks)
Quality	12 (10 open risks)
Quality/ Finance and Leeds Committee	1 risk

Movement of Risks		Risk Score Increasing	0
New	8	Risk Score Decreasing	0
Marked for Closure	3	Risk Score Static	8



Risk Overview



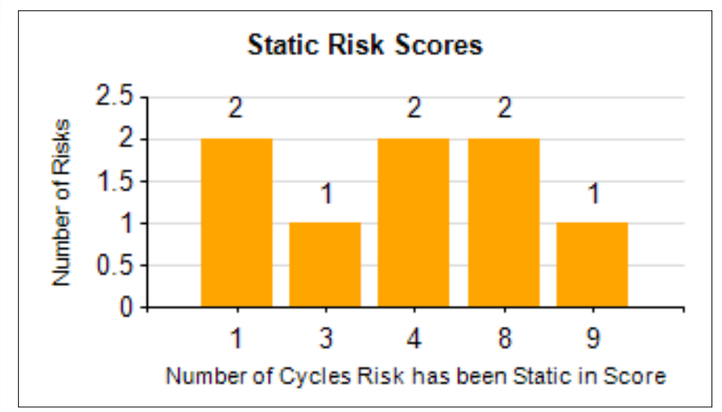


Key

- Quality and People's Experience Committee
- Finance and Best Value Committee
- Quality and Finance Sub-Committee / Leeds Committee

- New Risk
- Closed Risk
- Risk Score Increasing
- Risk Score Decreasing
- Risk Score Static

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



8 Static risks in Cycle 1, 2025/26

Leeds Health & Care Partnership

NHS West Yorkshire Integrated Care Board

Appendix 4

Leeds Health and Care Partners - Top Risks – May 2025						
The ICB in Leeds	20	**All Age Continuing Care (AACC)** 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.	20	**Risk of Harm – Children in crisis** 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.	16	**Tier 3 Weight Management Services** There is a risk that our current commissioned Tier 3 weight management service not being sufficient to meet demand due to limited local budget and workforce and the introduction of new drugs for weight management and associated NICE technology appraisals increasing demand and legal obligation. This could result in an increased number of referrals to right to choose providers and associated expenditure and potential detrimental impact on the quality and suitability of services for the population in Leeds.
Leeds Teaching Hospital Trust	20	**High occupancy levels and insufficient capacity and flow across the health and social care system causing impact on patient safety, outcomes, and experience** There is a risk to maintaining sufficient capacity to meet the	20	**Delivery of the financial plan and operational capital plan for 2025/26**. There is a risk that the Trust does not achieve its planned control total and deliver the operational capital plan in 2025/26 due to additional cost pressures and	16	**Workforce risk** The Trust needs to reduce its spend on WTE to achieve the 2025/26 financial plan. We have made significant progress already on controlling bank and agency costs resulting in lower opportunity

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

		needs of patients attending hospital and being admitted for planned/elective care and unplanned (acute) care caused by demand being greater than the available hospital capacity. Efficiency of patient flow and placement due to high occupancy across the health and care system impacts on patient safety, outcomes, and experience. There is a risk of patient harm, including healthcare associated infection, and deconditioning due to prolonged hospital stay. There is also a risk to the delivery of constitutional standards, impacting on the Trust's delivery and efficiency ratings and reputation.		under-delivery of WRP, in particular in relation to reductions in Length of Stay. This would have the following impact: Cash shortfall and risk to supplier payment. Potential to contribute to the Integrated Care System not meeting its overall control total. Reputational damage, as the Trust fails to deliver on a key statutory duty (financial plan) and the Trust fails to invest in equipment, estate, and digital infrastructure to support service development. Reducing the internal funding for the Trust's ambitious Five-Year Capital programme, potentially requiring capital cash support resulting in an increased cost in revenue. Potential non-compliance with regulatory requirements, including new medical devices regulation (Regulation EU 2017/45). Increased clinical risk due to inability to replace capital assets within agreed replacement schedules.		to reduce our spend on temporary workforce. In addition to the above we are experiencing scrutiny from the CQC on our maternity and neonatal services. There is a risk of a negative impact on the health and wellbeing of our workforce along with the risk of a decline in staff engagement and belief in The Leeds Way values.
Leeds Community Healthcare Trust	⇔	**Neurodiversity Waiting Times** There is a risk of unsustainable Neurodevelopmental assessment and treatment pathways (autism	⇔	**Imbalance of Capacity and Demand** Increasing demand for services (specific risks on the risk register	⇔	**Financial Position 2025/26** Risk of not being able to deliver a balanced revenue financial plan for 2025/26

