Leeds Health & Care Partnership

NHS West Yorkshire Integrated Care Board

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

1.45 pm to 4.30 pm, Wednesday 3 September 2025
(Private pre-meet for members 1.00 pm; meeting in public 1.45 pm)
HEART: Headingley Enterprise and Arts Centre, Bennett Road, Headingley, Leeds, LS6 3HN

AGENDA

No.	Item	Lead	Page	BAF Link	Time
1	**Welcome, Introductions**	**Rebecca Charlwood** Independent Chair	-	N/A	1.45
2	**Apologies and Declarations of Interest** - To note and record any apologies. - A register of interests of members can be found at mydeclarations.co.uk. Once redirected to the portal, please select 'filter', and in the 'All decision-making groups' field, select 'Leeds Committee of the WYICB' from the drop-down box.	**Rebecca Charlwood** Independent Chair	-	N/A	-
3	**Minutes of the Previous Meeting** - To approve the minutes of the meeting held 21 May 2025.	**Rebecca Charlwood** Independent Chair	004	N/A	-
4	**Matters Arising** - To consider any outstanding matter arising from the minutes that is not covered elsewhere on the agenda.	**Rebecca Charlwood** Independent Chair	-	N/A	-
5	**Action Tracker** - To note any outstanding actions.	**Rebecca Charlwood** Independent Chair	016	N/A	-
6	**People's Voice** - To receive a lived experience of health care services in Leeds: Healthwatch report: "What trans and non-binary people told us about GP care".	**Healthwatch Leeds Co-Chair**	-	N/A	1.50
7	**Questions from Members of the Public** - To receive questions from members of the public in relation to items on the agenda.	**Rebecca Charlwood** Independent Chair	-	N/A	2.05
8	**Place Lead Update** - To receive the attached update from the Place Lead.	**Tim Ryley** Place Lead	018	N/A	2.15

No.	Item	Lead	Page	BAF Link	Time
ROUTINE REPORTS					
9	**Quality and People's Experience Sub-Committee Update** - To receive an assurance report from the Chair of the sub-committee.	**Rebecca Charlwood** Independent Chair and Chair of the Quality and People's Experience Sub-Committee	034	N/A	2.30
10	**Finance, Value and Performance Sub-Committee Update** - To receive an assurance report from the Chair of the sub-committee.	**Cheryl Hobson** Independent Member and Chair of the Finance, Value and Performance Sub-Committee	037	N/A	2.35
FINANCE					
11	**Financial Position Update** - To receive an update on the financial position.	**Alex Crickmar** Director of Operational Finance	040	3.2	2.40
BREAK 2.55 – 3.05					
ITEMS FOR DECISION / ASSURANCE / STRATEGIC UPDATES					
12	**Procurement of New Contract for Interim Provider of Short-Term Community Beds** - To approve the proposals.	**Helen Lewis** Director of Pathway and System Integration	058	3.3	3.05
13	**Director of Public Health Reports** **(a) Marmot City Update** - To receive a verbal update pending a full update of the Year 3 Plans at the 11 February 2026 meeting. **(b) Director of Public Health Annual Report – "Heat In The City: Our Health in a Warming Leeds"** - To receive the report.	**Tim Fielding** Deputy Director of Public Health	069	1.1/1.2 4.4	3.20
14	**Health Inequalities/ Core20PLUS5 Update** - To receive an update.	**Nick Earl** Associate Director of Population Health	078	1.1/1.2	3.40
15	**Work, Skills and Health Programme Update – Healthy Working Life** - To receive an update.	**Nick Earl** Associate Director of Population Health	091	N/A	3.55
GOVERNANCE / RISK MANAGEMENT					
16	**Risk Register (Cycle 2 2025/26)** - To receive and consider the risk management information provided.	**Tim Ryley** Place Lead supported by **Asma Sacha** Risk Manager	105	All	4.10
FORWARD PLANNING					
17	**Items for the Attention of the ICB Board** - To identify items to which the ICB Board needs to be alerted, of which it needs to be assured, which it needs to action, and positive items to note.	**Rebecca Charlwood** Independent Chair	-	N/A	4.20

No.	Item	Lead	Page	BAF Link	Time
18	**Forward Workplan 2025/26** - To consider the workplan and any further items to be added.	**Rebecca Charlwood** Independent Chair	160	N/A	4.25
19	**Any Other Business** - To discuss any other business.	**Rebecca Charlwood** Independent Chair	-	N/A	4.30
20	**Date and Time of Next Meeting** The next meeting of the Leeds Committee of the WY ICB will be held from 1.15 pm to 4.30 pm on Wednesday 19 November 2025 (private pre-meet for members 1.00 pm; meeting in public 1.15 pm)	**Rebecca Charlwood** Independent Chair	-	N/A	-

Draft Minutes

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

1.15 pm, Wednesday 21 May 2025

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

Members	Initials	Role
Rebecca Charlwood	RC	Independent Chair, Leeds Committee of the WY ICB
Kashif Ahmed (deputising for CB)	KA	Deputy Director, Integrated Commissioning, Leeds City Council
Jason Broch (deputising for SF)	JB	Medical Director, ICB in Leeds
Alex Crickmar	AC	Director of Operational Finance, ICB in Leeds
Tim Fielding (deputising for VE)	VE	Public Health, Leeds City Council
Pip Goff	PG	Volition Director, Forum Central
Jo Harding	JH	Director of Nursing and Quality, ICB in Leeds
Cheryl Hobson	CH	Independent Member – Finance and Governance
Yasmin Khan	YK	Independent Member – Health Inequalities
Jane Mischenko	JM	Co-Chair, Healthwatch Leeds
Dr Sara Munro	SM	Chief Executive, Leeds and York Partnership Foundation Trust and Chief Executive Designate, Leeds Community Healthcare NHS Trust
Tim Ryley	TR	Place Lead, ICB in Leeds
In attendance		
Sue Baxter	SB	Head of Partnership Governance, WY ICB
Helen Lewis (minute 14)	HL	Director of Pathway and System Integration, WY ICB
Nick Lamper	NL	Governance Manager, WY ICB
Nicola Nicholson (minute 12)	NN	Associate Director for Strategy and Programmes, WY ICB
Sam Ramsay (minute 15)	SR	Senior Partnership Development Lead, WY ICB
Asma Sacha (minute 17)	AS	Risk Manager, WYICB
Kirsty Turner (minute 13)	KT	
Apologies		
Caroline Baria	CB	Director of Adults and Health, Leeds City Council
Selina Douglas	SD	Chief Executive, Leeds Community Healthcare NHS Trust
Victoria Eaton	VE	Director of Public Health, Leeds City Council

Dr Sarah Forbes	SF	Medical Director, ICB in Leeds
Julie Longworth	JL	Director of Children and Families, Leeds City Council
Dr George Winder	GW	Chair, Leeds GP Confederation
Prof. Phil Wood	PW	Chief Executive, Leeds Teaching Hospitals NHS Trust

Members of public and/or staff observing – 2

1 WELCOME AND INTRODUCTIONS

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

2 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.

It was acknowledged that a number of partners were involved in the Neighbourhood Working Guidance (and potentially other items on the agenda) but the report provided information and sought general support, so no specific need to manage interests was foreseen. Members were advised that, if anyone felt that their involvement in the consideration of any item conflicted them so as to affect their objectivity or impartiality, they should declare this and withdraw to the public gallery.

In respect of the item on Consolidating VCSE Mental Health Contracts (minute 14 below refers), PG declared a direct financial interest as a potential provider of the services and would withdraw to the public gallery for the duration of the consideration of the item.

3 MINUTES OF THE PREVIOUS MEETING

The minutes of the meeting held on 26 February 2025 were approved as an accurate record.

The Leeds Committee of the WY ICB:

- **APPROVED** the minutes of the previous meeting held on 26 February 2025.

4 MATTERS ARISING

No matters were raised.

5 ACTION TRACKER

An update on action 78/24 (BAF risk 2.5) would be provided in the Risk Management item later in the meeting (minute 17 below refers). The action was therefore **CLOSED**.

All other actions had been completed.

6 PEOPLE'S VOICE

JM introduced a video from the 'how does it feel for me?' series from Healthwatch Leeds recounting the continuation of Abdul's Story. Abdul had received a prostate cancer diagnosis and had suffered a stroke. Due to technical difficulties, it was not possible to screen the video in its entirety so a link to it would be circulated following the meeting.

JM noted that the key themes of the story were communication, compassion and co-ordination, known collectively as the three 'C's, and the importance of including carers.

TR commented that, even in the delivery of services costing billions of pounds, getting the small things right in the context of the individual was important; some of the routine aspects of care could still be inconsistent. SM added that there had been discussions at the Leeds Poverty Truth Commission about not overcomplicating letters and missing or obscuring the main point. PG observed that there were still instances of not adhering to accessibility standards in communications.

Members related examples of sending messages via texts and/or apps, and of accessible information being a number of clicks away from the point of access. If not carefully designed, digital channels could lead to exclusion and inequalities.

JM explained that Healthwatch had undertaken some work with Primary Care Networks (PCNs) around accessibility of their websites, including sensory needs and learning disabilities, and YK added that there was a need to change the approach to the three 'C's within the system. TR commented that it was hard to measure the success of what was done, and the elements of co-production and continuous improvement were important but were more challenging at the current time of pressure on the system and a lack of people, as there was a need for teams on the ground to have space and capacity to address these issues.

The Leeds Committee of the WY ICB:

- **RECEIVED** and **NOTED** the content of the People Story.

7 QUESTIONS FROM MEMBERS OF THE PUBLIC

No questions had been submitted.

8 PLACE LEAD UPDATE

TR presented a verbal update.

He noted that the 10 Year Health Plan was imminent, which would reflect the three "big shifts" of hospital to community, analogue to digital, and sickness to prevention.

The merger of the Department of Health and Social Care and NHS England would lead to the regions having significant authority, but would be undertaken on a different timescale from the changes to the ICB. Providers were required to reduce their post-COVID growth

by 50% in the current year. More of the performance management would be undertaken by NHS England and the regions, and provider alliances would need to be established.

ICBs were required to reduce their workforce costs by 50% by the end of December, and the ICB Blueprint had been shared at the beginning of May. ICBs would be different organisations going forward, with many functions moving elsewhere in time. The ICB was required to submit a detailed explanation of how it would reduce costs (including narrative and figures) to the region by 30 May.

There was not currently clarity around the timetable for any redundancy scheme. Formal consultation with staff was planned to take place in July and August, with the reordering of the organisation taking place in September to November. There were huge risks associated with the pace of change.

The integrator teams would hold some of the functions which would transfer in time; parts of the organisation would be significantly smaller and would do a very different job. There were ongoing conversations around governance and financial flows. Work was also ongoing with providers to determine how they would work together differently going forward. The Value Circle had been commissioned to provide independent support and challenge in Leeds and that would be launched on 30 May.

Sara Monro would be fulfilling the role of Interim Chief Executive of Leeds Community Healthcare NHS Trust (in addition to her role at Leeds and York Partnership Foundation Trust), following the departure of Selina Douglas.

Leeds had not been successful in its bid in relation to co-morbidities work.

The 2025/26 Planning Submission had now been submitted (including a Leeds balanced Financial Plan for this year), but there was still much risk in the system, including to the performance trajectories.

TF asked about the likelihood of there being a “place” level in the new structure, and how relationships would be maintained with place partners, and TR responded that this was part of an ongoing conversation and there was a piece of “place” work happening at a national level. Where things were being “transferred out”, there would be an alignment of providers, partners and local authorities. In parts of London (which was covered by five ICBs), there was an expectation that a provider or local authority would step forward to be the integrator of certain functions.

JH commented that there would be a need to work closely with local authorities pending the changes in the law, and guidance was expected in relation to topics such as the need for a multi-agency child protection scheme, which would be at odds with the ICB footprint.

Referencing the Home First and Mental Health Transformation, PG commented that the third sector must take the learning, and local nuance must not be missed in the pursuance of a “broad brush” direction.

JB added that some of the support and functionality that the collaboratives were going to need had previously been in the ICB. He shared TR’s concerns over the uncertainty and challenge.

JM described the pace of the changes as “incredible”, noting the dissonance between the concept of “to be transferred” and the immediacy of the cuts. This would clearly have an impact on delivery and the population.

TR advised that work was being undertaken around the impact and risk assessments; risk would sit wherever change was necessary.

RC also saw a risk of elements becoming ancillary to providers’ “main jobs”, along with the loss of organisational memory. For years the organisation had been working towards more autonomy at place level, so she saw Leeds as being relatively well-placed to deal with this.

YK was concerned, moving forward, about the level of assurance around the impact on the people served by the ICB and its staff. Work had been undertaken on a good will basis for some time and there was no spare capacity left. The impact of losing valuable skills could not be underestimated, the scale was “terrifying”, and the changes were going at pace, leaving no time to think. There was a risk that it would not be possible to maintain the quality of what was being delivered.

KA suggested that there were opportunities for the Local Government Association and other local government networks to feed back on this from a risk perspective, and how best to mitigate the risks.

The Leeds Committee of the WY ICB:

- **RECEIVED** and **NOTED** the content of the Place Lead Update.

9 QUALITY AND PEOPLE’S EXPERIENCE SUB-COMMITTEE ASSURANCE REPORT

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

JH advised that the reports from the maternity and neonatal services CQC inspections at LTHT in December 2024 and January 2025 were still awaited, along with that from the perinatal services Rapid Quality Review (RQR) meeting.

The Leeds Committee of the WY ICB:

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

10 FINANCE, VALUE AND PERFORMANCE SUB-COMMITTEE ASSURANCE REPORT

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

TR thanked the Chairs of both sub-committees and the sub-committees themselves, and noted the importance of acknowledging that these conversations were taking place.

The Leeds Committee of the WY ICB:

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

11 END OF YEAR FINANCE UPDATE FOR 2024/25 AND PROGRESS ON PLANS FOR 2025/26

AC presented a report, firstly providing an update 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 were:

- The Leeds Health and Care Partnership (LHCP) was reporting a year end position of £11.4m surplus which is £13.8m ahead of plan;
- The financial position had 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 was due to redistribution of £20m surplus within the WY ICB position (not ICB in Leeds) to Providers, of which £5.8m had been for Leeds Teaching Hospitals NHS Trust (LTHT); and
- The month 12 position for the ICS had been a £0.1m surplus against a planned balanced position: a positive variance against plan of £0.1m.

Secondly, the report presented the financial plan for 2025/26. The key points to note were:

- The WY ICS, Leeds and Health Care Partnership and the ICB in Leeds had submitted a balanced financial plan for 2025/26;
- However, the West Yorkshire position included system risk held against WY ICB of £33.2m which was yet to be allocated out to organisations/places (planned to be allocated in Q1); and
- There were significant efficiency assumptions within plans including:
    - £426.1m across WY ICS;
    - £152.2m across the Leeds and Health Care Partnership; and
    - £30.7m for the ICB in Leeds.

(AS joined the meeting).

SM observed that it was important to note the optics and messaging around the stretch target; there would be an impact on staff and services, and providers would need to deliver a surplus in the interests of the system.

RC asked whether there was another way of achieving the required outcomes, and SM saw the position as complicated because it went back to a fair-shares allocation of resources for weighted population needs. She saw an imbalance in where the deficit sat across the footprint.

AC advised that the £33m stretch was allocated to places across a range of metrics. If the plan were not delivered, a significant amount of revenue and capital would be at risk.

RC remarked that it was impressive to see a balanced submission, and asked whether assumptions had been made about the staff pay award. AC confirmed that the assumption made had been 2.8%, but the award may turn out to be 3% or more.

The Leeds Committee of the WY ICB:

(1) **NOTED** the draft Month 12 financial position; and
(2) **SUPPORTED** the 25/26 financial plan submission.

(NN and KT joined the meeting.)

(The meeting was adjourned for a break at 2.40 pm and reconvened at 2.50 pm.)

12 NEIGHBOURHOOD HEALTH GUIDANCE AND LEEDS APPROACH 2025/26

NN presented a report and undertook a presentation outlining how the government had 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. The report provided a summary of that approach and how neighbourhood health was being implemented in Leeds, aligned to the agreed partnership transformation programmes.

RC noted that this approach was building upon what was already in place, and TR concurred that the initiative was starting from a good position, but this would still be a challenge.

PG welcomed the developing conversation and observed that the third sector brought intrinsic value to this.

TR commented that it would be important to build provider partnerships in to the specification, and there would be an expectation that this would help deliver this tangibly better.

KA suggested that it would be helpful to have some useful principles for defining neighbourhoods going into the next tranche of commissioning to support this work. TR added that undertaking the work would help inform the best way of doing it.

The Leeds Committee of the WY ICB:

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

(HL joined the meeting.)

13 OULTON MEDICAL CENTRE: APPLICATION TO TRANSFER SERVICES FROM SWILLINGTON HEALTH PRACTICE

KT presented a report outlining the application received from Oulton Medical Centre in October 2024 to transfer all services from their branch surgery at Swillington Health Practice with a view to closing the premises from 31 August 2025.

The report set out the circumstances and rationale of the application and details of the engagement exercise which had taken place.

RC asked whether the furore initially caused by the proposal had now settled down, and KT confirmed that this was the case.

YK commented that she understood the rationale for the proposal, but asked whether there was an alternative way of providing neighbourhood health in the area. KT responded that neighbourhood health would continue and home visiting would apply. GP services had not been in place at this site for some time; people were therefore used to travelling and there were other parts of the city where they had to travel further.

PG asked whether some outreach could be provided and added that it was important not to ask people what they thought but then do what had been planned anyway.

TR acknowledged that there was a tension between what would ideally be done and what was a viable approach; while this may not be ideal, the alternative would be worse. A piece of wider estate work was taking place across Leeds, under the One City Estate initiative.

RC referred to the Pharmacy Needs Assessment and suggested that something similar for GPs would be helpful.

KT advised that the practice was aware that it still needed to take some health interventions out into the area. JB added that there were also other practices in the area.

The Leeds Committee of the WY ICB:

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

14 CONSOLIDATING VCSE MENTAL HEALTH CONTRACTS – LEEDS HEALTH AND CARE PARTNERSHIP:
(a) COMMUNITY SUPPORT AND SOCIAL RECOVERY
(b) EMPLOYMENT AND PEER SUPPORT

(PG declared a direct financial interest in this item as a potential provider of the services and withdrew to the public gallery for the duration of the consideration of the item.)

HL presented reports to provide assurance in respect of the robust procurement and evaluation undertaken and the recommendations for the appointment of the respective providers in respect of each of the above services. The reports detailed the next steps in terms of contract award and mobilisation of each service.

RC commented that provider collaborative bids from the voluntary sector were not often seen elsewhere. TR concurred that this was quite innovative for Leeds and thought should be given to more opportunities of this type.

HL advised that transformation funding had been utilised to support providers to work differently.

The Leeds Committee of the WY ICB:

(1) **NOTED** the process undertaken and **CONFIRMED** its acceptance that a fair and robust procurement process had been followed for selecting a provider for VCSE Mental Health – Community Support and Social Recovery service;
(2) **CONFIRMED** that a contract may be awarded for this service under the Most Suitable Provider Process; and
(3) **APPROVED** the award of a contract for this service to the identified bidder.
(4) **NOTED** the process undertaken and **CONFIRMED** its acceptance that a fair and robust procurement process had been followed for selecting a provider for VCSE Mental Health – Employment and Peer Support service;
(5) **CONFIRMED** that a contract may be awarded for this service under the Most Suitable Provider Process; and
(6) **APPROVED** the award of a contract for this service to the identified bidder.

15 LEEDS HEALTH AND CARE PARTNERSHIP MEMORANDUM OF UNDERSTANDING (MoU) REVIEW

SB presented a report setting out how each of the five places that made up West Yorkshire, as well as the West Yorkshire Integrated Care System, had a form of MoU or partnership agreement in place. A recent review of the partnership agreements had found that review dates had passed for four of the places including the one covering the Leeds Health and Care Partnership. Given that significant changes to place governance arrangements and the workings of the partnership were due to take place over the coming year, it did not seem a good use of capacity to review the document strategically at this stage. The Leeds Place Accountable Officer had agreed to review the MoU and make necessary minor changes to it to ensure it reflected current arrangements.

The report set out the minor changes made to the document. Any future changes would 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 Foundation Trusts provided an overview of new collaborative working arrangements that the Health and Care Act 2022 had 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 had been made, and had been approved by the ICB Board on 17 December 2024. These changes, which were subject to an NHS England application for approval before becoming live, were set out in the report.

Through 2025/26 material changes were expected to the MoU and these would give due consideration to the recent findings and recommendations of the review of place partnership arrangements led by Antony Kealy, as well as the work towards strengthening the Provider Collaborative approach within the Leeds Health and Care Partnership. Review cycles beyond 2025/26 were recommended at three-yearly intervals.

The committee was requested to approve the minor amendments on behalf of the partner organisations and, once approved, an updated version would be posted on the West Yorkshire ICB website.

The Leeds Committee of the WY ICB:

(1) **NOTED** and **APPROVED** the changes to the Leeds Health and Care Partnership MoU, on behalf of the partners represented;
(2) **NOTED** the material changes to the Leeds Health and Care Partnership MoU that were expected during 2025/26, and the subsequent move to a three-yearly cycle of review;
(3) **AGREED** to ensure that partner organisations receive and are made aware of the changes to the MoU; and
(4) **NOTED** 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 17 December 2024).

16 ANNUAL GOVERNANCE REVIEW

SB presented a report advising that the sub-committees of the Leeds Committee of the West Yorkshire Integrated Care Board were reviewed on an annual basis, in line with their terms of reference, to provide assurance that they were fulfilling their duties and remained effective.

The report presented a review of the two sub-committees, Finance and Best Value and Quality and People's Experience, during the period 1 April 2024 to 31 March 2025. From 1 April 2025, the Finance and Best Value Sub-Committee had been superseded by the Finance, Value and Performance Sub-Committee and the subsequent annual report would therefore reflect the new remit and body of work undertaken in its first year.

The committee was requested to receive the annual reports as assurance that the sub-committees had fulfilled their function.

The amended Finance, Value and Performance Sub-Committee and Quality and People's Experience Sub-Committee terms of reference (ToR) were also submitted for approval.

The Leeds Committee Annual Report and amended ToR were submitted for review and comment, ahead of formal approval at the West Yorkshire Integrated Care Board meeting on 24 June 2025.

The Leeds Committee of the WY ICB:

(1) **RECEIVED** and **REVIEWED** the sub-committee annual reports;
(2) **APPROVED** the amendments to the sub-committee terms of reference; and
(3) **REVIEWED** the Leeds Committee Annual Report and terms of reference ahead of formal consideration by the WYICB Board on 24 June 2025.

17 HIGH LEVEL RISK REPORT: CYCLE 1 2025/26 (MARCH – JUNE 2025)

AS presented 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 had been reviewed by the Leeds Senior

Managers and then by the Quality and People's Experience Sub-Committee and the Finance, Value and Performance Sub-Committee.

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

The report included a summary of the Board Assurance Framework (BAF), which had been reviewed by the Executive Directors of the West Yorkshire Integrated Care Board in the current cycle and would be presented to the ICB Board meeting on 24 June 2025. The BAF provided 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 could be confident that the systems, policies, and people in place were operating in a way that was effective in delivering objectives and minimising risks.

In presenting the report, AS also provided an update in respect of action 78/24 (BAF risk 2.5) as referred to in minute 5 above.

CH noted that corporate risks were not reviewed in Leeds as part of this process. TR explained that risks were categorised as corporate risks (those affecting the ICB as a whole and managed centrally by the ICB, or in one place on behalf of the ICB), place risks (those affecting a place and managed in that place), and common risks (those affecting more than one place and managed individually in places or in one place on behalf of a number of places).

Noting that Risk 2016 (the risk of harm as a result of the longer waits being faced by patients and limited capacity for treatments) was marked for closure, TF expressed concern over the possibility of longer waits becoming the new norm; HL advised that this risk was being closed on the register as it would be managed by providers in the future.

The Leeds Committee of the WY ICB:

- **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.

18 ITEMS FOR THE ATTENTION OF THE ICB BOARD

SB summarised the content to be included in the committee's report to the West Yorkshire ICB on items to which it would alert the board, those upon which it would offer assurance, and those of which it wished to advise the board. These included:-

- Neighbourhood Health
- CQC inspection of maternity services
- People Story and themes
- Decisions in respect of the VCSE Contracts, the MoU, the terms of reference of the sub-committees and the committee
- The operational and financial planning submission for 2025/26 (including the stretch targets)
- The risk to the Leeds position under transformational change

19 FORWARD WORK PLAN 2025/26

The Leeds Committee of the WY ICB:

- **REVIEWED** the work plan and **NOTED** that further updates on the implications of changes to the ICB and the 10 Year Health Plan would be provided at its September meeting.

20 ANY OTHER BUSINESS

No items were raised.

21 DATE AND TIME OF NEXT MEETING

The next meeting of the Leeds Committee of the WY ICB would be held at 1.15 pm on Wednesday 3 September 2025 at HEART: Headingley Enterprise and Arts Centre, Bennett Road, Headingley, Leeds, LS6 3HN.

The meeting concluded at 4.00 pm.

Action Tracker

Leeds Committee of the WY ICB

Action No.	Meeting Date	Item Title	Actions agreed	Lead(s)	Accountable body / board / committee	Status	Update
			No current open actions.				
Completed Actions							
78/24	**26 February 2025**	**Risk Management Report**	To feedback and reflect on the Place contributions to BAF risk 2.5 – 'There is a risk of an inability to deliver routine health and care services due to the emergence of a future pandemic leading to substantial loss of life and failure to deliver key functions and responsibilities.'	**AS**	**LCICB**		Update provided at meeting 21/05/25.
09/24	**22 May 2024**	**Place Lead Update**	To circulate the link to the recent Joint Targeted Area Inspection (JTAI) report.	**HS**	**LCICB**		Circulated 17/06/24.
17/24	**22 May 2024**	**Risk Management Report**	To review the articulation of risks included on the Leeds Place risk register to ensure that descriptions and mitigations are person-centred and reflect strategic risks set out within the BAF.	**SR/TR**	**LCICB**		Risk Register reviewed by Directors on 21/08/24. Outputs are set out in the Risk Management Report (11/09/24).

Action No.	Meeting Date	Item Title	Actions agreed	Lead(s)	Accountable body / board / committee	Status	Update
30/24	**11 September 2024**	**Fairer Healthier Leeds – a Marmot City**	To add 'Fairer Healthier Leeds – a Marmot City' update to the work programme for September 2025.	**HS**	**LCICB**		Added to the workplan.
35/24	**11 September 2024**	**Assurance and update on our plan for financial sustainability in 24/25**	To add a further efficiency scheme assessment process update to the work programme for February 2025.	**HS**	**LCICB**		Added to the workplan.
49/24	**27 November 2024**	**People's Voice**	To add a communications and engagement update to the forward work plan, focusing on plans for coproduction in relation to changes to services.	**HS**	**LCICB**		Added to the workplan.
52/24	**27 November 2024**	**Place Lead Update**	To circulate the Leeds system response submitted to the NHS 10 Year Plan consultation.	**TR/HS**	**LCICB**		Circulated via email 05/12/24.
58/24	**27 November 2024**	**Risk Management Report**	To add the risk associated with the suspension of Tier 3 Weight Management services to the Leeds Place risk register.	**AS**	**LCICB**		Risk added. Detail provided in the risk management report (26/02/25).

Meeting name:	Leeds Committee of the West Yorkshire Integrated Care Board
Agenda item no.	8
Meeting date:	3rd September 2025
Report title:	Accountable Officer (Leeds) Report
Report presented by:	Tim Ryley Accountable Officer (Leeds)
Report approved by:	Tim Ryley Accountable Officer (Leeds)
Report prepared by:	Tim Ryley, Helen Lewis, Nicola Nicholson, Gina Davy

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

Previous considerations:

Reflects a wide range of pieces of work underway and discussed in a number of places including PLT, ICB Directors meetings and at West Yorkshire ICB Board.

Executive summary and points for discussion:

The overall theme is that the NHS is once again in a period of considerable change. The main content is an overview of the ten-year plan and a summary of some of our work in response in terms of neighbourhoods and provider partnerships. These changes are also reflected in the revised NHS planning guidance and new performance assurance framework. This year is also one of considerable leadership across the NHS in the city and there are people to thank for their service and welcome to our health & care partnership. The Committee is asked to note this change and consider implications for the committees work and the city's health and care agenda.

The report also provides an update on winter planning, neurodiversity and weight management.

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

☒ Improve healthcare outcomes for residents in their system

☒ Tackle inequalities in access, experience and outcomes

☒ Enhance productivity and value for money

☒ Support broader social and economic development

Recommendation(s)

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

a. Note and discuss the report
b. Consider implications for the Committee and Leeds Health & Care Partnership

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

Appendices
1. Letter from Rob Webster re Agreement of Leeds Place Plan for 2025-26 300625
Acronyms and Abbreviations explained
1.

What are the implications for?

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

1. Introduction

The overall theme of this update is that the NHS is once again in a period of considerable change. The main content is an overview of the ten-year plan and a summary of some of our work in response in terms of neighbourhoods and provider partnerships. This national feeling of change is also reflected in the revised NHS planning guidance and new performance assurance framework. This year is also one of considerable leadership across the NHS in the city and there are people to thank for their service and welcome to our health & care partnership. The Committee is asked to note this change and consider implications for the committees work and the city's health and care agenda

2. NHS Ten Year Plan

a. *The Plan*

i. The UK government published "Fit for the Future: 10 Year Health Plan for England" in July 2025. It is undoubtedly ambitious in the scale of transformation it envisages. Its intent is to describe the means by which the NHS will meet the evolving healthcare needs of the population and ensure its long-term sustainability.

ii. At the centre of the plan are three major shifts in how the NHS will operate:

- ***From hospital to community***: The plan envisions more care delivered closer to people's homes, including through expanded neighbourhood health services and facilities.
- ***From analogue to digital***: The NHS will embrace new technologies and innovations to streamline processes, empower patients, and improve care delivery.
- ***From sickness to prevention***: There's a strong focus on preventative care and tackling the root causes of ill health, aiming to reach patients earlier and promote healthier choices. This is closely linked to neighbourhood health.

iii. The plan describes a number of important pieces of work that will need to be implemented to enable these shifts to take place: the neighbourhood health service, digital transformation, prevention and health inequality, accountability, workforce, innovation and productivity.

iv. ***Neighbourhoods:*** The paper will describe in more detail our response to neighbourhood health care later. However, in summary, the Ten-Year Health Plan envisages a neighbourhood health service consisting of a network of integrated, multi-professional teams working in local communities, often co-located in new neighbourhood health centres (NHCs). These will be a **"**one-stop shop" for patient care, providing services like general practice, diagnostics, mental health support, and more, closer to people's homes. The plan aims to shift a larger proportion of health spending towards out-of-hospital care within the next 3-4 years and invest in more GPs and utilising online platforms like the

NHS App. Importantly for Leeds changing the GP funding formula to be more weighted to addressing health inequalities.

v. ***Digital transformation:*** The plan sets out the intention that the NHS App will be expanded and become the "front door" for all healthcare services, enabling patients to manage appointments, access health records, receive reminders and notifications, and engage in preventative care. There will also be a Single Patient Record (SPR), consolidating patient information and enabling real-time data sharing across different care settings to improve coordinated care. The plan envisages AI playing an important role in diagnostic and administrative tasks increasing productivity, and technology more broadly supporting remote monitoring across a range of care settings.

vi. ***Prevention and health inequalities*:** It is envisaged that a number of key policies to address obesity will be published and implemented in areas such as food advertising, free school meal expansion, and health food sales reporting for companies in the food sector. There is a strong emphasis on prevention efforts being focussed in areas with the worst health outcomes. There is a particular emphasis on areas including expanding access to weight loss medications and treatments and increasing childhood immunization rates and expanding access to cancer screening services. The plan also supports developing a new genomics population health service for early disease detection and personalized prevention.

vii. ***Workforce development:*** The plan is to focus more on increasing training places and retaining existing staff and shifting a greater proportion of staff into community and primary care. It is envisaged that this will reduce the reliance on international recruitment and eliminate expensive agency staffing by the end of this parliament. Alongside the general increase in training there is to be a particular focus on nursing apprenticeships and medical school places for underprivileged backgrounds.

viii. ***Innovation and productivity:*** There is a strong emphasis especially in the first three years of the plan on improving productivity. At the heart of this are plans to deliver a 2% year-on-year productivity gain for the next three years and ending the practice of providing additional funding to cover deficits. Alongside this there is an intention change funding flows to support the move towards prevention and neighbourhood health and multi-year budgets and outcome-based payment models to incentivize quality and efficiency.

ix. ***New Provider Models and Clearer Accountability:*** Alongside the previously announced merger of NHS England and refining the purpose of ICB's to be strategic commissioners, the plan describes the emergence of new provider arrangements, these include multi neighbourhood providers (MND's) and Integrated Health Organisation (IHO's) responsible for their population's health. These changes will include moving all NHS providers to a revised form of

Foundation Trust status. A lot of detail is still required in this area. Our initial response to this component of the plan will be described in more detail below.

b. Opportunities and Risks

i. From a positive perspective there are many parts of the plan that we would welcome in Leeds. The emphasis on addressing obesity is welcomed. The greater focus on prevention, the shifting of resources toward prevention and work to address inequality all reflect the existing partnership priorities. We would also welcome different approaches to funding flows and addressing funding of GPs to reflect inequality. The focus on outcome-based payment is also positive and in line with thinking in Leeds. In Leeds we have a strong record on supporting community-based approaches (Local Care Partnerships, PCN development, LCC priority wards etc.) and therefore welcome the emphasis on neighbourhood.

ii. However, there risks which have been raised both locally and nationally. These include:

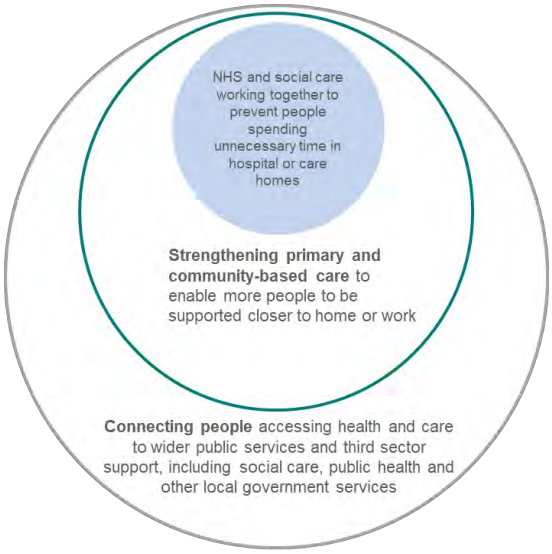
- The feasibility of implementing such radical changes within the ambitious timelines, especially given current financial pressures**.** Unlike previous plans there is no substantial new investment.
- Concerns about the reliance on unproven benefits of technology and AI, and the need for robust evaluation and investment in underlying infrastructure**.** In Leeds we would add the concerns around digital inclusion.
- The continued uncertainty surrounding social care funding and the lack of a detailed plan for its reform alongside the NHS plan.
- Potential for the plan to be overly centralized in its approach, despite claims of devolving power to local leaders, and a stronger emphasis on individual providers running counter to wider integration and prevention.
- The early focus on improving productivity and performance driving NHS organisations away from collaboration and a focus on prevention and inequalities.
- The danger that a Neighbourhood Health Service will be seen as a purely NHS vehicle and exclude wider partners thereby failing to address social determinants which will be critical to improving outcomes as described elsewhere in the plan.

iii. The Ten-Year Health Plan represents a significant commitment to reforming the NHS, aiming to deliver a more responsive, preventative, and patient-centred service for the future. However, successful implementation will depend on addressing these challenges and ensuring that the plan is translated into tangible improvements in care for all patients. The following three sections provider Board members with an update on three key pieces of work that are at the heart of the plan: neighbourhoods, partnership development and ICB changes.

3. ***Neighbourhood Health & Bid***

a. National approach

i. The national neighbourhood health guidelines, published in Jan 2025, provided a three-circle model for neighbourhood health (see diagram below). The model described the aims for all neighbourhoods over the next 5-10 years. 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.



ii. For 2025/26, through standardising and scaling the initial 6 components, systems are required to focus on the innermost circle to prevent people spending unnecessary time in hospital and care homes; these are: Population Health Management; Modern General Practice; standardising community services; neighbourhood multi-disciplinary teams; integrated intermediate care with a 'home first' approach; and urgent neighbourhood services.

b. Leeds Health and Care Partnership Transformation Programmes

i. Within Leeds, we have used our population health management approach, to support the identification of our partnership transformation programmes for 2025/26. These focus on those within the most complex needs and will develop more proactive approaches to care closer to people's homes working with neighbourhood MDTs. Through this we will test, learn and grow neighbourhood health approaches for population cohorts that sit within the inner circle of the neighbourhood health model.

ii. The initial national focus of neighbourhood health is on people with frailty and multiple long-term conditions. In Leeds, these population cohorts are the focus of HomeFirst Phase 2 proactive care project, which is working with all GP

practices and health & care partners to create models of care focusing their registered population.

iii. The health and care transformation programmes won't deliver the entirety of neighbourhood health and across Leeds we have begun work on capabilities that are also required to be in place for the successful delivery of Neighbourhood Health.

c. National Neighbourhood Health Improvement Programme (NNHIP)

i. Recognising the scale of the transformation required and the opportunity to share best practice from across the country, a National Neighbourhood Health Implementation Programme (NNHIP) has been launched.

ii. The NNHIP is a large-scale change programme to create exemplars and support places to embed the culture and capability required to deliver a Neighbourhood. They are aiming to work with 42 places across the UK taking a "Test-Learn-Grow" approach, initially focusing on adults with multiple LTCs to inform future strategy & policy including identifying barriers and enablers.

iii. By being on the programme Leeds would benefit from:

- Dedicated support including a national coach and networks to support peer learning and evidence, best practice and tools and materials
- Facilitated workshop (accelerating learning and networking) and be facilitated to plan and execute change
- Online information exchange and direct coaching.
- Explore new financial flows to incentivise achievement of key population outcomes

iv. *Leeds's NNHIP application*

Leeds applied to be part of the NNHIP with the DHSC/NHSE announcing which places have been successful on September 5th. Originally the approach for identifying neighbourhoods to be the initial focus was to use a methodological approach and look at multiple factors to arrive at a mix of places which have more developed ingredients and places with less, so that we can test, learn and grow. However, since it was a mandatory requirement to have Primary Care Networks (PCNs) and Clinical Directors formally sign-up, expressions of interest from PCNs who would want to be considered were sought to be part of 'wave 1.' The PCNs which came forward and met the requirements of the national programme were all included.

- HATCH LCP (encompasses the neighbourhoods of Chapeltown, Burmantofts, Harehills and Richmond Hill – with a focus on Chapeltown PCN).
- Inner South LCP (Beeston and Middleton and Hunslet PCNs). This area (Middleton) has also been identified as one of the Government's 25 trailblazer neighbourhoods to support community development.

- East Leeds Collaborative (includes Cross Gates PCN, Seacroft PCN and York Road PCN).

v. Within these identified neighbourhoods, 51.5% of the population live within IMD 1, aligning with Council priority wards and representing some of the city's most disadvantaged communities.

vi. We will look to test different and specific aspects of neighbourhood health. These include: creating neighbourhood health hubs, how to utilise existing assets as a neighbourhood network, further develop our physical assets, understand the core components for co-ordinating care based on individual need, identify where the duplication is now and what the different interventions look like that could better support people to help manage their multiple LTCs and wider needs, and build a multi-agency neighbourhood team including third sector partners, maximising general practice, Local Authority and the NHS input, which focuses on population needs and not individual organisations. We also want to test some of the proposed models (Single and Multi-Neighbourhood Providers) and develop our understanding of how to organise care under future contractual and financial incentive arrangements.

vii. Whether Leeds is successful or not in the application, we will still continue with the development and rollout of neighbourhood health across the city focusing on the partnership transformation programmes.

viii. *Neighbourhood health implications and opportunities for Leeds*

The national aim (and ours locally) is that neighbourhood health becomes the norm across all of Leeds and will be 'rolled out.' An element of the work is to understand what essential ingredients are needed, how they come together and proportions they are needed - based on the needs and make-up of local areas

ix. Neighbourhood health reinforces our approach to integrated working through partnership in Leeds and builds strong foundations we have in place such as the strong collaborative working approach across partners in Leeds within Local Care Partnerships (LCPs) and wrapped around Primary Care Networks (PCNs). There are lots of great examples of working in a neighbourhood way with a focus on the wider determinants of good health and wellbeing which are led by the Council and third sector partners. The neighbourhood health programme will build on this and incorporate into a wider approach.

x. Neighbourhood health reinforces our approach to integrated working through partnership in Leeds and builds strong foundations we have in place such as the strong collaborative working approach across partners in Leeds within Local Care Partnerships (LCPs) and wrapped around Primary Care Networks (PCNs). There are lots of great examples of working in a neighbourhood way with a focus on the wider determinants of good health and wellbeing which are led by the Council and third sector partners. The neighbourhood health programme will build on this and incorporate into a wider approach.

xi. The NNHIP is only one part of a wider neighbourhood health programme in Leeds – which is currently being defined and needs all partners and stakeholders to help shape. Though the NNHIP has specific criteria and focus, in Leeds we will determine our approach for our broader neighbourhood health programme taking a 'test, learn and grow' approach to rollout neighbourhood health and to include the wider determinants of health and wellbeing – Leeds Ambitions. This will ensure that all parts of Leeds will be reached but in a way that we can manage capacity without it becoming stretched, learn things for accelerating and scaling, move at pace with focus and tailor delivery based on the local needs and make-up.