		and ADHD) due to demand for services surpassing the capacity resulting in unmet need of patients and long waiting lists which will cause impact to patient outcomes.		relate to Neighbourhood Teams, CAMHS, Speech and Language Therapy, ICAN) coupled/reflected with increased complexity of the services required, resulting in reduced quality of patient care, delay in treatment, deterioration in health and wellbeing of patients, and additional pressure on staff, exacerbated by vacancies to some hard to recruit to roles.		given underlying deficit and range of cost pressures. This is exacerbated by the reported planning positions of partner NHS organisations in Leeds, Leeds City Council and across the West Yorkshire Integrated Care System. There is expected to be little or no real terms growth in 2025/26, and a significant national efficiency ask to which will be added a requirement for LCH to address its own underlying deficit and play a major part in a Leeds place response to the Leeds financial planning gap. Whilst work across Leeds and the ICS has commenced to identify savings from transformation, improved system working and efficiencies, difficult decisions to be made about services the Trust is able to offer patients may be required and is being managed through the Quality and Value Programme. It is likely that require service changes will impact on stakeholders.
Leeds and York Partnership	⇔	**System flow and Out of Area Placements**	⇔	**Financial Position** There is a risk that the Trust does	⇔	**Investment in Mental Health and Learning Disability**

Foundation Trust		There is a risk to the quality of care of our service users as a result of ineffective patient flow within the system with an increasing use of Out of Area Placements, compounded by a lack of recurrent funding and a resulting financial cost to the system.		not meet its planned efficiency targets in 24/25 which could impact on delivering the overall financial plan. Non recurrent mitigations are not sustainable and there is a likely impact on quality of care over time. This is due to the underlying deficit and service pressures which compound the in-year position.		**Services** There is insufficient capacity to meet the level of demand of mental health needs within Leeds; this is manifested through the availability of core funding for our workforce and impacts on resource.
Leeds GP Confederation	⇔	**Strategic**: There is a risk that both main aspects of the Confederation's purpose are compromised due to strategic decisions that are out with of our control. Voice & representation; if the funding for this is reduced or lost. Combined with PCNs taking Enhanced Access 'in-house' the combined affect will be a much-compromised Confederation infrastructure with limited ability to deliver purpose.	⇔	**Financial**: Following an efficiency review we have mitigations for our 2024/25 deficit. Mitigations include increasing income through winning tenders but there is a risk that these contracts do not yield the level of income required. In addition, reducing running costs largely through changing the workforce profile. Whilst being closely monitored there is a risk that mitigations will not work and we will return to a risk of deficit.	⇔	**Operational**: Being agile for PCN requirements. Standing down services and standing up new services; all require workforce flexibility. Where workforce is limited, this may compromise the ability to flex services at the speed required. Delivery of new collaborative contracts and responding to tenders.
Forum Central - Voluntary, Community and Social Enterprise	⇔	**Strategic:** Reduced capacity to provide a strategic voice for health & care third sector and manage rep & eng across the ICB/LHCP systems, compounded by changing structures and roles	⇔	**Financial:** Where reduction in VCSE service capacity means these service users have no alternative but to present directly to NHS services such as A&E or crisis centres (increasing service demand) or	⇔	**Operational:** Increased demand and level of complexity of need of people accessing VCSE services, alongside reduced capacity due to reduced contract values and contracts ending / short