4. Provider Partnership Work

a. Initial ask and link to Ten-Year Health Plan

i. In May 2025, Chief Executives/Accountable Officers of the statutory NHS organisations and the Council commissioned "thevaluecircle" to undertake an independent strategic review of options for establishing a provider partnership between the large statutory NHS providers in Leeds and the local authority

ii. The review is in response to:

- the imminent changes to the ICB and the national expectation that some functions will transfer to the statutory NHS providers and the local authority,
- organisations having to operate within reduced resources and the opportunity to identify where there are the opportunities to do things in a more integrated way

iii. The July publication of 10 Year Health Plan for England further highlights the importance and alignment of the review by setting out explicit expectations around:

- the responsibility of places to shift the focus and resources of care delivery from hospital to community, analogue to digital and from sickness to prevention
- the positioning of a neighbourhood health model at the centre of future health and care architecture
- the development of an integrated health organisation at place and its connection with the single and multi-neighbourhood delivery options

iv. Approach Taken

During June and July, "thevaluecircle" conducted one-to-one sessions with senior leaders from the statutory NHS organisations and the Council to gather insights and perspectives. "Thevaluecircle" have also had discussions with General Practice and the third sector. This has been complemented by a desk-based review of Leeds' partnership working documents, to build upon work to date.

v. Key messages emerging from the initial phase of engagement are as follows:

- *Strong foundations:* While there is a solid base to build upon, some fragmentation remains - highlighting the potential value of a provider partnership in creating greater integration.

- *Shared purpose:* Establishing a collective description of the vision with a strong emphasis on action, impact, and practical outcomes.

- *Clear governance:* Ensuring robust and transparent governance structures are in place, reducing duplication and bureaucracy.

- *Financial sustainability:* Working together to ensure we can have a financially sustainable system for the long-term.

- *Local authority role:* Clarifying and strengthening the role of the local authority within the provider partnership.

- *Integration with Primary Care and the Third Sector:* Exploring how a provider partnership between the statutory NHS organisations and local authority will work effectively alongside any other provider partnerships which may develop which include primary care and voluntary/community sector organisations.

vi. *Next Steps*

Towards the end of September, “thevaluecircle” will publish a draft report summarising key findings and setting out recommendations for this provider partnership. This will include a proposed 12- month implementation roadmap.

5. Our Response – ICB Changes and update

a. The Ask

In the middle of March, the government announced the merger and 50% reduction of NHS England and the Department of Health and Social Care, and a repurposing of ICB’s along with the same 50% reduction. ICB’s were to focus purely on strategic commissioning with some functions moving either to NHS regions or to providers. A draft ICB Blueprint (attached) set this out. The West Yorkshire ICB share of the national 50% reduction was a 45% reduction. This is a reduction in the workforce establishment of 1060wte to c650wte.

b. The Current Arrangements

In its first three years West Yorkshire ICB has taken a very forward-looking approach. It has delegated a significant amount of its available funding, decision making, functions and staff to each of the five places within West Yorkshire in line with their population size. Each place has an executive accountable officer (Place) who sits on the ICB Board and there is a place committee of the Board that ensures the functions and responsibilities of the ICB are discharged in that place. In Leeds c£1.9bn of NHS funding comes through this arrangement with a team of about 240 people. The Leeds Committee of the ICB includes representation from all health & care partners including Leeds City Council and has an Independent Chair. This bold approach has been nationally recognised. However, the requirement to form a different type of organisation, a strategic commissioner, and to dramatically reduce

our workforce rapidly, alongside the emergence of provider partnerships and neighbourhoods has meant that a different approach is being developed.

c. Work To Date

During April and May, the ICB established a future design group, and the executive team operated as a programme board and designed at pace a revised ICB operating structure within the £19 per head envelope. We have also set up a Transition Committee which ensures non-executive oversight of the work, and which includes wider partner members to ensure the ICB changes are considered in light of other changes and wider considerations. This committee meets monthly. The executive team at least weekly. During June, July and August we have run a series of scenario testing workshops on the broad model with senior staff and partners and run 12 drop-in sessions with staff to describe the overarching model. We have used the delays to further modify our proposals in light of this work.

d. Summary Proposal

i. ICB's will become strategic commissioners. The specific nature of strategic commissioning is set out in the national diagram below.

ii. The ICB will have three core functions. It will be the **strategic commissioner** for West Yorkshire, **convenor** of the Integrated Care System, and **integrator** of providers and services:

- **Strategic commissioner –** the ICB will ensure that services are planned and delivered in a way that meets the needs of the population both now and in the future. It involves a systematic approach to defining and measuring outcomes, using data and intelligence to make informed decisions about resource allocation and service delivery.

- **Convenor** - the ICB will bring together all partners in the Integrated Care System to agree and deliver its five-year strategy and ensure delivery of local and national priorities by working together effectively and taking mutual responsibility for the results. It will co-ordinate the governance of the partnership and its wider arrangements for collaboration, within a framework of distributed leadership.

- **Integrator** – Place-based integrator teams will assess population health risk and facilitate place provider partnerships to co-design new integrated models of care, and work with partners on implementation of local pathway changes and neighbourhoods. In time this function will move to local provider partnerships.

iii. In practice the proposal this will mean that a number of functions currently operated at place level including among others All age Continuing Health Care, Medicines Optimisation and Communication will be consolidated. There will be three place teams, one covering Leeds, one covering Bradford, and then collectively one covering Calderdale, Kirklees and Wakefield. These teams will be much smaller with somewhere around 40 staff each. ICB Boards will be much smaller and more akin to existing NHS Boards without wider partnership members, though in areas such as West Yorkshire with a mayor, the WY Mayor will be on the ICB Board. It is unlikely that there will be a Leeds committee in its current form and work is still underway to understand revised financial flows and delegation.

e. ***Timelines/Delays***

i. The original plan was that these changes and reductions were to happen during the third quarter of this financial year. Proposals were submitted by West Yorkshire ICB to NHS England built on detailed proposed design structures by the end of May with a view to start consultation in early July. However, whilst the ICB is ready there are three conditions which the ICB Board have insisted are required to be met that are outside local decision-making powers:

- That the national approach to resourcing the redundancies has been agreed, and the funds are available. The national estimate is somewhere between £500m and£1bn. Clearly the ICB cannot proceed to offer redundancy without understanding how it will be paid for.

- The new NHS Regional Blueprints are published. Unless we are clear what functions are transferring to regions and how this affects relevant staff groups as well as our own structures, we would be in a difficult position to consult on a structure. At the time of writing these are still not agreed.

- Moderation is complete. All 42 ICBs submitted proposals at the end of May for moderation and a compliance check with the asks. It is clear that there was considerable variation in approach and a number of issues were identified. Again, these could materially impact on both our structures and our cost envelope. These are not yet resolved.

ii. The ICB in West Yorkshire have, along with some others, therefore paused the launch of a consultation and the implementation indefinitely. We anticipate the minimum time frame from the start of any consultation until completion of all the changes would be c8months.

f.*Opportunities and Risks*

i. Clearly there are significant risks in the scale of changes the NHS nationally and locally are going through. In many ways the ICB will be a new organisation having to operate in a different way. However, in the delays whilst deeply frustrating and hard for staff, there are opportunities to test thinking with wider partners and colleagues which will further mitigate these risks.

ii. Positively West Yorkshire ICB will continue to maintain some presence in Leeds and unlike other ICB's nationally recognises the importance of places. The expectation is that we will continue to deploy resources through places as previously even if the mechanics behind this may evolve. The early work to develop local provider partnerships should be seen as an opportunity for NHS in Leeds to continue to shape services alongside Leeds City Council. However, the changes to the ICB give an added impetus to this work. It will be important to ensure that we work through the detail over the coming months and during the next year secure opportunities and mitigate risks.

6. Revised NHS Performance Assessment Framework

a. **The Approach.** NHS England has released the NHS Performance Assessment Framework (NPAF) for 2025/26. It replaces the National Oversight Framework in setting out how success and areas for improvement are identified across Systems. The Framework applies to all Integrated Care Boards (ICBs) and Trusts, who provide services. The intention is to provide consistent assessment of performance to enable targeted improvement. It will work alongside the Strategic Commissioning Framework to support ICBs strengthen their role as commissioners and providers with capabilities to drive the 3 shifts. The final version of the framework was released in July after the publication of the 10-year Health Plan.

b. **Assessment.** Assessment will metric based on four domains: operating priorities, quality and safety, public health & outcomes and finance and productivity. Each organisation will be put in segment 1(High Performing) to 5 (Poorly Performing). Organisations in segment 4 will have a diagnostic review to see if they need to move into segment 5 and be placed in the Recovery Support Programme. It is anticipated that the opening segmentation for all trusts will be formally published shortly. ICB's are not being segmented this year due to the organisational change programme.

7. NHS Planning Guidance

a. West Yorkshire ICB have formally reviewed the Leeds plans for this year and agreed them. The letter from Rob Webster the Accountable Officer is attached for information (appendix 1).

b. Looking forward. draft planning guidance has recently been sent to the ICB and other NHS organisations across England ahead of anticipated published guidance in September. This is a positive improvement in timeliness on recent years and to be welcomed. The requirement will not only be for annual plans but for revised five-year plans to be developed in the autumn.

c. The expectation for these plans does not retain a focus on being a system submission which carries some risks. There will be a stronger requirement on testing affordability and deliverability within the available resources at organisational level. Boards are expected to play an active role in setting direction, reviewing drafts, and constructively challenging assumptions – rather than simply endorsing the final version of the plan.

d. At the same time NHS England is continuing to work on developing more detail on initial priorities that emerge from the NHS Ten Year plan and these will inform the guidance that is expected including on where resources are allocated. We will update the committee further at our October meeting.

8. Winter Planning

a. The system continues to work to develop its winter plans, while mindful that we treat surge planning as a year-round activity given that we have seen pressures already earlier in the year. System Partners are identifying schemes that can help ensure flow through existing resources as effectively as possible, supplementing assessment and care capacity wherever possible. We will also be repeating our successful partnership with the GP Confederation to provide additional appointments for children and adults with respiratory conditions, which we know can increase rapidly once children go back to school in the autumn and which can contribute significantly to pressures in Emergency Department and Primary Care.

b. It is likely that this year will be a period of intense scrutiny from NHSE and ministers, and there have already been a high number of overlapping asks and metrics around Urgent and Emergency Care, Discharge and Winter Planning that have gone to all partners. We will continue to work collaboratively both within Leeds and West Yorkshire to do what we can to provide assurance and mitigation, but also need to recognise the significant financial risks facing all partners across the City as we go into this challenging period. We are also aware that industrial action from resident doctors may continue throughout this period and be supplemented by action by other professional groups. This will add further to system pressures. Patient safety remains our highest priority and we continue to do all we can to improve system flow and unnecessary bed days in hospital.

9. Neurodevelopment and Weight Management Updates.

a. In line with the national growth in demand for assessment and support for people with suspected neurodiversity (Autism and ADHD), the Leeds Place has seen an exponential growth in demand and spend on Right to Choose provision. This national legislation allows people to choose any national provider that has a contract anywhere in the country for assessment for their mental health conditions. Because the national criteria for referral are quite loose, and we do not have a robust interface service in place for all ages, we have seen a continued growth in GPs sending people to a multitude of providers. The West Yorkshire and Leeds team have carried out a number of actions to try to improve the value for money in this area, as while we fully recognise that a diagnosis can be life changing for some people, unless people are accessing Medication for ADHD, the diagnosis in and of itself does not necessarily bring additional support to help people navigate the difficulties they can sometimes face.

b. In Leeds we have developed a service for adults wishing to consider a referral for an ADHD diagnosis. This is entering its 3rd month, and we will soon be able to see what benefits it has brought to people in understanding and support, and how this impacts on whether or not they choose to continue to a diagnosis. We have also contributed to a West Yorkshire process for accreditation of local providers, so that we are more assured of quality, data, outcomes and the ability of partners to recognise each other's assessments, thus reducing service gaps and increasing the confidence of primary care to provide shared care for people needing ongoing medication. We are working with our NHS Trusts to ensure our outstanding longest waiters are offered choice of the new capacity, to try to equalise waiting times and to continue to validate who is actually waiting and who has been seen elsewhere. LCH are working with Northpoint to review the children and young people on their waiting lists, and we are working with Education colleagues in Leeds City Council to further develop our integrated support offers for children and families, so that there is no need to wait for a formal diagnosis to help address the needs that have been identified. This is a long term and national issue, and we are doing our best to negotiate it locally. We are also aware of the poor health outcomes that some people with neurodiversity can face, and this important work therefore also ties in with our PLT priority around children with complex needs and wider system work on proactive care.

c. Access to weight management services and drugs is a similar challenge, where the growth in awareness and a wish to access medication for obesity alongside the growing numbers of people who are obese is creating similar pressures. In Line with NICE, the WY Transformation Committee has confirmed that access to specialist weight management services will be in line with the national criteria for access to Tirzepatide, which is a significantly higher threshold than our previous specialist weight management offer. LCH has worked incredibly hard to change their model and increase productivity, so we are now able to offer more treatment within the same envelope, but the capacity is still completely outstripped by the demand. We are aiming to meet the numbers of people accessing medication

described by NICE, and we are also working with PCNs to roll out primary care-based models which may well be the future for delivery for many patients. We have significant spend with a national company Oviva, who has strongly marketed its weight loss services in West Yorkshire and are trying to ensure we have a consistent and aligned offer with the same thresholds for all providers now our commissioning policy has been signed off. None of this addresses the gap between the considerable demand for weight management services and the ability of the ICB to fund them, but we are also focusing on ensuring people are aware of all the various national and other offers available to them. We recognise that there are strong links to neighbourhood health and proactive care in this area.

10. Personnel changes

a. Since our last meeting there have been significant changes in the leadership across Leeds announced:

- Dame Linda Pollard has retired as Chair of LTHT and Anthony Kildare started as the incoming Chair at LTHT from the 1st of August.
- Brodie Clarke has retired as Chair at LCH. Subject to the partnership review above, x has taken on the role as the Interim Chair.
- Dr Sara Munro is now the interim Chief Executive at LCH as well as continuing as Chief Executive at LYPFT again whilst the partnership review above is taking place.
- Dr Phil Wood has announced his plans to retire as CEO of LTHT and Clare Smith, Chief Operating Officer and Deputy Chief Executive at LTHT has been appointed as Chief Executive at York and Scarborough NHS Trust.

b. I would like to acknowledge the huge contribution to the city those who are retiring or moving on have made to the city both within their leadership of specific organisations and in the creation of the Leeds Health & Care Partnership. We wish them well in whatever comes next.

c. We also want to welcome those who will be joining Leeds and look forward to working with them.

11. Recommendations

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

1) Note and discuss the report
2) Consider implications for the Committee and Leeds Health & Care Partnership.

Committee Escalation and Assurance Report – Alert, Advise, Assure

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

Date of meeting: 16 July 2025

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

Date of meeting reported to: 3 September 2025

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

Key escalation and discussion points from the meeting
Alert:
Quality Highlight Report The Sub-Committee was informed that Wheatfields Hospice remained under enhanced monitoring following its closure in August 2024. The final report following an unannounced Care Quality Commission (CQC) visit in May 2025 was pending. Staffing had been reported as an ongoing concern. Assurance was given that regular engagement with hospice leadership and the Sue Ryder Regional Chief Nurse was ongoing. **Quality Highlight Report – Maternity and Neonatal Services Update** The Sub-Committee received an update on the CQC final report into maternity and neonatal services which had been published on 20 June 2025. The maternity service had received an overall rating of Inadequate and would be part of a national maternity investigation commencing in September 2025. Risk stratification processes for neonatal babies were reported as a key factor in the rating. The long-term mitigation of the risk had been dependent on the proposed centralisation of maternity and neonatal services at the St James Hospital site as part of the rebuild programme, which had since been delayed. Members were informed that a Quality Improvement Group (QIG) had been established and immediate actions were underway. NHS England (NHSE) was seeking assurance via the monthly QIG meetings with national clinical leaders in attendance. In addition, the Leeds ICB Quality team continued to hold bi-monthly Perinatal Surveillance meetings with oversight of all perinatal and neonatal activity and performance. The Trust was also working closely with the Maternity Safety Support Programme (MSSP). It was agreed that the QPEC would seek further assurance on the quality improvement work via regular updates in the Quality Highlight Report, with a verbal update being provided by the Chief Nurse at Sub-Committee meetings.

Advise:

Healthwatch England Complaints Report
The Sub-Committee received the key findings and recommendations of the Healthwatch England (HWE) Complaints Report. The report had found that in 2024, 56% of people who had experienced poor care had taken no action and only 9% had made a formal complaint. When the survey had previously been conducted in 2014, 39% of people had said they had made a formal complaint when asked a similar question. 56% of people who had made a formal complaint had been dissatisfied with both the process and the outcome of their complaint. In addition, people had reported their experience of long waits for responses, with ICBs taking an average of 54 working days to respond to complaints they handled as commissioners of NHS services.

The report identified education and employment as being key factors in how confident people felt to make complaints when they had received poor healthcare. Reduced budget allocations to local authorities to arrange statutory NHS complaints advocacy were also reported as key factors.

The report included 12 recommendations including one recommendation that NHSE should require NHS bodies to collect wider data about complainants, such as gender, ethnicity and disability, to ascertain who does and does not submit complaints.

The Sub-Committee was assured that Healthwatch Leeds was working with system partners to implement the recommendations. However, the Sub-Committee agreed to make the Leeds Committee aware of the need for a collective complaints report for Leeds, which would provide greater assurance.

Leeds Community Equipment Services (LCES)
The Sub-Committee received an update on the review of LCES following initial concerns regarding delays in allocating equipment to children. Members were informed that service activity for adults and children in 2024/25 had decreased whilst waiting times had increased. This was reported as being due to the increasing complexity of requests and service delivery issues around staffing and stock availability.

Following the review, a rolling programme of service and system development workstreams had been implemented and was progressing alongside a planned relocation programme to a larger estate. A Partnership Board comprising representation from system partners had been established to oversee the development work.

The Sub-Committee requested further assurance at its next meeting regarding the process of allocating equipment and the management and escalation of the associated risks.

Quality Highlight Report
The Sub-Committee was informed that Ofsted had conducted a short Inspecting Local Authority Children's Services (ILACS) inspection of the Leeds Children’s

Social Work Service (CSWS), which had concluded on 4 July 2025. The inspection was the first for the CSWS under the revised framework.

Assure:

Risk Management Report (Leeds Place risks 2494, 2415)
The Sub-Committee received the Leeds Place risk report for risk cycle 2 of 2025/26. Nine high-scoring risks were aligned to the QPEC and two risks were shared with the Finance, Value and Performance Sub-Committee.

Two risks had reduced risk scores since the previous cycle. Firstly, 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. The risk score had been reduced from 20 to 16 due to improved partnership working being reported by the risk owner. Secondly, risk 2415 – There is an increasing risk of widening health inequalities and poorer health outcomes across Leeds due to the reduction or loss of Voluntary, Community and Social Enterprise (VCSE) services – had a reduced risk score from 16 to 12 due to work being progressed to align future funding of VCSE organisations in Leeds with principles set out in the position statement around joint commissioning and longer-term contract arrangements.

The Sub-Committee was informed of an emerging risk – Risk of detrimental effects on young people due to delays in carrying out health assessments on looked after children in care. The new risk had been added to the Leeds Place risk register.

Members discussed risk regarding maternity and neonatal services in Leeds. Assurance was given that the risk had been added to the WYICB corporate risk register and the Maternity Population Board risk register.

Quality Highlight Report – Laboratory Information Management System (LIMS)
The Sub-Committee received an update for assurance on the LIMS pathology incident review. The review findings indicated that, while there had been technical testing of the new system and its middleware prior to implementation, there had been limited clinical input. In addition, the review had found that there had been insufficient end-to-end testing. A helpdesk had been set up in response to the incident and had received 43 escalation emails. Once reviewed, it had been found that there were no incidents of specific clinical harm.

The Sub-Committee was assured that lessons had been learned and applied in the second release of the LIMS implementation. Weekly meetings had been held with identified stakeholders to work through different clinical impacts, maximum end-to-end testing had been carried out and a single-route mechanism had been set up for Primary Care to escalate issues.

Committee Escalation and Assurance Report – Alert, Advise, Assure

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

Date of meeting: 23 July 2025

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

Date of meeting reported to: 3 September 2025

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

Key escalation and discussion points from the meeting
Alert:
Financial Position Update for Month 3 The Sub-Committee received the Month 3 financial position for the Integrated Care System (ICS), Leeds Health and Care Partnership (LHCP) and the ICB in Leeds. The ICB in Leeds reported a breakeven financial position which was in line with plan. The main overspending areas within the ICB were Mental Health (MH) and Independent Sector (IS) Acute Services, offset by underspends in GPIT and running costs. Work was ongoing to agree IS and ND Indicative Activity Plans (IAPs) with providers. While the ICB was broadly on plan to deliver £31m in savings, both IS Acute Services and MH services continued to be key risks in the delivery of the efficiencies plan. The Sub-Committee was informed that the ICB had an additional stretch target of £2.5m which represented its share of the ICS stretch target of £33m, with the three NHS Providers in Leeds having a stretch target of £2.7m in total (£0.9m each). The LHCP had reported a Month 3 position of £12.7m deficit which was circa £1m behind plan. The deficit was driven by the position in Leeds Teaching Hospitals NHS Trust (LTHT). A national deep dive of the LTHT plan had been carried out at the end of June 2025 due to the level of risk in delivery of efficiency plans. The Sub-Committee wished to alert the Leeds Committee to the scale of risk to the delivery of the 2025/26 financial plan and efficiencies.
Advise:
Leeds Quarterly Performance Report The Sub-Committee received updates on the key performance metrics aligned to the NHS operational planning guidance 2025/26, the NHS Oversight Framework and LHCP Transformation Programmes. Members discussed the need to further develop performance reporting in light of the current organisational restructure and the pending regional blueprint.

The Sub-Committee discussed the impact of the three shifts within the NHS Ten Year Plan with regard to the LHCP five transformation programmes. Assurance was given that the three shifts were fully embedded in the transformation programmes. With regard to the shift from analogue to digital systems, the Sub-Committee noted that the Leeds Committee had oversight of the digital agenda and was best placed to discuss this within the context of the NHS Ten Year Plan.

Action Tracker
Further to its discussion at its previous meeting, the Sub-Committee again discussed the funding decision made at Partnership Leadership Team (PLT) around the Enhance programme. A further discussion regarding the programme would take place outside of the Sub-Committee meeting to clarify the position fully.

Adult Neurodivergence Services: Deep Dive
The Sub-Committee received the deep dive review into adult neurodivergence (ND) services which highlighted risks and issues in connection with the local pathways for people seeking assessment and support related to potential Attention Deficit Hyperactivity Disorder (ADHD) or autism. There was significant financial risk in year due to: increased demand for formal diagnoses of autism and ADHD; the lack of a national tariff for Right to Choose (RtC) providers; and a significant double running issue.

A number of identified workstreams within the adult ADHD pathway-related work programme were being developed. These included a West Yorkshire (WY) ND Commissioning Policy and ND provider accreditation, as well as a needs-led early intervention pilot, or Front Door Hub, with the GP Confederation. Assurance was given that early support for adults with suspected ADHD represented an improved offer which could meet people's needs and reduce demand for formal assessment. In addition, the Hub would collate health inequalities data which was not currently available from private providers.

Continuing Healthcare: Deep Dive
The Sub-Committee received the All Age Continuing Care Service (AACCS) deep dive review. In all, 15 projects were being undertaken within the 2025/26 AACC programme of work to improve the quality of patient care and achieve a financial efficiency of circa £3.7m. A number of financial efficiencies had already been achieved including £2.8m saved via local authority negotiations with care homes and home care providers.

The programme of work aimed to improve the quality of the patient journey as well as improving data collection. Assurance was given that all of the 15 projects required the completion of an Equality Impact Assessment (EIA). The Sub-Committee was fully assured that the AACCS work programme would not lead to funding reductions for people receiving full care. However, the Sub-Committee wished to make the Leeds Committee aware of the significant risk to the work programme as a result of the organisational restructure of the ICB. This was due to variability and a lack of clarity around how Places would negotiate locally within the WY model of continuing healthcare.

Assure:
Risk Management Report Members received a report on the Risk Register for risk cycle 2 of 2025/26. Four risks were aligned to the Finance, Value and Performance Sub-Committee and one risk was shared with the Quality and People's Experience Sub-Committee (QPEC). There had been no change to the risk scores of the high-scoring risks around financial challenges. The Sub-Committee discussed risk 2415 – There is an increasing risk of widening health inequalities and poorer health outcomes across Leeds due to the reduction or loss of Voluntary, Community and Social Enterprise (VCSE) services. The risk score had decreased from 16 to 12 due to work being progressed to align future funding of VCSE organisations in Leeds with principles set out in the position statement around joint commissioning and longer-term contract arrangements. Members noted that two key areas of financial risk were continuing healthcare and ND assessment services, both of which had been subject to scrutiny at the Sub-Committee meeting. In the light of these concerns, and the continued uncertainty around the delivery of financial breakeven for 2025/26, the Sub-Committee agreed that it was partially assured of the effective management of the risks, controls and assurances in place.

Meeting name:	Leeds Committee of the West Yorkshire Integrated Care Board
Agenda item no.	11
Meeting date:	3 September 2025
Report title:	Financial Position Update
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 Performance Sub Committee
Directors Team Meeting

Executive summary and points for discussion:

The purpose of this report is to provide an update to the Committee on the Month 4 financial position of the ICB in Leeds, the wider Leeds Place and West Yorkshire Integrated Care System (ICS) Position. The key points to note being:

- At month 4 the ICB in Leeds is reporting a year to date (YTD) breakeven financial position. However, this is c.£1.8m behind plan at month 4, mainly due to the stretch target now being included within plans.

  The ICB in Leeds is still forecasting a balanced full year forecast position to deliver the stretched plan of a £5.2m surplus (including £2.5m stretch for the ICB in Leeds, £2.7m stretch across LTHT, LYPFT and LCH). However, there are significant risks to delivery given the YTD position in the ICB and Providers.

  The main overspending areas within the ICB were within Mental Health and Acute Services offset by underspends in primary care and running costs.

- The Leeds Health and Care Partnership is reporting a month 4 position of £18.3m deficit which is c.£7m adverse to plan. This is driven by the position in the ICB in Leeds (£1.8m) and LTHT (£5.6m).

- The month 4 year to date position for the WY ICS was a £36.8m deficit against a planned £24.9m deficit; an adverse variance against plan of £11.9m. The month 4 adverse variance of £11.9m has deteriorated from the adverse variance at month 3 of £4.0m. The deterioration in month is driven predominantly by £3.7m cost of industrial action which will not be covered by national funding, and £3.2m of pay overspends.

Which purpose(s) of an Integrated Care System does this report align with?
☐ Improve healthcare outcomes for residents in their system ☐ Tackle inequalities in access, experience and outcomes ☒ Enhance productivity and value for money ☐ Support broader social and economic development
Recommendation(s)
The Leeds Committee of the West Yorkshire Integrated Care Board is asked to: • Review and comment on the ICB in Leeds month 4 position including key risks and mitigations • Review and comment on the Leeds Place month 4 position • Review and comment on the West Yorkshire ICS Financial Position • Consider any specific areas that they wish to escalate to other Committees or forums for follow up
Does the report provide assurance or mitigate any of the strategic threats or significant risks on the Corporate Risk Register or Board Assurance Framework? If yes, please detail which:
The report provides an update in terms of financial sustainability and deliver of in year financial plans.
Appendices
N/A
Acronyms and Abbreviations explained
N/A

What are the implications for?

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

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NHS West Yorkshire
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NHS West Yorkshire ICB

Leeds Place Financial Position

Month 4 2025/26

Contents

ICB in Leeds Integrated Care Board (ICB) Month 4 Financial Position

ICB in Leeds Month 04 - Breakeven forecast

NHS West Yorkshire Integrated Care Board

	YTD Plan	YTD Spend	YTD variance	Annual Plan	Forecast Spend	Annual Variance
	£000	£000	£000	£000	£000	£000
RESOURCE						
Allocation - Programme	589,815	589,815	0	1,766,495	1,766,495	0
Allocation - Primary Care Co-Commissioning	62,818	62,818	0	188,453	188,453	0
Allocation - Running Costs	2,034	2,034	0	6,103	6,103	0
Allocation - Specialist Commissioning	0	0	0	0	0	0
TOTAL RESOURCE	**654,667**	**654,667**	**0**	**1,961,050**	**1,961,050**	**0**
SPEND						
Acute	319,589	320,619	(1,031)	958,766	959,753	(987)
Mental Health	103,935	104,302	(367)	311,574	313,813	(2,239)
Community	69,464	70,151	(687)	210,780	211,245	(465)
Continuing Care Services	30,673	30,700	(26)	92,020	92,125	(105)
Prescribing and Primary Care	62,035	61,764	271	186,066	185,434	632
Primary Care Co-Commissioning	64,464	63,551	912	193,391	192,402	989
Other	2,144	1,974	171	6,433	5,945	487
Specialised Commissioning	0	0	0	0	0	0
Programme Reserves	(1,405)	150	(1,555)	(9,282)	(9,773)	491
Subtotal Programme spend	**650,899**	**653,211**	**(2,312)**	**1,949,747**	**1,950,945**	**(1,198)**
Running Costs	2,034	1,549	485	6,103	4,905	1,198
TOTAL SPEND	**652,933**	**654,760**	**(1,827)**	**1,955,850**	**1,955,850**	**0**
Surplus / (Deficit)	**1,733**	**(94)**	**(1,827)**	**5,200**	**5,200**	**0**

ICB in Leeds Month 04 – Key headlines

NHS West Yorkshire
Integrated Care Board

At month 4 the ICB in Leeds is reporting a year to date (YTD) breakeven financial position. However, this is c.£1.8m behind plan at month 4, mainly due to the stretch target now being included within plans.

The ICB in Leeds is still forecasting a balanced full year forecast position to deliver the stretched plan of a £5.2m surplus (including £2.5m stretch for the ICB in Leeds, £2.7m stretch across LTHT, LYPFT and LCH). However, there are significant risks to delivery given the YTD position in the ICB and Providers.

The main overspending areas within the ICB were within **Mental Health and Acute Services** offset by underspends in **primary care and running costs**.

- Mental Health has a forecast overspend by year end of £2.2m which is driven by continued demand pressure on Neurodiversity services (£5.5m-£7.1m potential risk) and a high-cost package of c£1m, both of which are partly offset by non-recurrent benefits.
- Acute Services are showing a forecast overspend of £1.0m, based on Q1 data, due to increased independent sector spend on elective services. This is potentially at further risk if indicative activity plans sent to IS Providers is not adhered to, including plans to equalise waiting times in the independent sector relating to cataracts.

These are both being offset by underspends within:

- Primary Care is showing a forecast underspend of £1.6m. This is due to identification of further efficiency savings of £0.5m within GPIT which is included within our stretch efficiency plan and non-recurrent benefits.
- Running costs are showing a forecast underspend of £1.2m against budget because of the vacancy freeze during the organisational change process. The ICB in Leeds has also received a share of the WY running costs underspend (£0.7m).

ICB in Leeds Month 04 – Efficiencies

NHS West Yorkshire
Integrated Care Board

Efficiencies	YTD Plan	YTD Saving	YTD Variance	Annual Plan	Forecast Saving	FOT Variance
	£000's	£000's	£000's	£000's	£000's	£000's
Acute	3,109	300	(2,809)	9,336	6,036	(3,300)
Community	1,344	1,180	(164)	4,055	4,455	400
Continuing Care Services	2,228	1,244	(984)	6,714	3,746	(2,968)
Mental Health	1,916	1,105	(811)	5,767	9,439	3,672
Primary Care	3,332	3,179	(153)	10,000	10,998	998
Other	0	485	485	0	1,198	1,198
Total	**11,929**	**7,493**	**(4,436)**	**35,872**	**35,872**	**0**

At month 4 the ICB in Leeds is reporting behind plan YTD by £4.4m on efficiency delivery but is forecasting delivery of plan by year end.

The YTD adverse variance is due to two main areas within **Acute Services and Mental Health:**

- Acute service efficiency is impacted by the new Independent Sector contracts not being agreed until the start of Q2, therefore some elements will not be delivered until later in the financial year.
- Mental Health Services are showing behind plan at M4 due to increased Neurodiversity spend but the ambition is that we will recover some of the position due to the setting of IAPs, front door hub pilot, commissioning policy and accreditation process.

ICB in Leeds Month 04 – Risks and mitigations/actions

NHS West Yorkshire
Integrated Care Board

Key risks

• Delivery of efficiency plan, most notably IS Acute plans and ND being the current highest risks.

• Delivery of ICB share of £5.2m Place stretch target (£2.5m) – still reviewing potential opportunities, but some upsides expected to support delivery e.g. running costs, are currently being offset by cost pressures.

Key actions

• Focus on delivery of overall efficiency plan (now £35.8m). Key areas of focus currently include:

- Agreement and delivery of IS Acute Indicative Activity Plans (IAPs)
- Agreement and delivery of ND IAPs including front door hub, commissioning policy, accreditation
- Weight Management – Commissoning policy and IAPs
- Prescribing and CHC efficiencies
- Identify further opportunities to deliver £2.5m stretch

• Focus on supporting system transformation priorities to create long term financial sustainability

Leeds Place
Month 4 Financial Position

Leeds Place - Month 04 Financial Position

NHS West Yorkshire Integrated Care Board

Organisation	YEAR TO DATE - M4 I&E reported Month 4 25/26			FORECAST - M01 to M12 I&E forecast		
	Plan £m	Actual Surplus / (Deficit) £m	Reported Variance £m	FOT Plan £m	FOT Surplus / (Deficit) £m	FOT Variance £m
Leeds ICB	1.7	(0.1)	(2)	5.2	5.2	0
Leeds and York Partnership NHS Foundation Trust	0.0	0.1	0	0.0	0.0	0
Leeds Community Healthcare NHS Trust	0.0	0.1	0	0.0	0.0	0
Leeds Teaching Hospitals NHS Trust	(12.8)	(18.4)	(6)	0.0	0.0	0
Leeds Place Total	**(11.1)**	**(18.3)**	(7)	**5.2**	**5.2**	0

Overall, the Leeds Place is reporting a £18.3m deficit at Month 4, which is c£7m adverse to plan. This is driven by the position in the ICB in Leeds (£1.8m) and LTHT (£5.6m).

Overall, the Leeds Place is forecasting delivery of a £5.2m surplus position in line with plan but this now includes the £5.2m stretch target as the Leeds Place share of the overall £33m gap identified in planning across WY. This stretch has been agreed to be split between the ICB in Leeds (£2.5m) and Providers (£0.9m each, £2.7m total).

Leeds Place Month 04 – Efficiencies

NHS West Yorkshire Integrated Care Board

anisation	YTD Plan	YTD Saving	YTD Variance	Annual Plan	Forecast Saving	FOT Variance
	£000's	£000's	£000's	£000's	£000's	£000's
Leeds ICB	11,929.00	7,493.00	(4,436.00)	35,872.00	35,872.00	0.00
Leeds and York Partnership NHS Foundation Trust	5,427	4,940	(487)	18,500	18,501	1
Leeds Community Healthcare NHS Trust	4,668	4,775	107	14,000	14,107	107
Leeds Teaching Hospitals NHS Trust	18,999	17,114	(1,885)	89,000	89,000	0
al	**41,023**	**34,322**	**(6,701)**	**157,372**	**157,480**	**108**

Overall, the Leeds Place has delivered £34.3m savings at Month 4, which is £6.7m adverse to plan. The main adverse variances are in the ICB in Leeds and LTHT.

Overall, the Leeds Place is forecasting to deliver its planned savings of c.£157.5m, however delivery of this is at increasing risk.

Leeds Place Month 04 – Efficiency Status

NHS West Yorkshire Integrated Care Board

ciency Status	Fully Developed - in delivery	Fully Developed - delivery not yet started	Plans in Progress	Opportunity	Unidentified	Total
	£000's	£000's	£000's	£000's	£000's	£000's
Leeds ICB	20,978	4,236	8,424	2,234	-	35,872
Leeds and York Partnership NHS Foundation Trust	18,500	-	-	-	-	18,500
Leeds Community Healthcare NHS Trust	11,223	-	259	2,625	-	14,107
Leeds Teaching Hospitals NHS Trust	46,230	4,307	35,792	2,671	-	89,000
al Efficiencies	**96,931**	**8,543**	**44,475**	**7,530**	**-**	**157,479**

Overall, the Leeds Place has £90m of its £154m efficiency target in delivery, with a further £8.5m developed but not yet started.

There are plans in progress for £44m, of which £35.8m sit in LTHT which will need to become the focus of delivery with a further £7.5m of opportunities to review across the Leeds Place.

West Yorkshire ICS
Month 4 Financial Position

West Yorkshire ICS Financial position - Month 04

NHS West Yorkshire Integrated Care Board

Organisation	YEAR TO DATE - M4 I&E reported Month 4 25/26			FORECAST - M01 to M12 I&E forecast			Scenarios - Organisation assessment			
	Plan £m	Actual Surplus / (Deficit) £m	Reported Variance £m	FOT Plan £m	FOT Surplus / (Deficit) £m	FOT Variance £m	Best Case Variance £m	Likely Case Variance £m	Likely Case (Mitigated) £m	Worse Case Variance £m
Bradford ICB	1.6	(1.1)	(2.7)	4.7	(0.3)	(5.0)	(3.1)	0.0	(5.0)	(23.8)
Calderdale ICB	1.5	1.6	0.1	4.4	4.9	0.5	0.0	0.0	0.5	(2.6)
Kirklees ICB	2.9	2.9	0.0	8.7	8.7	0.0	0.0	0.0	0.0	(7.1)
Leeds ICB	1.7	(0.1)	(1.8)	5.2	5.2	0.0	0.0	0.0	0.0	(23.4)
Wakefield ICB	0.9	(0.7)	(1.6)	2.6	0.4	(2.2)	0.0	0.0	(2.2)	(13.9)
WY ICB	(3.4)	(0.5)	2.9	(10.1)	(3.4)	6.7	3.2	0.0	6.7	18.1
West Yorkshire ICB Total	**5.1**	**2.1**	**(3.1)**	**15.4**	**15.4**	**(0.0)**	**-**	**-**	**-**	**(52.7)**
Airedale NHS Foundation Trust	(5.3)	(6.8)	(1.5)	(3.6)	(3.6)	0.0	0.0	0.0	(12.5)	(15.9)
Bradford District Care NHS Foundation Trust	(0.8)	(0.7)	0.1	2.0	2.0	0.0	0.0	0.0	(3.3)	(4.0)
Bradford Teaching Hospitals NHS Foundation Trust	(7.8)	(8.3)	(0.5)	(2.7)	(2.7)	0.0	0.0	0.0	(4.2)	(19.0)
Calderdale And Huddersfield NHS Foundation Trust	(2.4)	(2.4)	0.0	(3.0)	(3.0)	0.0	0.0	0.0	0.0	(21.5)
Leeds and York Partnership NHS Foundation Trust	0.0	0.1	0.1	0.0	0.0	0.0	0.9	0.0	0.0	(3.2)
Leeds Community Healthcare NHS Trust	0.0	0.1	0.1	0.0	0.0	0.0	0.6	0.0	0.0	(2.3)
Leeds Teaching Hospitals NHS Trust	(12.8)	(18.4)	(5.6)	0.0	0.0	0.0	0.0	0.0	(54.2)	(101.8)
Mid Yorkshire Hospitals NHS Trust	0.9	(1.4)	(2.3)	(8.1)	(8.1)	0.0	0.0	0.0	(3.9)	(16.1)
South West Yorkshire Partnership NHS Foundation Trust	(2.4)	(2.0)	0.4	0.0	0.0	0.0	0.0	0.0	0.0	(9.9)
Yorkshire Ambulance Service NHS Trust	0.4	0.8	0.4	0.0	0.0	0.0	0.0	0.0	0.0	0.0
West Yorkshire Provider Total	**(30.1)**	**(38.9)**	**(8.8)**	**(15.4)**	**(15.4)**	**-**	**1.5**	**-**	**(78.0)**	**(193.7)**
West Yorkshire ICS Total	**(25.0)**	**(36.8)**	**(11.9)**	**0.0**	**0.0**	**(0.0)**	**1.5**	**-**	**(78.0)**	**(246.4)**

West Yorkshire ICS Month 04 – Key Headlines

NHS West Yorkshire Integrated Care Board

West Yorkshire Integrated Care System (ICS)

- The month 4 **year to date** position for the ICS was a **£36.8m deficit** against a **planned £24.9m deficit**; an adverse variance against plan of **£11.9m.**
- The month 4 adverse variance of **£11.9m** has deteriorated from the adverse variance at month 3 of **£4.0m**, a deterioration of **£7.9m**.
- The deterioration in month is driven predominantly by **£3.7m cost of industrial action** which will not be covered by national funding, and **£3.2m of pay overspends**.
- The other drivers of the month 4 adverse variance continue to be **slippage on delivery of waste reduction/efficiencies,** part offset by underspends in other areas**.**
- Above position includes **assumed receipt of Deficit Support funding of £16.4m** (4/12ths of total annual value of £49.2m)
- The ICS continues to forecast a balanced plan to NHSE at Month 4 (based on receipt of £49.2m deficit support funding).