		means incr number of risks; issues and opportunities missed. Missed opportunities due to extreme system financial pressures not looking to VCSE sector to mitigate wider system pressures. Reducing and ending contracts rather than investing on best value cost benefit options which support system goals. Lack of clarity of where system decisions made so uncertainty of where to focus limited resources to support the most effective decision making as a system. Significant risk of health inequalities being missed/not recorded/not escalated due to immature systems and processes that are focused on no. of people affected not level of health inequality faced. i.e. discussions of risks at pop board level not captured/ escalated to committee level due to not hitting risk scoring threshold e.g. redn in commissioned bereavement support.		are unable to return home after a stay in hospital (reducing service efficiency). VCSE is effectively being stopped from supporting HLP priority goals. If resources could be shifted it would relieve system pressures. System is making counterproductive decisions due to financial pressures. Loss of contracts and / or lack of full cost recovery leading to closure of local Third Sector organisations. Resulting in loss cannot be built back from and learning from previously successful programmes. Pilots and new services should have legacy planning prior to being commissioned/funded as s/t funding decreases cost / benefit of service due to balance of time spent budgeting / recruitment rather than delivery.		term funding. As VCSE sector is increasingly unable to support existing as well as rising demand amongst the most vulnerable groups and communities we expect to see Harm to people, especially those with the greatest Health Inequalities (HIs) Cuts and restrictions on NHS/LCC services, in addition to rising poverty, mean VCSE Organisations are reporting increased demand from new users who cannot be safely or appropriately supported by third sector providers: this represents an additional harm to people, both using services and workforce.
Leeds City Council	⇔	**Workforce** Workforce resource not in place	⇔	**Major cyber incident** Cyber-attack / major IT outage	⇔	**Sustained financial pressures**

		to deliver the service to the required standard. Worsening workforce pressures (including health, safety and wellbeing) and market sustainability position. Problems in both Adults and Health and Children and Families directorates in recruiting and retaining care staff (in particular: social workers, professionals, educational psychologists, schools) leading to increased resource pressures and adverse impact on our ability to deliver a wider range of services. Workforce capacity pressures also within the wider social care market arising from anticipated increases in staff-related costs i.e. NLW/RLW, increase in NI Employer Contributions. Risk that the workforce capacity gap could worsen. <u>Sources:</u> Increased demand and complexity and experience of working in increasingly complex community contexts, including at times, heightened community		has an adverse impact on our ability to keep delivering critical services (including those for Health and Social Care). <u>Sources:</u> Internal and external threats to cyber security e.g., human error, malware, ransomware and increasing sophistication of cyber-criminal activity. Cyber disruption from geopolitical conflicts.		Financial and budgetary pressures within the organisation - in particular for Adults & Health and Children & Families directorates - is still very real/relevant and is high risk. <u>Sources</u> including market pressures relating to capacity and to increased cost of placements and packages of care.

		tension. High vacancy factors that are proving difficult to fill. Market sustainability and competition in the labour market (internal and external to the sector). Underinvestment in the labour market. Staff leaving the sector(s) for better paid and less stressful jobs in other industries. Long term problems from the pandemic and Brexit.				

LEEDS COMMITTEE OF THE WEST YORKSHIRE INTEGRATED CARE BOARD WORK PROGRAMME 2025-26

ITEM	May 25	Sept 25	Nov 25	Feb 26	Lead
STANDING ITEMS					
Welcome & Introductions	X	X	X	X	Chair
Apologies & Declarations of Interest	X	X	X	X	Chair
Minutes of previous meeting	X	X	X	X	Chair
Matters Arising	X	X	X	X	Chair
Action Tracker	X	X	X	X	Chair
Questions from Members of the Public	X	X	X	X	Chair
Summary & Reflections	X	X	X	X	Chair
People's Voice	X	X	X	X	JP/JM
Place Lead Update	X	X	X	X	TR
Forward Work Plan	X	X	X	X	Chair
Items for the Attention of the ICB	X	X	X	X	Chair
Population and Care Delivery Board Update		X	X	X	Various
GOVERNANCE & FINANCE ITEMS					
Sub-Committee Alert, Assure Advise (AAA) Reports	X	X	X	X	Chairs
Risk Management Report and Board Assurance Framework (BAF)	X	X	X	X	TR
Financial Position Update	X	X	X	X	AC
Annual Governance Review	X				SB
Partnership MoU Refresh	X				SB
ITEMS FOR DECISION					
GP Procurement / Merger / Closure of Practices	X	X			KT
Financial Plan 2026/27 / Medium Term Plan				X	AC
Procurement and Contract Decisions		X	X		HL
Joint Working Agreements					LM
STRATEGY & ASSURANCE					
Marmot City Update		X			VE
Health Inequalities / Core 20 Reporting		X		X	NE/NN
National Guidance Updates (Planning / Neighbourhood Working / Growth Accelerator Programme)	X	X		X	HL
Director of Public Health Annual Report		X			VE