Recommendations

NHS West Yorkshire
Integrated Care Board

The Committee is asked to:

- Review and comment on the ICB in Leeds month 4 position including key risks and mitigations
- Review and comment on the Leeds Place month 4 position
- Review and comment on the West Yorkshire ICS Financial Position
- Consider any specific areas that they wish to escalate to other Committees or forums for follow up

Meeting name:	Leeds Committee of the WY Integrated Care Board
Agenda item no.	12
Meeting date:	3 September 2025
Report title:	Procurement of new contract for integrated provider of Short-Term Community Beds
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:	Helen Lewis, Helen Smith, Miles Jefford, Peter Simpson, Victoria Ajayi

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

Previous considerations:

A detailed proposal on the options to reprocure community beds in Leeds was developed last year by the HomeFirst and Pathway Integration team. The service detail was previously approved through the HomeFirst Governance structure and considered by the Leeds Finance and Best Value Sub-Committee in May 2024. In 2024 this committee approved procurement on this basis, but the procurement did not result in a contract being awarded.

The Finance and Best Value Sub-Committee recommended to the Leeds Committee of the ICB, the Provider Selection Regime (PSR) procurement route of **Competitive Process**. We have not revisited this decision in 2025 as nothing has changed in the market or the legislation that requires a further review. However, we are now ready to progress again to a competitive process for the procurement of an integrated beds model and believe that many of the issues from last time have now been addressed.

Executive summary and points for discussion:

This paper is being presented for a decision on the recommended procurement route for the Short-term Community Beds.

The Leeds Committee is asked to approve the choice of the selected Provider Selection Regime (PSR) process to use. This is in line with the WY ICB financial scheme of delegation as the contract value exceeds £5m. It is outlined within the scheme of delegation that appropriate PSR process and principles must be followed as laid out in the ICB Standing Financial Instructions and Procurement Policy.

The recommended procurement route is **competitive process** through the Provider Selection Regime, as set out in the main body. This will allow the ICB to assess the capability of all interested providers.

The spend related to this contract is classified as current spend, rather than new or repurposed spend as there are several existing service providers and the service is a key element of the journey of care for the City, to ensure improved outcomes both on discharge and admission avoidance. The community bed service is a core element of intermediate care in line with national guidance. Considerable improvement work has taken place over the past two years, with further efficiencies having been embedded, which has led to a lower spend and better outcomes for the City. We were previously judged as having too much dependency on bed based rehabilitation, but the system has greatly improved its focus on 'Home First' and improved flow through its rehabilitation beds, with more focus on people returning to their usual place of residence at the earliest opportunity.

The proposed future annual contract value will be £17,600,000 (at 25/26 prices). This embeds the recurrent QIPP achieved in 2024-2026 but also has been adjusted to allow for a higher dependency of patients through some of our beds. This contract value consolidates additional staffing, so reduces the dependency on ad hoc agency costs, which should improve efficiency and quality. An integrated model should be more cost effective, with less duplication of management costs and a more streamlined model of clinical support. It is proposed that the service should be commissioned for 10 years (8 plus 2) with the ability to resize in response to demand and model changes during the length of the contract. This is in recognition that the service is an essential element of intermediate care provision and part of a complex set of service interactions which could and should change over time.

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

☒ Improve healthcare outcomes for residents in their system

☐ Tackle inequalities in access, experience and outcomes

☒ Enhance productivity and value for money

☐ Support broader social and economic development

Recommendation(s)

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

1. Approve the Provider Selection Regime (PSR) route for the Short-term Community Bed service
2. The recommended route for procurement is **Provider Selection Regime: Competitive Process**
3. **Approve** the reinvestment of the current spend on beds into an integrated model
4. Agree to delegate the approval of the selected provider to the Chair. This stage of the process is due around 17 December and cannot wait until the next formal committee for approval as this would delay award and mobilisation.

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 procurement of sufficient capacity to meet the demand for pathway 2 (people requiring a bedded setting for rehabilitation and recovery) on discharge from hospital (and as a step up from community) will support the mitigation of the System Flow risk on the Corporate Risk Register.

Appendices
1. Appendix 1: Direct Award A, B and C criteria not met 2. Appendix 2: Most Suitable Provider Process criteria not met 3. Appendix 3: Competitive Process criteria
Acronyms and Abbreviations explained
4. CCB – Community Care Bed 5. STCB – Short-term Community Bed 6. PSR – Provider Selection Regime

What are the implications for?

Residents and Communities	Improvements in the availability of bed-based intermediate care and quality of outcomes from the service resulting from embedding the HomeFirst improvements and learning from the Intermediate Care Frontrunner work into the service specification
Quality and Safety	By commissioning an integrated provider responsible for all elements of the service the governance around quality and safety will be improved. Improvements in the clarity of responsibility within the clinical model will further improve the quality and safety culture within the service. Requiring the use of an integrated clinical IT system should address some long-standing risks around person centred care and the fact that different members of the team were accessing different information.
Equality, Diversity and Inclusion	There will be improved access to support people with a learning disability where they have a primary need related to their physical recovery. There will be improvements to the inclusion of the service as the proposed contract addresses known difficulties within the current contract e.g. access to special diets.
Finances and Use of Resources	The proposed contract value embeds the efficiency improvements from the HomeFirst Programme. The envelope has been balanced with the quality of care to ensure the people have improved long term outcomes and this has a beneficial impact on the cost of long-term care within the city.
Regulation and Legal Requirements	The recommended provider selection regime route will address all legal requirements under the new Provider Selection Regime.

Conflicts of Interest	Some of the current beds are provided by members of the Health and Care Partnership and it is probable that members of the Health and Care Partnership will bid for the proposed STCB service.
Data Protection	**n/a**
Transformation and Innovation	The service specification for the STCB service builds in the transformation and innovation work delivered through HomeFirst. The proposed service specification further incentivises the incoming provider to continually improve the service offer and work as a part of the LHCP in transforming intermediate care services
Environmental and Climate Change	The efficiency improvements embedded in the contract allow for the same demand to be met by fewer beds and will therefore reduce the carbon footprint of the service in comparison to the current service offer. We are also requiring the embedding of a digital clinical system which should reduce the use of paperwork in these settings.
Future Decisions and Policy Making	The proposed service specification and length of contract will support any incoming provider to work as a system partner in delivering any future changes to the service or wider intermediate care offer as a result of future LCHP decisions or changes in policy
Citizen and Stakeholder Engagement	The work uses the I statements developed by the Home First team in conjunction with patients and carers.

1) Purpose of the report

1) This paper is being presented for a decision on the recommended Provider Selection route for the short-term community beds.

2) The service

2.1. The contracts for our community care beds (CCB) come to an end on 30 June 2026. These are a core element of our intermediate care offer in Leeds and delivered in line with the national Intermediate Care Framework. They support people who are unable to be safely cared for at home by providing short-term rehabilitative and re-abling care. They can be accessed at the point of discharge from hospital or as step up from the community. We have extended most of our contracts after we were unable to make an award for a fully integrated offer last time.

2.2. The proposal is to procure a higher quality, more efficient community bed service by embedding into the contract the learning and improvements made from the HomeFirst Programme and Intermediate Care Frontrunner work which has been used to develop the service specification. The proposed service will bring together under one integrated contract all bed bases and the disparate elements of the current service provision e.g. medical and pharmacy services. The procured service will be called Short-Term Community Beds.

3) Value of the proposed contract

3.1. The contract value embeds the improvements in bed numbers delivered in 25/26 and the enhanced staffing levels agreed to mitigate the reductions in bed numbers and improve quality and outcomes.

3.2. In addition to the core contract value, a surge fund has been proactively ring-fenced, should we see seasonal demand increases in the requirement for bed-based care. This will only be released when demand exceeds or is expected to exceed a pre-agreed level and no mitigation has been possible.

3.3. Flexibility has been built into the contract and service specification to incentivise future efficiencies in the service delivery model and allow the contracted service value to be adjusted if there are changes to the level of service demand over the life-time of the contract.

4) Length of the proposed contract

4.1. The proposed contract length is 10 years (8 plus 2) to reflect the ambition to create a system partnership arrangement to work as an integral member of the LHCP as we continue to improve our intermediate care services offer. The proposed integrated contract represents a significant change to the model of service configuration and delivery. The contract length takes into consideration the size of the proposed service and the requirement to invest in estate and equipment and should enable the incoming provider to invest in the service by providing sufficient time for them to recover their investments. It would also mean that the service would not come to an end / transition to another provider or service model in or around winter.

5) Recommended procurement route

5.1. The PSR route recommended for approval is the competitive process. The rationale for this recommendation is set our below:

Is the service within scope of the PSR? Yes

5.2. The STCB service is in scope of the PSR as it a healthcare service, as per Regulation 3(1), and defined in section 275(1) of the 2006 Act as a "comprehensive health service designed to secure improvement in the physical and mental health of the people of England, and in the prevention, diagnosis and treatment of physical and mental illness."

Choosing the most appropriate provider selection process;

5.3. The options to use direct award A, direct award B and direct award C are not available as the criteria is not fulfilled. See appendix 1.

5.4. This leaves 2 options available most suitable provider and competitive process.

5.5. The option to use the most suitable provider process is not available as the criteria is not fulfilled. See appendix 2.

5.6. The criterion 'the relevant authority is able to identify the most suitable provider without running a competitive exercise' is unable to be met as the ICB does not hold provider landscapes that we can assess the potential providers against. Therefore, there is no confidence the ICB 'can, acting reasonably, clearly identify all likely providers capable of providing the health care services and passing any key criterion or sub-criterion which has been designated as pass/fail' as set out in Regulation 6 of the PSR.

Viable provider selection process;

5.7. Due to the options of direct award A, B, C and most suitable provider not being available the ICB must follow the competitive process to determine the provider of the short-term community bed provision from July 2026. This is because the regulation 6 states this provider selection process must be followed when the relevant authority is not required to follow direct award processes A or B, and the relevant authority cannot or does not wish to follow direct award process C or the most suitable provider process. See appendix 3.

6) Next Steps

6.1. Following the development of the service specification and further oversight from the Finance and Best Value Sub-Committee in 2024 the next step is to move to the procurement process for this service. We plan to publish the specification in September 2025 immediately after this meeting.

7) Recommendations

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

a) **APPROVE** the Provider Selection Regime (PSR) process for the Short-term Community Bed service

b) The recommended route for procurement is **Provider Selection Regime: Competitive Process**

c) Approve the reinvestment of this current spend on beds into an integrated model

d) Delegate the approval of the selected provider to the Chair of this Committee, so as not to delay the award and mobilisation.

8) Appendices

1) Appendix 1: Direct Award A, B and C criteria not met

2) Appendix 2: Most Suitable Provider Process criteria not met

3) Appendix 3: Competitive Process criteria

Appendix 1: Direct Award A, B and C criteria not met

Criteria to be fulfilled to utilise process	**Fulfilled ✗ / ✓**
Direct Award A; *The type of service means there is no realistic alternative to the current provider. This process must not be used to award contracts when establishing a new service.*	
Direct award process A must be used when all of the following apply:	
there is an existing provider of the health care services to which the proposed contracting arrangements relate	✓
the relevant authority is satisfied that the health care services to which the proposed contracting arrangements relate are capable of being provided only by the existing provider (or group of providers) due to the nature of the health care services.	✗
Direct Award B; *People have a choice of providers, and the number of providers is not restricted by the relevant authority.*	
Direct award process B must be used when all of the following apply:	
the proposed contracting arrangements relate to health care services in respect of which a patient is offered a choice of provider	✗
the number of providers is not restricted by the relevant authority	✗
the relevant authority will offer contracts to all providers to whom an award can be made because they meet all requirements in relation to the provision of the health care services to patients	✗
the relevant authority has arrangements in place to enable providers to express an interest in providing the health care services	✗
Direct Award C; *The existing provider is satisfying the existing contract and likely to satisfy the new contract, and the proposed contracting arrangements are not changing considerably from the existing contract.*	
Direct award process C may be used when all of the following apply:	
the relevant authority is not required to follow direct award processes A or B	✓
the term of an existing contract is due to expire and the relevant authority proposes a new contract to replace that existing contract at the end of its term	✓
the proposed contracting arrangements are not changing considerably	✗
Considerable change being met where the change; a) renders the proposed contracting arrangements materially different in character to the existing contract when that existing contract was entered into or: b) meets all the following: • the change, (to the proposed contracting arrangements as compared with the existing contract), is attributable to a decision made by the relevant authority • the lifetime value of the proposed new contract is at least £500,000 higher (i.e., equal to or exceeding £500,000) than the lifetime value of the existing contract when it was entered into • the lifetime value of the proposed new contract is at least 25% higher (i.e., equal to or exceeding 25%) than the original lifetime value of the existing contract when it was entered into.	

the relevant authority is of the view that the existing provider (or group of providers) is satisfying the existing contract and will likely satisfy the proposed contract to a sufficient standard	×

Appendix 2: Most Suitable Provider Process criteria not met

Criteria to be fulfilled to utilise process	**Fulfilled ✗ / ✓**
Most Suitable Provider; *The relevant authority is able to identify the most suitable provider without running a competitive exercise.*	
This provider selection process <u>may</u> be used when all of the following apply:	
the relevant authority is not required to follow direct award processes A or B	✓
the relevant authority cannot or does not wish to follow direct award process C	✓
The relevant authority is able to identify the most suitable provider without running a competitive exercise.	✗
Relevant authorities are expected to develop and maintain sufficiently detailed knowledge of relevant providers, including an understanding of their ability to deliver services to the relevant (local/regional/national) population, varying actual/potential approaches to delivering services, and capabilities, limitations, and connections with other parts of the system. Relevant authorities may wish to consider undertaking pre-market engagement to update or maintain their provider landscape knowledge. We expect this knowledge to go beyond knowledge of existing providers and to be a general feature of planning and engagement work, developed as part of the commissioning or subcontracting process rather than only at the point of contracting. Without this understanding, relevant authorities may not have enough evidence to confirm the existing provider is performing to the best quality and value, miss opportunities to improve services and identify valuable innovations, and ultimately lead providers to make representations (see standstill period). We expect relevant authorities not to treat providers from VCSE and independent sectors differently from NHS trusts and foundation trusts or local authorities solely based on that status.	

Appendix 3: Competitive Process criteria

Criteria to be fulfilled to utilise process	**Fulfilled ✗ / ✓**
Competitive Process; *This involves running a competitive process to award a contract.*	
This provider selection process <u>must</u> be used when all of the following apply:	
the relevant authority is not required to follow direct award processes A or B	✓
the relevant authority cannot or does not wish to follow direct award process C and cannot or does not wish to follow the most suitable provider process.	✓

Meeting name:	Leeds Committee of the West Yorkshire ICB
Agenda item no.	13
Meeting date:	3rd September 2025
Report title:	Director of Public Health Annual Report 2025 – Heat in the City: Our Health in a Warming Leeds
Report presented by:	Victoria Eaton – Director of Public Health (Leeds)
Report approved by:	Victoria Eaton – Director of Public Health (Leeds)
Report prepared by:	Dawn Bailey – Consultant in Public Health (Leeds City Council)

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

Previous considerations:

The Director of Public Health Annual Report 2023 was brought to the Leeds Committee of the West Yorkshire ICB to consider the key findings and recommendations.

In addition to sharing the key findings and recommendations for the 2025 Director of Public Health Annual Report, this report provides a progress update on the priorities outlined in Annual Report 2023 (contained within the full version of the DPHAR 2025 report – Page 68).

Executive summary and points for discussion:

The Director of Public Health (DPH) has a statutory duty to publish a report annually describing the health of the population and make recommendations to improve health. The Director of Public Health Annual Report 2025 is called 'Heat in the City: Our Health in a Warming Leeds.'

The report provides the Leeds Committee of the West Yorkshire ICB with:

- An overview of the lived experiences of Leeds residents, frontline workers, academic partners and subject matter experts alongside a review of national and local data and evidence relating to the impacts of heat on health.
- An outline of opportunities for citywide, system collaboration to achieve the recommendations within the 2025 Director of Public Health Annual Report.
- Key findings and recommendations contained within the Director of Public Health Annual Report 2025, focuses on actions to address the health impact of rising temperatures though a holistic approach.
- A progress update on the priorities as outlined in the Director of Public Health Annual Report 2023 (contained within the full version of the DPHAR 2023 report).

Which purpose(s) of an Integrated Care System does this report align with?
☒ Improve healthcare outcomes for residents in their system ☒ Tackle inequalities in access, experience and outcomes ☒ Enhance productivity and value for money ☒ Support broader social and economic development
Recommendation(s)
The Leeds Committee of the West Yorkshire Integrated Care Board is asked to: 1. Note the key findings and recommendations of the 2025 Director of Public Health Annual Report at Appendix 1. Executive Summary report at Appendix 2. Film 'Heat In The City: Our Health in a Warming Leeds' at Appendix 3. 2. Explore opportunities for citywide, system collaboration to achieve the recommendations within the 2025 Director of Public Health Annual Report.
Does the report provide assurance or mitigate any of the strategic threats or significant risks on the Corporate Risk Register or Board Assurance Framework? If yes, please detail which:
N/A
Appendices
1. To read the report click here 2. To read the Executive Summary click here 3. To watch our film 'Heat In The City: Our Health in a Warming Leeds' click here
Acronyms and Abbreviations explained
N/A

What are the implications for?

Residents and Communities	The DPH report highlights that rising temperatures pose significant health risks to Leeds residents, particularly those in deprived and vulnerable communities. It calls for inclusive, community-led approaches to mitigating risks including implementing the recommendations of the UKHSA Adverse Weather Plan 2025. The WY ICB is requested to work collaboratively with residents, local authorities, and partners to support equitable, sustainable, and health promoting environments across Leeds.
Quality and Safety	N/A
Equality, Diversity and Inclusion	The report shines a light on a range of local lived experiences representing cultural diversity, life

	course, geography and people living with long term health conditions. The report outlines the unequal health impacts of rising temperatures on Leeds' most vulnerable communities. It highlights the need for targeted and inclusive, actions that address the risks faced by older adults, children, people with long-term conditions, and those in deprived and ethnically diverse communities. The ICB is requested to ensure that mitigation strategies are aligned with commitments to reduce health inequalities and promote equality, diversity, and inclusion across the system.
Finances and Use of Resources	The report identifies rising temperatures as a growing public health challenge with direct implications for service demand, resource allocation, and strategic investment. Addressing these risks will require targeted financial planning to support adaptation measures, protect vulnerable populations, and build system resilience. The system must ensure that resources are targeted equitably and efficiently, with a focus on long-term sustainability and health improvement.
Regulation and Legal Requirements	NA
Conflicts of Interest	NA
Data Protection	NA
Transformation and Innovation	The report highlights rising temperatures as a driver for transformation across the health and care system. It calls for innovative, evidence-based approaches to mitigate heat-related risks and build resilience. The WY ICB should continue to support and invest in transformation initiatives that align with strategic priorities and climate commitments.
Environmental and Climate Change	The report highlights the urgent need to address the environmental determinants of health in the context of rising temperatures impacted by climate change. Rising temperatures, poor housing, and urban heat intensify health risks, particularly for vulnerable populations. The ICB are requested to support and align with city-wide efforts to protect the most at risk from the adverse impact of rising temperatures.
Future Decisions and Policy Making	A number of the recommendations within the report are directed at Leeds Health & Care Partnership and NHS organisations. Leeds Committee of the West Yorkshire ICB to consider how these are considered in future decisions and policy making.

Citizen and Stakeholder Engagement	The report demonstrates the value of inclusive citizen and stakeholder engagement in shaping climate and health responses. It highlights how lived experience, community voice, and partnership working have informed the report's findings and recommendations. The WY ICB to continue to prioritise meaningful engagement with residents and partners to co-produce equitable, effective, and locally relevant strategies that address the health impacts of rising temperatures.

1. Main Report Detail

Key Findings

1. Outline: The Director of Public Health Annual Report 2025:

1.1 This report attached at Appendix 1, focuses specifically on the effects of increasing temperatures on the health of the public in Leeds and explores how we can protect people and populations from environmental hazards and the spread of infectious diseases caused by increasing temperatures.

1.2 It also highlights three key areas: Unequal impacts of rising temperatures on health; How rising temperatures can affect long-term health conditions; Emerging risks: Vector borne infections and air quality.

1.3 Brings together lived experiences of Leeds residents, frontline workers, academic partners and subject matter experts alongside a review of national and local data and evidence relating to the impacts of heat on health.

1.4 Stresses the importance of recognising the unequal impacts of heat on certain communities and the compounding impact that multiple vulnerabilities can create for some people.

1.5 Key findings and recommendations include a focus on initiatives and policy change that utilise a health equity approach and that work towards building community resilience against the impacts of heat on health.

1.6 Highlights the many things we are doing to support the impact of heat on health in Leeds, aligned to the three pillars of the Best City Ambition – Health & Wellbeing; Inclusive Growth; and Zero Carbon.

1.7 Will be proactively shared with a wide range of stakeholders and is publicly available on the Leeds Observatory site.

2. **Key Findings**

The following outlines the key findings in the Director of Public Health Annual Report 2025 ‘Heat in the City: Our Health in a Warming Leeds

2.1 Rising temperatures in Leeds: Leeds has experienced significant increases in temperature over the last two decades, with the hottest years on record occurring since 2002. Since the 1980’s, there has been an 87.5% increase in recorded “summer days” where temperatures reach or exceed 25°C in Leeds, with the frequency of “hot summer days” where temperatures reach or exceed 30°C tripling. The Met Office issued its first red extreme heat warning during the summer of 2022, when temperatures in West Yorkshire exceeded 40°C the first time on record.

2.2 Heat impact on hospital admissions and mortality: National data suggests on days when temperatures reach and exceed 25°C there is an increased demand on GPs and emergency departments for heat related illness leading to a potential 8000 additional hospital admissions per year. Data gathered during previous heatwaves (3 consecutive days meeting or exceeding the heatwave temperature threshold (25 degrees)) in England show GP demand is highest for children aged 4-14 and people aged 75 and over. The highest number of daily deaths was recorded on a summer day in 2022, coinciding with a Met Office ‘Red Extreme’ weather warning.

2.3 Unequal impacts of heat: Personal, environmental, and social factors affect people's resilience during hot weather. Groups such as older adults, people with long term health conditions, young children, and those living in deprived, urban areas, are disproportionately at risk from the impacts of rising temperatures. People in low-income households often face additional challenges, such as less income to adapt their surroundings and an increased likelihood of having a long-term health condition and/or disability. These layers of risk, increase an individual's vulnerability to the harmful effects of heat on health. Warmer weather can exacerbate the symptoms of existing respiratory and cardiovascular conditions. Medications taken for long term conditions such as diabetes can make it more difficult for people to keep cool during warmer weather.

2.4 The Urban Heat Island Effect: building materials such as concrete and asphalt retain heat more than natural surfaces, so urban areas can be hotter than rural ones. The Met Office predict that during a heat wave, inner city Leeds can be up to 8°C warmer than outer areas. Leeds has a densely populated city centre with the number of people living in inner-city areas increased by over 2,000 people between 2011 and 2021. Many of the most deprived wards are located in the city centre. Housing vulnerability: Housing conditions contribute significantly to the risks people face in extreme heat. Some building types such as high-rise flats and back-to-back housing, overheat more easily than others and may lack the facility for residents to effectively cool down and often have less access to gardens and outdoor green space.

2.5 Emerging risks caused by Infections and air quality: Increasing temperatures mean that insects such as mosquitoes and ticks can increasingly thrive and breed in UK regions which increases the threat of diseases such as lyme disease, malaria, and West Nile. Pollen seasons are also becoming longer and more intense, because of warmer temperatures. More people are seeking medical support for a phenomenon called "thunderstorm asthma" where excessive pollen and particles are drawn in by higher winds and broken down by rain and humidity into more easily inhaled particles causing asthmatic symptoms.

3. **Report Recommendations**

There are nine recommendations outlined in the report informed by national and local evidence, and insight from communities and frontline workers. A summary of the key recommendations is as follows, full details can be found below and in the main report.

Leeds is taking action to protect people's health as our climate warms. The Council and its partners are working together to promote national guidance on extreme weather, improve access to cool spaces, raise awareness, and involve communities. Planning and housing policies will better reflect heat risks, and research will help us understand which areas are most vulnerable.

There's also a focus on supporting outdoor workers, tackling health inequalities, and training frontline staff to help those most at risk.

The nine recommendations in full arising from the report are as follows:

3.1 Leeds City Council, Leeds Health and Care Partnership, anchor organisations and third sector to work collaboratively to promote and implement the advice and actions in the UK Health Security Agency Adverse Weather & Health Plan.

3.2 Leeds City Council, Leeds Health and Care Partnership, anchor organisations and third sector partners to work collaboratively to further improve access to cool spaces across the city by:

- Building on and promoting Leeds cool spaces guidance with partners.
- Ensuring there is a fair spread of cool spaces according to need across the city including community venues and seating in shaded areas.
- Increasing public awareness of cool spaces.

3.3 Leeds City Council, Leeds Health and Care Partnership, and third sector partners to work together to review and increase opportunities for community engagement around the health impacts of increasing heat through the development of a city-wide action plan.

3.4 Academic partners to support citywide work to strengthen local research, evidence, and evaluation in relation to urban-heat mapping and climate vulnerability tools.

3.5 Leeds City Council will ensure that heat and health is considered in the planning and sustainable development context, particularly within densely populated inner-city areas by ensuring:

- That planning applications are informed by ward specific heat data.
- Health Impact of heat is included in health needs assessments.
- Continued development of design guidelines for green spaces that are adaptable to the changing climate.

3.6 West Yorkshire Combined Authority and Leeds City Council will continue to work together to:

- Identify opportunities for funding and investment in energy efficiency measures within Leeds housing stock.
- Lobby for improvement in national policy around rental housing to ensure landlords are responsible for making improvements that protect against heat as well as cold.

3.7 Leeds City Council, Leeds Health and Care Partnership, anchor organisations, third sector and local businesses to work collaboratively to consider increased risk of vector borne diseases and heat for outdoor workers/workers at risk.

3.8 Health and Wellbeing Board to continue to address health inequalities via the Fairer, Healthier Leeds (Marmot City) and other health inequalities work.

3.9 Leeds City Council, Leeds Health and Care Partnership, anchor organisations, and third sector partners to develop skills and knowledge amongst frontline workforce in protecting people at increased risk from the adverse health impacts of heat.

4. Association of Directors of Public Health (ADPH) Annual Report Competition

The Director of Public Health Annual Report 2025- Heat in the City: Our Health in a Warming Leeds was submitted to the Association of Directors of Public Health (ADPH) as part of the annual report competition and celebration, the Leeds report was highlighted as one of the top 5 reports.

What impact will this proposal have?

5. The report will:

5.1 Raise the profile of how increasing temperatures disproportionately effects vulnerable populations.

5.2 Encourage actions to be implemented that address key recommendations to mitigate the harms of increasing temperatures.

5.3 Maintain commitment and focus on the Best City Ambition and Leeds Health & Wellbeing Strategy in Leeds.

5.4 Emphasise the importance of early intervention and prevention to improve health outcomes in relation to heat

5.5 Encourage cross sector community led solutions to build resilience.

Next Steps

Delivery of the recommendations will commence and run throughout the financial year 2025-2026 and beyond. System wide partners have a role in taking account of and putting in place actions that address the recommendations in the report and the Director of Public Health is responsible for reporting progress on actions across the system.

6. Recommendations

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

1. Note the key findings and recommendations of the 2025 Director of Public Health Annual Report at Appendix 1. Executive Summary report at Appendix 2. Film Appendix 3.

2. Explore opportunities for citywide, system collaboration to achieve the recommendations within the 2025 Director of Public Health Annual Report.

Appendices

1. To read the report click here
2. To read the Executive Summary click here
3. To watch our film ‘Heat In The City: Our Health in a Warming Leeds’. click here

Meeting name:	Leeds Committee of the West Yorkshire Integrated Care Board
Agenda item no.	14
Meeting date:	3 September 2025
Report title:	Health Inequalities / Core20+5 Update
Report presented by:	Nick Earl
Report approved by:	Sarah Forbes, Helen Lewis
Report prepared by:	Nick Earl, Emily Carr, Kirsty Turner, Neve Harris

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

Previous considerations:

In February 2025 the Leeds Committee agreed to restructure its place sub-committees and realign responsibilities. Health inequalities reporting was aligned directly to the Leeds Committee. This paper provides an update on the ICB's work on health inequalities. It follows an update to the Delivery Sub-Committee in January 2025.

Executive summary and points for discussion:

This paper provides an overview of work to address health inequalities by the ICB in Leeds. It provides an update on our priority programmes, an update on Core20+5 measures where available, an overview of our wider work to address health inequalities and an update of partnership activity in this space (with a specific focus on the Health Equity Index).

It seeks to provide assurance to the Committee that the ICB in Leeds is exercising its functions in regard to the need to reduce health inequalities and to highlight the evolution of the Core20+5 approach within Leeds. Committee members are also invited to reflect on potential learning opportunities from this work on health inequalities that might inform the future operating model of the ICB as a strategic commissioner and the implications for providers and provider partnership responsibilities.

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 assurance that the ICB in Leeds is, in the exercise of its functions, having regard to the need to reduce health inequalities

b. Note the evolution of the Core20+5 approach – with a focus on deprivation across strategies and programmes, and use of a Health Equity Index across partners

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:

WYICB Board Assurance Framework - Strategic Risk 1.1 - There is a risk that our local priorities to narrow inequalities are not delivered due to the impact of wider economic social and political factors. WYICB Board Assurance Framework - Strategic Risk 1.2 - There is a risk that operational pressures and priorities impact our ability to target resources effectively towards improving outcomes and reducing inequalities for children and adults.
Appendices
1. Table 2 Core20+5 Clinical Indicators
Acronyms and Abbreviations explained
ICB – Integrated Care Board Core20+5 – NHS England programme guiding action on health inequalities SMI – Severe Mental Illness IMD – Index of Multiple Deprivation HATCH – a collaboration of health and care organisations in one neighbourhood in Leeds NNHIP – National Neighbourhood Health Implementation Programme GPOP - The General Practice Outcomes Programme ODA – Office of Data Analytics LD – Learning Disability VCSE - Voluntary, Community and Social Enterprises LGBTQIA+ - individuals who are lesbian, gay, bisexual, transgender, queer, or questioning MCoC (CoC) – midwifery continuity of carer (continuity of carer) LTHT – Leeds Teaching Hospitals Trust BAME – Black, Asian and Minority Ethnic ICD – International Classification of Disease COPD - Chronic obstructive pulmonary disease A&E – Accident and Emergency Department rtCGM – real time Continuous Glucose Monitoring SPA – Single Point of Access

What are the implications for?

Residents and Communities	
Quality and Safety	
Equality, Diversity and Inclusion (EDI)	Provides assurance on our ongoing EDI work
Finances and Use of Resources	
Regulation and Legal Requirements	Provides assurance on our legal requirement to give due regard to health inequalities.
Conflicts of Interest	
Data Protection	
Transformation and Innovation	Ensures transformation programmes are aligned to health inequality needs locally.
Environmental and Climate Change	
Future Decisions and Policy Making	Future ICB decision-making should be informed by learning from health inequalities work.
Citizen and Stakeholder Engagement	

i. Context

i.i This report arrives at the Leeds Committee ahead of structural changes to the functions and capabilities of all Integrated Care Boards. In presenting this update, which includes performance challenges as well as successes, we note that our *current* statutory duties around health inequalities remain unchanged and seek to assure the Committee around our activity in addressing health inequalities. We also emphasise that the *future* duties of ICBs retain the strong focus on health inequalities - the national ICB Blueprint directs ICB's to grow (or protect) functions and capabilities associated with understanding health inequalities in order to guide future commissioning and resource allocation:

> *The NHS needs strong commissioners who can better understand the health and care needs of their local populations, who can work with users and wider communities to develop strategies to improve health and tackle inequalities and who can contract with providers to ensure consistently high-quality and efficient care, in line with best practice.*

i.ii The ICB supports Leeds both as a strategic commissioner and as a system partner and integrator at place. As a city, Leeds adopts a collaborative approach to addressing health inequalities across its health and care organisations - with a strong focus on deprivation. This focus sits at the heart of our Health and Wellbeing Strategy, underpins our Marmot City work, informs the health and care partnership goals in the Healthy Leeds Plan (as well as the associated priority programmes that follow from these), and aligns to the national 'core' component of the national Core20+5 initiative.

i.iii This report provides an update on ICB work, as part of our health and care partnership, to address health inequalities. It includes a snapshot update on: (1) Progress against partnership priority programmes; (2) Core20+5, (3) Wider ICB activity to address health inequalities; (4) Partnership activity: Leeds Health Inequalities Oversight Group and Marmot.

1. Progress against partnership goals and priority programmes

1.1 Leeds has 5 priority programmes agreed across partners that seek to address current and future health risks for the Leeds population. The priorities were identified based on (i) their contribution to one or both of the Healthy Leeds Plan Goals for the most deprived populations in Leeds[1] or (ii) their contribution to reducing critical health and care risks across the city.

1.2 The ICB in Leeds is prioritising delivery resource towards the partnership agreed areas of transformation and change. Table 1 below provides an overview of each programme, alignment with health inequalities and status.

[1] The two goals are associated with reducing both current and future health risks (Goal 1 - reducing preventable unplanned care utilisation, Goal 2 - increasing early identification and intervention)

Table 1: Overview of Leeds Priority Programmes of work

Programme	Population in focus	Current status	Alignment with health inequalities
Home First 2 (overlap with Core20+5 'plus' group - multiple Long-Term Conditions)	People amenable to proactive care, or those in need of intermediate care services (~60k people)	7 strands of work, two in delivery (intermediate care, advanced respiratory) 4 in planning and one in diagnostic.	People in the most deprived areas of Leeds develop multi-morbidity 10-15 years earlier, are twice as likely to experience frailty and spend longer living with frailty.
Community Mental Health Transformation (Links to Core20+5 clinical area - SMI)	Those with SMI or a personality disorder (~15k people)	Rollout and evaluation	2024 Joint Strategic Assessment found that SMI is most pronounced in the most deprived areas of Leeds, with additional inequalities linked to ethnicity – for example SMI in Black Caribbean groups is 2.6% vs. ~1% in White British groups..
Early Identification of Cardiovascular Disease (Links to Core20+5 clinical area - hypertension).	Those with poorly managed or undiagnosed hypertension (~113k people) Targeted focus on global majority males in IMD1	Early implementation (recruitment and testing)	CVD, for which hypertension is a key risk factor, accounts for 3rd largest difference in healthy life expectancy (after mental health and respiratory) between IMD1 / IMD10. Global majority males living in IMD1 areas within Leeds have hypertension identified at a disproportionately late stage.
Children and Young People with complex needs or at risk (Links to Core20+5 'plus' group – children looked after)	Children with complex needs at risk of escalation and children looked after in residential placements (initial estimate ~2k)	Scoping and development.	70% of our children looked after are from the 20% most deprived areas in the city. 57% of care starters are from IMD1 communities.
Neighbourhood Health - NNHIP	Starting in HATCH, Inner South and East Leeds LCPs (~195k people)	Scoping and development. Application submitted (Aug) to join national programme.	51.5% of the focus population live in IMD 1, and residents are much more likely to be of global majority background (for example, around 60% in HATCH).

1.3 For those programmes at an appropriate stage of development (beyond scoping and development), work has been undertaken to quantify their likely impact and to understand how programme activity measures can be linked to population impact (including for specific areas of inequality used to initiate or

design each programme area). For example, understanding how programme activity to diagnose high blood pressure for those in specific population cohorts (e.g. out of work) might result in a future reduction in heart attacks or strokes within that cohort.

2. Core20+5

2.1. There are three components to the national Core20+5 approach. Deprivation (Core20), specific target groups (plus) and clinical areas of opportunity (5). As a place-partnership, Leeds has chosen to focus predominantly on the deprivation aspect of the Core20+5 approach. In addition to this focus on deprivation, two of the Leeds priority programmes target one of the potential plus group (people with multiple long-term health conditions and children looked after) and two are focussed on areas of clinical opportunity (people with or at risk of SMI and people with or at risk of hypertension).

2.2. Whilst the remaining clinical and plus-groups are not necessarily focus areas for the partnership, there is a variety of initiatives underway to support improvements for these populations. The Leeds Office of Data Analytics (ODA) has initiated work to develop a Core20+5 dashboard to support the Leeds system in monitoring performance across all Core20+5 metrics. Development of the dashboard has been paused, and to some degree this work has been superseded by the adoption of a locally owned Equity Index (described later), but the latest updates for available indicators are provided in Table 2 in the Appendices.

2.3. Across the 10 clinical areas, 8 have metrics available and Leeds is improving or performing well against 5. We are performing poorly against maternity continuity of care and there have been notable changes in activity for children's tooth extractions (an increase) and children's mental health referrals (a decrease but still at a high level). Further work is currently underway to better understand these changes.

2.4. Data alone also rarely captures the full picture. In different circumstances a change in performance can be either positive or negative - for example the rising service use associated with tooth extractions might represent an increase in capacity or an increase in demand. Diagnostic work with service leads, service users and critical insight sources such as Healthwatch is needed to understand 'why' performance is changing.

3. Wider ICB in Leeds activity to address health inequalities

3.1. Beyond delivery of our priority programmes of work, the ICB in Leeds is involved in several projects, areas of work and ongoing improvements relating to health inequalities. Key ones this year include:

3.1.1. **The General Practice Outcomes Programme (GPOP)**

A key tool for addressing variation and health inequalities in general practice is the General Practice Outcomes Programme. This is a local enhanced service covering circa £9m. For 2025/26 this programme has targeted improving variation in key areas linked to Core20+5 and our local priority programmes of work. The funding targets enhancements in:

- Hypertension treatment to target with specific population cohorts
- Increasing the detection of Chronic Kidney Disease
- Delivery of health checks for people with a learning disability or SMI
- Improving outcomes for people living with frailty

Despite challenges linked to collective action, GPOP has driven notable improvements in support for those with learning disabilities or severe mental illness. GP health check performance for these populations has exceeded planned assumptions (90.4% for LD at end of year 24/25 and 85.9% for SMI 6-component health checks).

This work sits alongside a wider set of tools and resources to support general practice in addressing health inequalities, including improving overall access to services and access to translation and interpretation services.

3.1.2. **Leeds Healthy Working Life Project**

West Yorkshire is one of 3 ICBs within the Government's Health and Growth Accelerator programme, working to help 552 more people in Leeds to become economically active through health-orientated interventions. Unemployment is a key indicator of inequality and deprivation (it makes up part of the Index of Multiple Deprivation scores), and this work will therefore have a notable impact on health inequalities in Leeds. The programme is underway with £3.2m of national funding, bringing resources into the city. A paper describing the programme is included for the Leeds Committee alongside this paper.

3.1.3. **Voluntary, Community and Social Enterprises**

The Voluntary, Community and Social Enterprises (VCSE) sector plays an important role in addressing the causes of inequality and in meeting the health impacts that arise. The ICB both at West Yorkshire level and in Leeds has been working to ensure that where possible we provide more clarity on our

commissioning intentions and focus on inequality and giving longer-term certainty in our procurement and contracting approach. This work has been well received whilst there is always more to do. The resilience of the sector will continue to be an important feature of the cities approach to addressing inequality. A number of pieces of work described elsewhere in this paper reflect our joint working relationship and this will be picked up further in neighbourhood development.

3.1.4. **Equitable decision-making and impact assessment**

The decisions the ICB in Leeds takes linked to changes in existing services (including decommissioning) are as important as its decisions linked to commissioning new services. Last year, the ICB in Leeds undertook a substantial piece of work to understand and improve its business processes around equitable decision-making. A revised process, in line with national best practice, has supported the ICB in Leeds this year to review, via an assurance panel of senior clinical and independent members, 78 different service reviews – each with an assessment of impact on inequalities (via a Quality and Equality Impact Assessment and / or an Equality Impact Assessment). 20 of these proposals were 'returned' by the panel – with the panel challenging whether potential mitigations, risks and impacts for the populations affected had been sufficiently considered.

3.1.5. **EDI annual report**

The ICB in Leeds has produced an annual Equality, diversity and inclusion report covering work the ICB delivers, supports or commissions across Leeds. It summarises key aspects of our work on inequalities and inclusion (including the role of the ICB as an employer) covering:

- Key networks for sharing best practice (Equality Leeds Forum, Leeds Equality Network, LGBTQIA+ Health and Wellbeing Network).
- Insight, communication and involvement functions (People's Voices Partnership, insight reports, Communities of Interest Network).
- National equality mechanisms such as the Equality Delivery System
- A description of over 30 projects and services commissioned or supported by the ICB in Leeds that focus on addressing health inequalities (to keep this report concise, the list of projects is not replicated here, but is publicly accessible through the link above).

4. Partnership activity: Leeds Health Inequalities Oversight Group and Marmot

4.1. Leeds has a strong history of partnership working at place. Nationally, there is a clear ambition for this type of system working, where ICB's become system leaders for population health and "develop and foster strategic partnerships

across their footprints" (ICB Blueprint). This has implications for how work on health inequalities at place is shaped and managed, particularly as ICB's reduce in size and adopt a greater focus on strategic commissioning.

4.2. Last year Leeds established its local **Health Inequalities Oversight Group**. This is a provider led and co-ordinated forum of NHS partners that seeks to align provider work on health inequalities locally and ensure that inequalities are always considered, and in a consistent way across partners, rather than through multiple differing initiatives and approaches. It draws on ICB support in key areas (such as business intelligence, or co-ordination across places) but given the nature of the forum has significant buy-in and support across provider partners (members include Chief Medical and Chief Operating Officers).

4.3. The most recent Health Inequalities Oversight Group meeting focussed on three key areas – all relevant to this report. This included:

4.3.1. Guidance and advice to how partnership priority programmes could strengthen their approach to health inequalities during delivery phases.

4.3.2. Reflection on the Core20+5 approach and development of a local Health Equity Index.

The Health Equity Index represents the next iteration in how Leeds implements a Core20+5 approach, building on learning from other areas. It provides a mechanism by which inequalities can be considered directly in performance metrics and allows providers to report and monitor inequalities consistently across different services. This means metrics can be owned, interpreted and acted upon directly by those managing a service. It is also applicable to General Practice[2]. At the July meeting of the Health Inequalities Oversight Group, partners agreed to use this index and disaggregate service performance by IMD, Ethnicity, Learning Disability and Age. This fits with Core20+5 but provides a focus on specific characteristics. It is anticipated that Leeds will increasingly adopt this to understand health inequalities at place.

4.3.3. Discussion around how the Provider Partnership project[3] could support work to address health inequalities, and agreement on key input into this work from members of the Health Inequalities Oversight Group.

[2] Establishing inequality reporting metrics from national commissioning data is much harder than embedding the same approach using local provider data, and use of local data is likely to increase the speed, consensus and uptake of any insight generated.
[3] In May 2025, The Value Circle were asked to undertake a strategic review to explore options and a roadmap for establishing a provider partnership between the major statutory NHS providers in Leeds and the local authority.

4.4. In 2023 Leeds made a commitment to become a Marmot City, undertaking a two-year partnership with the Institute of Health Equity to drive action on the social determinants of health and reduce health inequalities. Whilst the NHS and healthcare in general plays a smaller role in addressing the wider determinants of health, it acts as a key partner at place. The ICB supports this work through participation in delivery partnership meetings, and support for specific programme activities. An update on this work is provided in the preceding paper and the Institute of Health Equity report is available here.

5. Going forward

5.1. This report summarises a breadth of work across the ICB in Leeds and its partners at place on health inequalities. The national restructuring of NHS bodies presents a risk to this work that will need to be managed in the short term (given the potential impact on focus, attention and morale), and long term (given the potential future changes in ICB resource). Importantly, there is a wealth of learning and experience arising from this work that could guide and inform the future function and setup of the ICB. From the examples presented above there are likely to be opportunities for the ICB, as a strategic commissioner, to: (i) scale and adopt the technical data and analytics expertise for health equity Leeds has demonstrated, particularly where these may not exist in providers; (ii) leverage learning from partnership work on health inequalities and provider-partnership structures, particularly if these reduce the need for ICB-support; and (iii) ensure business processes for decision-making embed health equity and balance the degree of assurance with the scale of the likely impact.

6. Recommendations

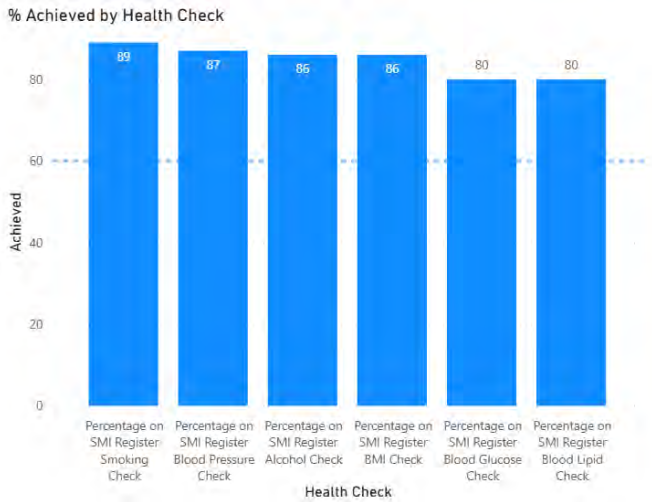
The Leeds Committee of the West Yorkshire Integrated Care Board is asked to:

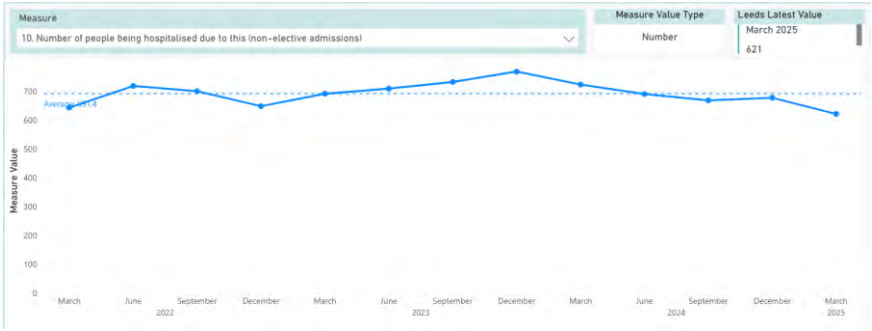
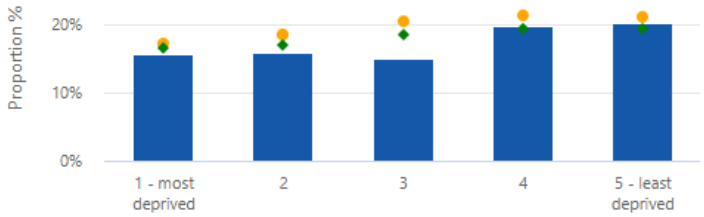
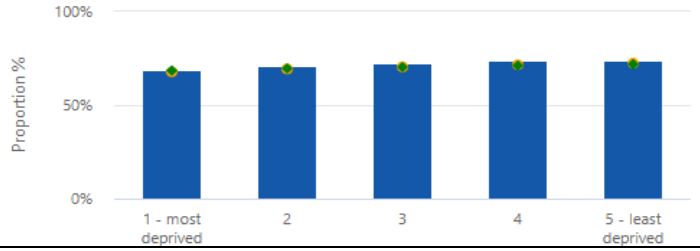
1) Receive assurance that the ICB in Leeds is, in the exercise of its functions, having regard to the need to reduce health inequalities

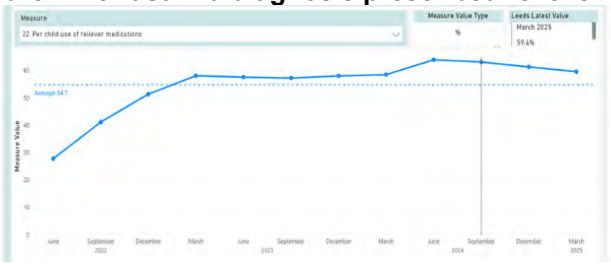
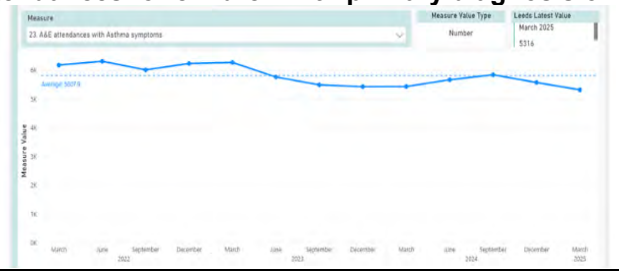
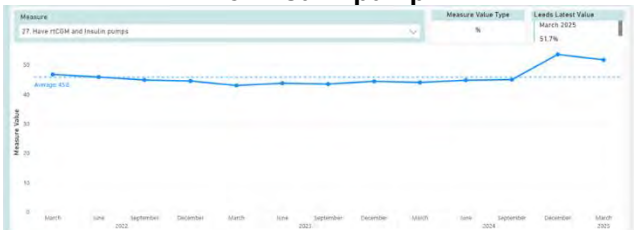
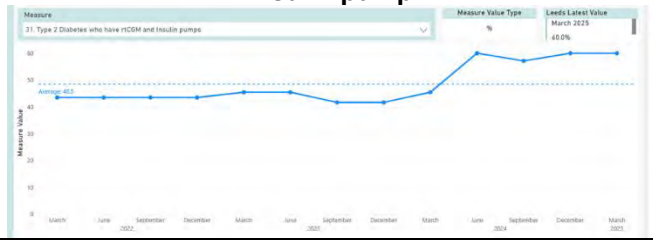
2) Note the evolution of the Core20+5 approach in Leeds – with a focus on deprivation across strategies and programmes, and use of a Health Equity Index across partners at place

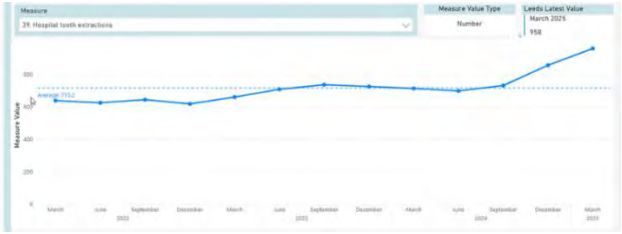
The Leeds Committee may wish to discuss or reflect upon potential learning opportunities linked to health inequalities for adoption within the future operating model of the ICB.

APPENDICES: Table 2 Core20+5 Clinical indicators

Area	Indicator status	Commentary
Adults: Maternity Continuity of care for BAME women and women from the most deprived groups	**% women on continuity of carer pathway by 28-week appointment** 	Data shown for March 2022 to March 2025. The national average of women receiving midwifery continuity of carer is around 22% with many units struggling to operate in this model. MCoC in Leeds peaked in 2022 at 30%. Since March 2023 this has declined to 4%, although this figure is across everyone and COC teams were deliberately located in key areas of need, so this figure will be higher for BAME and deprived populations. For a period LTHT trialled enhanced continuity via group work, which evaluated well, however due to the recent pressures this has been stood down. In early 2025 CQC issued a section 29a warning notice re. maternity staffing levels at LTHT. The current focus of the department is fulfilling the CQC action plan, satisfying the requirement of the Rapid Quality Review. In July the LTHT board formally agreed to join the Maternity Safety Support Programme.
Adults: SMI Annual physical health checks for all people with SMI	**% of all Physical Health Checks for people with SMI** 	Data shown for Q4 2024/5, from national data flows. The end of year delivery of annual health check for people with SMI was 74.4% (for all 9 health checks) and 85.9% (across 6 checks). This continues to be a core indicator included in our local enhanced service with practices (GPOP).

Adults: COPD Chronic respiratory disease - Uptake of COVID, flu and pneumonia vaccines to reduce infective exacerbations and admissions	**Non-elective admissions for adults with COPD** 	Data shown for March 2022 to March 2025. The indicator for vaccine uptake is currently unavailable within this dashboard. The figure shows the number of Inpatient emergency admissions (adults 18+) with a recorded primary diagnosis ICD code relating to COPD in the previous 12 months. Emergency admissions are down (621) against the long term average (691).
Adults: Cancer 75% of cases diagnosed at stage 1 or 2 by 2028	[Indicators unavailable]	The indicator for detection of cancer at stage 1 or stage 2 is currently unavailable within this dashboard.
Adults: Hypertension Case-finding and optimal management and lipid optimal management	**Hypertension prevalence by deprivation quintile (vs. national performance)**  **Hypertension treated to appropriate threshold (vs. national performance)** 	Data shown for March 2025. Hypertension treat to target is a core indicator within our local incentive scheme for practices (GPOP). Our performance in this area is increasing over time – with efforts focussed on reducing variation between practices and encouraging PCNs to review activity. A clear deprivation gradient exists for registered prevalence, with Leeds slightly behind national and West Yorkshire performance (shown in green and yellow respectively). The gradient is shallow, and differences between local and national performance nearly disappear when considering whether those identified as having hypertension are treated to threshold.

Children: Asthma Addressing over-reliance on medication and decrease number of attacks	**% children with asthma diagnosis prescribed reliever meds**  **A&E attendances for children with primary diagnosis of asthma**  	These figures show performance from March 2022 to March 2025 on a rolling 12 month basis. There is a rapid increase from September 2022 (~41%) to December 2022 (~50%). Rates have plateaued above average since early 2023 around 58-60%, with the most recent value at 59.4%. Average attendances around 5,800 attendances per year. Latest figure for March 2025 below average at around 5,300. Both graphs show that while there is a sustained high level of reliever medication use, there is an improvement in preventing these symptoms from escalating to accident and emergency attendances.
Children: Diabetes Increase access to real-time continuous glucose monitors and insulin pumps in most deprived quintiles and from ethnic minority groups and proportion of those with Type 2 diabetes receiving recommended care.	**% children with Type 1 or Type 2 diabetes and prescription for rtCGM or insulin pump**  **% children with Type 2 diabetes and prescription for rtCGM or insulin pump**  	These figures show performance from March 2022 to March 2025. Rates of recorded prescriptions for type 1 or type 2 were consistent until Q4 2024 where rates increased ~7% to 51.7%. For just type 2, current performance is at 60% relative to an average of 48.5% - with a marked increase from March 2024. Positive performance improvements align with NHS England initiatives to increase access to most deprived quintiles and from ethnic minority backgrounds.

Children: Epilepsy Increase access to specialist nurses and access in first year for those with LD or autism.	[Indicators unavailable]	The indicator for access to epilepsy specialist nurses is currently unavailable within this dashboard.
Children: Oral health Tooth extractions due to decay for children admitted, at or under 10	**Dental tooth extractions for children under 10** 	Data from March 2022 to March 2025. There has been a recent increase in inpatient admissions for children aged 10 and under, from Q4 2024. The latest value of 958 admissions (March 2025) is above the average measure value of 715. The West Yorkshire dental commissioning team are aware of the increase and are looking into it further. Performance indicators in other areas have improved (e.g. children seen in 12 months has increased to 61% against a national average of 54.9%).
Children: Mental health Improve access rates to children and young people's mental health services for 0-17 year olds, for certain ethnic groups, age, gender and deprivation.	**Prevalence of mental health conditions in children and young people**  **Children's referrals to mental health services** 	Data shown from March 2022 to March 2025. Prevalence has been consistent between ~2.0% to 2.5%, with the latest value at 2.6%. Trends aligned with the national planning measure focus. There has been a steady decline in referrals to mental health services from ~950 to 545 between December 2023 and March 2025. The decline matches the trend for referrals into MindMate Single Point of Access (SPA). Since December 2023, referrers have been aware of long processing waits by the SPA, and the SPA have also been actively communicating about waits – which may have deterred potential referrals (the figure also only captures referrals, not the proportion of children who go on to access and receive support – which may have changed as well). In July 2024 Leeds also discontinued commissioning of the MarketPlace and Leeds Mind THRU project, which may have affected referral numbers. A new service, the Children's Society Time for Young People service, was launched at the same time –it is possible referral levels have not recovered.

Meeting name:	Leeds Committee of the West Yorkshire Integrated Care Board
Agenda item no.	15
Meeting date:	3rd September 2025
Report title:	Work, Skills and Health Programme Update – Healthy Working Life
Report presented by:	Nick Earl, Associate Director of Population Health, ICB in Leeds
Report approved by:	Helen Lewis, Director of Pathway and System Integration, ICB in Leeds
Report prepared by:	Lindsay McFarlane, Programme Director, ICB in Leeds

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

Previous considerations:

Not previously discussed with the ICB in Leeds Committee. Early agreement of the initiatives was supported by Leeds Delivery Sub-Committee (January 2025), West Yorkshire Transformation Committee (January 2025) and Leeds Partnership Leadership Team (February 2025).

Executive summary and points for discussion:

This paper is designed to provide an awareness and update on the Leeds Healthy Working Life Programme (previously known as Health and Growth). This paper is designed to provide an update on progress to date and the key learning.

Committee members are asked to:

- Note the rapid progress made and updates as included within this paper
- Note the lessons learnt
- Agree that if recurrent monies are confirmed for 2026/2027 by NHS England; that a recommendation is made by the ICB matrix team to the ICB committee in January 2026 regarding the schemes that we might continue, stand down or modify (with consideration of the early evaluation of initiatives to date and a return on investment assessment). At this point, we may also consider new schemes informed by learning and updated data.

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. Receive this paper which provides an awareness / update on the Work, Skills and Health Programme with a focus on the Leeds Healthy Working Life Programme 2. Acknowledge the very positive work and implementation that has been completed in a relatively short timescale by all providers 3. Agree that if recurrent monies be confirmed for 2026/2027; that a recommendation is made by the ICB matrix team to the ICB committee in January 2026 regarding the schemes that we might continue, stand down or modify.
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. Overview of Pillars 1 & 3
Acronyms and Abbreviations explained
1. LHCA – Leeds Health and Care Academy 2. VCSE – Voluntary, Community and Social Enterprise

What are the implications for?

Residents and Communities	To improve population health outcomes. To increase economic growth by reducing health-related labour market inactivity. To shift from a model of care that treats sickness to one of prevention, which tackles health inequality. To support **552** more people in Leeds to be economically active in one year through health-orientated interventions, compared to a do-nothing scenario (% of West Yorkshire's target of 1,300 people).
Quality and Safety	All initiatives consider quality and safety of delivery with Standard Operating Procedures in Place where required.
Equality, Diversity and Inclusion	An overarching Quality and Equality Impact Assessment has been completed.
Finances and Use of Resources	There is financial transparency on the allocation of resources as outlined within this paper.
Regulation and Legal Requirements	N/A
Conflicts of Interest	Initiatives contracted/procured in accordance with NHS procurement legislation.

Data Protection	Data Protection Impact Assessments have been completed for initiative(s) as required
Transformation and Innovation	All initiatives are being fully evaluated
Environmental and Climate Change	N/A
Future Decisions and Policy Making	Accelerator site learnings/evaluation is being fed into NHS England to inform national policy making in relation to ‘Get Britain Working’
Citizen and Stakeholder Engagement	Engagement on patient experience is being collated through qualitative evaluation of schemes

1. Introduction / Background to the Healthy Working Life Accelerator Programme

The **Healthy Working Life Accelerator** in West Yorkshire Programme was introduced on the 26th of November 2024. The Government White Paper 'Getting Britain Working' announced funding for eight Trailblazer locations to help them tackle economic inactivity. Three of these locations were identified as Accelerators, receiving extra funding to target the health drivers of economic inactivity. West Yorkshire was named as both a Trailblazer and Accelerator and that it was to receive £37m divided across the Combined Authority (£10m), Local Authorities delivering Connect to Work (£16m) and the NHS West Yorkshire ICB (£11m).

It was agreed that there would be place based initiatives/focus to ensure collaboration with local councils/partners along with WY wide initiatives for the £11m ICB income received.

Leeds received £3.2m for place initiatives to be delivered in 2025/2026. The programme started on 1 April 2025 and runs until the end of March 2026.

It should also be noted that the West Yorkshire Work and Health Plan was launched by the Mayor Tracy Brabin and former Chair of the West Yorkshire ICB Cathy Elliott on 10 March 2025. The West Yorkshire Work & Health Partnership commissioned the co-production of a Work, Health and Skills Plan in 2024. The Partnership convenes partners and stakeholders from the Combined Authority, the West Yorkshire ICB, Job Centre Plus and the five local authorities, along with partners from the wider health, employment and skills system and the Voluntary, Community and Social Enterprise (VCSE) sector.

Key points in the Plan include:

• The **vision** for the Work, Health, and Skills Plan is **for West Yorkshire to have the healthiest residents and workforce in England by 2040**.
• We will do this by **creating a work, health, and skills system which provides person – centred support to individuals and helps employers fill vacancies and create a diverse, skilled workforce.**
• We will know we have succeeded when we see **more people, especially those with health conditions and disabilities, enter, remain, and progress in good quality work**.

Within this vision, the Plan has a **clear objective**:
• To reduce economic inactivity and health and socio-economic inequalities by supporting more residents with health conditions and disabilities to access or keep good quality work.

1.1 Our approach to establishing the Leeds Healthy Working Life Accelerator Programme

The approach to the **Leeds Healthy Working Life Accelerator** has been informed by insight and population health data and is catered to the specific health and care needs of people living across the city. The aims of the Accelerator are to:

- Improve population health outcomes.
- Increase economic growth by reducing health-related labour market inactivity.
- Shift from a model of care that treats sickness to one of prevention, which tackles health inequality.

Its objectives are to:

- Support **552** more people in Leeds to be economically active in one year through health-orientated interventions, compared to a do-nothing scenario (% of West Yorkshire's target of 1,300 people)
- Take a new system-wide approach to this challenge and to learning and testing at scale.

The Accelerator funding opportunity has facilitated real focus on the Work, Health and Skills Plan and has accelerated partnership working in this area; for example, ICB collaboration with the Combined Authority.

1.2 The Data

The percentage of people in Leeds who are economically inactive due to ill health reporting various conditions (these may not be main reason for economic inactivity) are outlined below:

- Cardiovascular disease, respiratory conditions, digestive issues, diabetes: 55.9%
- Musculoskeletal conditions: 45.7%
- Mental health: 29.7%
- Other conditions including epilepsy and progressive illnesses: 28.7%
- Difficulty seeing or hearing: 15.5%

Source of data: Annual Population Statistics (APS); April 2023 – March 2024

We utilised this data, and our knowledge of existing service/pathway challenges to inform the development of initiatives as outlined in **section 2.0**.

1.3 The Pillars of the Healthy Working Life Programme

As mentioned above, West Yorkshire received both Trailblazer and Accelerator funding. The overarching Healthy Life's programme is therefore grouped into three key pillars of activity as below. The ICB in Leeds are responsible for implementing **Pillar 2,** which will contribute to reaching the total target of **552** people across Leeds.

The pillars are summarised below, with these principles agreed quickly in early 2025 collaboratively by Leeds partners and West Yorkshire.

Figure 1: The Three Pillars

Pillar	**Area of focus/priority**	**Leeds 25/26 Funding**
1 - Social care & NHS workforce	Providing support for our health and care workforce, with a focus on mental health, MSK and cardio-metabolic conditions	**£697,000** (direct transfer to Leeds Health and Care Academy)
2 - Prevention & early intervention activity	**Providing support for the resident or GP registered population living with one or more long term condition** In addition, Leeds has received £226,416 for investment in digital therapeutics	**£2,289,600** **£226,416**
3 - Employment support & employer liaison	Aligning health-specific support with both wider national funding streams supporting	(£1m across WY)

	people back into work, and the workforce and prevention pillars	

Pillar one activities are driven by the Leeds Health and Care Academy and Pillar three activities are driven by Leeds City Council and the Combined Authority West Yorkshire. More detail concerning these pillars are provided in **appendix 1**. The ICB in Leeds received within its financial allocation funding for pillar 1, which is in the process of being transferred to the Leeds Health and Care Academy.

2.0 ICB in Leeds Pillar 2 - Prevention and Early Intervention Initiatives

Confirmation of resources to West Yorkshire and places was confirmed in December 2024, with implementation of schemes to commence by April 2025. Our Leeds allocation of £2.5 million for pillar 2 schemes for was confirmed in January 2025. The ICB project team (a small matrix team consisting of pathway and system integration, BI, contracting, communications, evaluation resource and programme support) had to develop /consider potentially suitable initiatives quickly using the data available to us. This process and suggested allocation of financial resource across providers at the time was ratified by the Leeds Partnership Executive Group in early 2025 and the January Leeds Delivery Sub-Committee meeting, with Directors from Leeds kept informed/briefed. From a Leeds perspective we worked to ensure priority initiatives also supported the current Leeds system risks and priorities; like weight management, ADHD and 3 plus LTCs. Feedback was received from partners to inform this with engagement via the Leeds Long Term Conditions Population Board.

The initiatives and their current implementation status, reach, value, etc. is outlined below in **Figure 2**.

Figure 2: Pillar 2 Initiatives

Initiative Name	Funding Allocated	Anticipated Reach – Number of people supported via the initiative & referral route where known.	Start Date and Lead Provider
Digital Therapeutics – MSK App	£325,000	Whilst there will be a maximum reach of 5000 people for the GetUBetter app, we have agreed to capture evaluation data for a target of 822 people using the app, as triage / significant administration required to support the evaluation.	Tender waiver signed by ICB. 1st Sept 2025 start date due to lead in time for procurement of app. Mobilisation is progressing well. Leeds GP Confederation.
William Merritt – Daily Living Aids and Assistive Technology	£40,000	160 people to be supported/evaluation data captured for	Contract Signed June 2025. Referrals commenced July 2025. William Merritt is a VCSE organisation.
Individual Placement and Support (IPS) for people with SMI	£155,000	58 people to be supported/evaluation data captured for **Who can refer:** Any professional from primary care, secondary mental health services, or the third sector can refer individuals by completing online referral form available via admin@workplaceleeds.org.uk	Full offer commenced in June 2025 – small trial in south of city commenced May. Contract signed. 87 referrals so far. 84 people seen. Leeds MIND
Expansion of NHS Talking Therapies with a focus on economic inactivity	£161,508	300 people to be supported/evaluation data captured for	Scheme/referrals commenced 1st July 2025 North Point
Hypertension – Blood Pressure Monitoring	£150,000	Tailored support to 50 people with hypertension diagnosed following earlier identification. Initiative has greater reach – however evaluation data cannot be captured for these. **Who can refer:** • initial contact with participants will be opportunistic from Community Organisations. This may happen through existing groups/events or through specific outreach. Within the Community, participants will be offered an initial BP check. • If the initial BP check is high, participants will be encouraged to uptake a referral to social prescribers at Linking Leeds.	Expected start 1st September 2025 Leeds City Council

		The social prescribers will then complete the necessary data for NHS England, find out more about the participants concerns and offer 7 day at-home blood pressure monitoring. • If the average reading over 7 days from at-home blood pressure monitoring is still showing as high, Linking Leeds will then refer the participant to their GP. • If the participant does not want the option of Linking Leeds, they will be encouraged to go to their local community pharmacy.	
ADHD Patient Optimisation	£375,000	750 people to be supported/evaluation data captured for	Service commenced April 2025. Referrals are being received into the service with a phased roll-out across PCNs. Significant volume of referrals. Leeds GP Confederation
Physical Activity - LEAP	£110,000	300 people to be supported/evaluation data captured for	Service commenced April 2025. Referrals are being received into the service – 46 so far Active Leeds / Leeds City Council
Weight Management hubs in Primary Care	£120,000	60 people to be supported/evaluation data captured for	Service commenced August 2025. Three PCNs selected to work with following EOI. Seven strong applications in total. Leeds GP Confederation
Enhanced support for people living with pain and fatigue	£110,000	288 people to be supported/evaluation data captured for **Who can refer:** Patients cannot self-refer. They need to be under care of long covid service to access the VR.	14th and 19th August - 1st groups to go live. Leeds Community Healthcare
Diabetic Foot Pathway Enhancements	£80,000	50 people to be supported/evaluation data captured for	Service/referrals commenced July 2025. Leeds Teaching Hospitals.
Multiple Long Term Conditions incl MH (previously SEISMIC) Hub	£290,000	200 people to be supported/evaluation data captured for	Service/referrals to commence October 2025 Design has commenced – using design sessions in Sept/Oct to finalise model for delivery in year 1 building on current models in 3 PCN's.

			Lead provider TBC
FIT Note exploration	£270,000	Enabling initiative.	Project meetings have commenced with data analysis to inform potential offer to primary care. Meeting scheduled with Leeds Medical Committee on the 9th September to discuss options.
Data Linkage	£100,000	Enabling initiative. This will allow linkage of employment status for all citizens across WY, with this ability to link to NHS data already held by the ICB. The outcome and benefit will be the ability to target cohorts more effectively.	Work underway and approval to link DWP with NHS commissioning data confirmed by NHSE. Identifying a national contact within the DWP who is able to take this forward is proving challenging, but significant support from the regional DWP team.

As above, implementation progress from all providers has been extremely positive. Implementation has been facilitated via fortnightly steering group meetings (internal ICB matrix team) and the formation of a provider network (see **section 6.0**).

Other financial allocations aligned to the project to facilitate implementation are outlined in **Figure 3:**

Figure 3: Other costs

	Total £	**Current status**
Programme Costs	£129,500	Matrix team to support this work in place.
Evaluation	£100,000	Ongoing evaluation of the programme is needed. West Yorkshire recruitment panel declined appointments beyond March 2026. Because ongoing evaluation is needed, we have agreed that Leeds Health and Care Academy (hosted by LTHT) will host a Band 6 evaluation lead until end of March 2027. This role will complete evaluation for Pillar 1 and Pillar 2. Recruitment is currently underway by LHCA.

Financial spend is on track/all balance.

3.0 Evaluation

The Health and Care Evaluation service in Leeds has worked with the West Yorkshire wide evaluation steering group and provided advice and support on the development of the evaluation. This has included:

- Supporting the development of the necessary contractual and information governance framework to allow the flow of data for both the national and local evaluation outputs through the use of NHS contracting mechanisms;
- Working with the steering group on the development of an outcome framework and indicators to support a robust, West Yorkshire wide evaluation that allows for the variety of different interventions across the region;

- Supporting the development of tools and guidance to support the collection of data by a wide range of different organisations on different scales;
- Supporting the recruitment of appropriately skilled analysts to carry out the evaluation including the development of a robust partnership with Leeds health and care academy to recruit a Leeds analyst until March 2027;
- Identification of a list of priority programmes in Leeds that will benefit from being evaluated in a greater depth;
- Provision of support to colleagues and providers in Leeds and other places in the ICB with the implementation of an evaluation methodology.

4.0 Contracting/procurement

The ICB consolidated contracting team have supported Leeds in the development and implementation of a range of processes including contract variations, grants, MOUs and direct award of new contracts to ensure that the funding could be passed to providers and schemes could be mobilised as soon as possible. Depending on the type of service (health or non-healthcare) a flowchart/set of steps was developed to support the team in deciding the contracting approach that adhered to the ICB Scheme of Delegation as well as meeting NHS procurement regulations.

The team have also developed an NHS standard contract template to enable the flow of the required minimum dataset containing personal level data from each scheme provider via the DSCRO, which will support monitoring and the final evaluation. This was particularly important as many of the scheme providers are small organisations that have limited experience of flowing data in this way.

5.0 Communications and case studies

The West Yorkshire ICB in Leeds' communications function is supporting the Leeds Healthy Working Life programme in the following ways:

- Working with the central West Yorkshire ICB Communications team to develop the Healthy Working Lives Programme branding and advice to local initiatives on its correct use.
- Developing the Leeds Healthy Working Life programme web page, which captures the local approach and celebrates the work being done at place and the difference the programme is making to peoples' lives. This will continue to be developed throughout the programme.
- Working with local initiatives to identify case studies promoting the work being done to improve peoples' lives across Leeds: Healthy Working Life CASE STUDIES :: West Yorkshire Health & Care Partnership
- Providing communication guidance to the Leeds Healthy Working Lives steering group.
- Providing specific guidance to specific Leeds-place initiatives on request, and providing hands-on communications support where required.

6.0 Leeds provider network

A Provider Network has been established and meets approximately monthly and provides a supportive space for Project Leads and project representatives from all providers, with a key purpose to support colleagues in the following focus areas:

- Collaboration - space for sharing expertise, understanding, learning, testing, innovating
- Enhancing communication;
  - Ability to align comms & engagement approach and improve understanding across projects
  - Support the delivery of common messages to patients
- Sharing Best practice - sharing and implementing across diverse organisations
- Enhanced learning - shared understanding of all projects
- Building consistency - e.g. same evaluation across services
- Problem Solving - using collective knowledge to inform approaches
- Developing Efficiency - potential to reduce costs for future service delivery & optimise referrals to projects across all 3 pillars
- System working - building relationships and systems around people not structures
- Developing a shared legacy - of improvement that informs future service delivery

7.0 Key learning

Our key learning gleaned from the programme to date, includes:

- Committed matrix team to deliver and facilitate this programme
- Great collaborative working between Leeds place and WY team; led by Jennifer Connelly
- Great collaboration with pillars 1 and 3; facilitated by regular Monday check-in meetings with LCC, Combined Authority, Public Health and LHCA
- Targeted initiative generation informed by data, risks and our local awareness prevented a bidding process/too many bids which we couldn't progress
- Evaluation and IG has been the hardest part of implementation
- Provider network key for facilitation of regular messaging, sharing best practice, etc
- Now that the majority of initiatives have mobilised we look forward to understanding how these begin to evaluate and the benefits being delivered.

8.0 Future funding

Within the 10-year plan and via central government there is increasing focus and spotlight on economic inactivity and accelerator programmes. We are very hopeful that similar monies are committed for 2026/27. Should this be the case and we received an indication of this by the end of the year, we propose that a recommendation is made by the ICB matrix team to the ICB committee in January 2026 regarding the schemes that we might continue, stand down or modify. We have flexibility in the current contract arrangements to complete a one-year extension with relative ease.

9.0 Recommendations

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

1) Receive this paper which provides an awareness / update on the Work, Skills and Health Programme with a focus on the Leeds Healthy Working Life Programme
2) Acknowledge the very positive work and implementation that has been completed in a relatively short timescale by all providers
3) Agree that if recurrent monies are confirmed for 2026/2027; that a recommendation is made by the ICB matrix team to the ICB committee in January 2026 regarding the schemes that we might continue, stand down or modify.

9.0 Appendices

1) Overview of Pillars 1 & 3

APPENDIX 1 - Overview of Pillars 1 & 3

Pillar 1 – Targeted support for social care and NHS workforce – interventions coordinated by the Leeds Health and Care Academy (LHCA).

Thrive at Work in Leeds is a programme hosted by the Academy's Talent Hub which launched on 22nd April. It is a hub-and-spoke model which helps individuals who are at high risk of becoming or remaining off sick or leaving employment as a result of their health, to access tailored support to stay well and remain in work. Focusing primarily on mental health and musculo-skeletal injuries and conditions, the service takes a holistic approach to help staff manage their conditions and access treatment, whilst also making workplace adaptations which enable them to remain in work, return to work or transition into a more suitable role where appropriate.

Services in Place:

- Integrated Coaching Service
- Mental Health Fast Track
- Workplace Adjustment
- MSK support

Implementation Approach:

- Flexible, adaptive delivery enabling timely engagement with partners and responsiveness to system needs.
- Inclusive eligibility criteria to reflect the interconnected nature of the H&SC ecosystem, including those who support the workforce indirectly.

Progress to Date:

- 17 weeks into delivery ~350 referrals received; majority via self-referral, now shifting focus to line manager and provider referrals for earlier intervention.
- Depression and anxiety remain the most common reasons for referral.
- All individuals are supported. Those who do not meet the high-risk threshold are supported through signposting and alternative provision.

Emerging Insights:

- Early qualitative feedback and draft case studies indicate high value and positive reception.
- Employers respond strongly when benefits are framed around retention, wellbeing, and productivity, particularly in VCSE and social care sectors.
- The cultural shift required for the health and social care workforce to start with preventative, coaching-based models rather than medical models of care may be greater than initially anticipated.

Operational Learnings:

- Pragmatic commissioning enabled rapid mobilisation but prioritised flexibility over value-for-money assessments.
- Future evaluation is planned to compare cost-effectiveness of different funding models.
- 12-week evaluation data expected to offer stronger evidence of impact.

A workplace promise to underpin the Thrive at Work delivery model with a view of providing training and supporting culture shift in workplace to prioritise continued engagement in work and achieves this by:

- Increasing knowledge and skills training for managers and HR staff on health and staying in work
- Driving collective leadership development that champions workforce wellbeing.
- Strengthening policies and communications that support people to stay in work.
- Building on and connecting with existing infrastructure and good practice.
- Leaving a legacy beyond the pilot, embedding new ways of working.

In addition to Thrive at Work, Pillar 1 also includes a West Yorkshire wide programme to introduce a "Career Compass Healthy Transitions" tool, to the Career Compass platform. This project is also being led by the Leeds Health and Care Academy as an enhancement to the core platform. The aim of the project is to create an interactive digital tool which can help people who are working (or hoping to work) in health and social care, to consider how their health needs can and should inform their personal career choices throughout their lives.

The new tool will be live by the end of November 2025 and the project plan is currently on track. Below is an outline of the progress to date.

- Scoping and research phase supported by C&K Careers completed
- Self-assessment questionnaire and outputs currently in development with stakeholders
- Technical development supported by HMA scheduled to begin in September with launch planned for November

Pillar 3 - Employment support & employer liaison - activities are driven by Leeds City Council and the Combined Authority West Yorkshire (WYCA)

Deliverables include a Employment Hub (Ehub)

Through agreement with WYCA, support to residents on the Pillar 3 Accelerator has been combined with other funds (including DWP Trailblazer) to offer support to individuals who are either unemployed, economically inactive or employed.

There is a strong focus on those with health conditions and or economically inactive, the accelerator element is focussed on supporting those who are in work who are at risk of losing their jobs due to their health condition or disability.

Between the various funded programmes there is one offer to all residents and will see over 1400 individuals receive support by April 2026. To date over 700 people have been supported with the most frequent health condition being mental health.

Delivery of support is through local Employment Advisors who are based in the local community and can offer:

- Individual support tailored to needs
- Careers advice and guidance
- Opportunities to learn new skills
- CV writing and completing application forms
- Interview practice
- Access to local job and apprenticeship opportunities
- Opportunities to hear from a range of local employers
- In-work support
- Information and guidance on self-employment
- Advice on benefits calculations and managing debt
- Referrals esleeds@leeds.gov.uk or 0113 3784576 website:

  https://www.inclusivegrowthleeds.com/employmenthub

Meeting name:	Leeds Committee of the WY ICB
Agenda item number:	16
Meeting date:	3 September 2025
Report title:	Risk Register (Cycle 2 2025/26)
Report presented by:	Asma Sacha, WY ICB – Risk Manager
Report approved by:	Sue Baxter, WY ICB - Head of Partnership Governance
Report prepared by:	Asma Sacha, WY ICB – Risk Manager

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

Previous considerations:

Leeds Directors meeting – Comments via email 9 July 2025
Leeds Quality and People's Experience (QPEC) 16 July 2025
Leeds Finance, Value and Performance Sub-Committee 23 July 2025

Executive summary and points for discussion:

This report provides details of all risks on the Leeds Place Risk Register at the end of the current risk review cycle (Cycle 2, 2025/26) in Appendix 1. The total number of place risks for consideration, the numbers of risks which are marked for closure, new, increasing or decreasing in score are set out in the report, along with the numbers of Critical and Serious Risks.

The paper includes the Cycle 2 review of the Board Assurance Framework (BAF) for all five places which is attached at Appendix 3. The BAF provides the ICB with a method for the effective and focused management of the principal risks and assurances to meet its objectives. By using the BAF, the ICB can be confident that the systems, policies, and people in place are operating in a way that is effective in delivering objectives and minimising risks.

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 review the risks and:

- **RECEIVE** and **NOTE** the High-Scoring Risk Report as a true reflection of the risk position in the ICB in Leeds following any recommendation from the relevant sub-committees.
- **CONSIDER** whether it is assured in respect of the effective management of the risks and the controls and assurances in place.

- **RECEIVE** and **NOTE** the Board Assurance Framework for Cycle 2 2025/26

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

The report provides details of all risks on the Leeds Place Risk Register and an update of the Board Assurance Framework review. The various ICB Risk Registers support and underpin the BAF, and relevant links will be drawn between risks on each going forward.

Appendices:

Appendix 1: Leeds Place Risk Register, Cycle 2 2025/26
Appendix 2: Leeds Place Risks on a Page Report, Cycle 2 2025/26
Appendix 3: West Yorkshire ICB Board Assurance Framework, Cycle 2 2025/26
Appendix 4: Leeds Health and Care Partnership Top Risks – July 2025

Acronyms and abbreviations explained:

- Static – 'x' archives – risk score has been unchanged for 'x' risk cycles
- Static description – neither the risk score nor its description has changed since the previous cycle
- Reached tolerance – current risk score has reduced to target score so risk may be closed

What are the implications for:

Residents and Communities	Any implications relating to individual risks are outlined in the Risk Registers
Quality and Safety	Any implications relating to individual risks are outlined in the Risk Registers
Equality, Diversity and Inclusion	Any implications relating to individual risks are outlined in the Risk Registers
Finances and Use of Resources	Any implications relating to individual risks are outlined in the Risk Registers
Regulation and Legal Requirements	Any implications relating to individual risks are outlined in the Risk Registers
Conflicts of Interest	None identified.
Data Protection	Any implications relating to individual risks are outlined in the Risk Registers
Transformation and Innovation	Any implications relating to individual risks are outlined in the Risk Registers
Environmental and Climate Change	Any implications relating to individual risks are outlined in the Risk Registers
Future Decisions and Policy Making	Any implications relating to individual risks are outlined in the Risk Registers
Citizen and Stakeholder Engagement	Any implications relating to individual risks are outlined in the Risk Registers

1. Purpose of this report

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

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

2. Context and Background information

2.1 The WY ICB risk management arrangements categorise risks as follows:

- Place – a risk that affects and is managed at place
- Common – common to more than one place but not a corporate risk
- Corporate – a risk that cannot be managed at place and is managed centrally

2.2 The West Yorkshire Risk Management Policy and Framework was approved at the West Yorkshire ICB Board on 24 June 2025 which details the risk management process including the risk scoring matrix.

2.3 During each risk cycle, risk leads across the ICB review the risks on each place risk register. This supports the identification of place risks scoring 15+ and common risks on the registers. The detailed review and mapping of the risks also enables the flagging of potential anomalies in scoring or wording between different places, supporting the discussions that ensure the continued evolution of the risk register.

2.4 All corporate risks, place risks scoring 15 and above and common risks will be presented to the relevant WY ICB committee and to the WY ICB Board on the following dates:

- West Yorkshire ICB Finance, Investment and Performance Committee – 2 September 2025 (AM)
- West Yorkshire ICB Quality Committee – 2 September 2025 (PM)
- West Yorkshire ICB Board – 23 September 2025

2.5 The Cycle 1, 2025/26 Corporate Risk Register, the common risk mapping across the five places and the Cycle 1 Board Assurance Framework was presented to West Yorkshire Integrated Care Board on 24 June 2025.

3. Key Points

3.1 This report set out the key changes to the risk profile of the Leeds place during risk cycle 2 2025/26 which commenced on 25 June 2025 and will end after the WY ICB Board meeting on 23 September 2025.

3.2 The extract of the Risk Register (Appendix 1) provides further detail of all risks including the key controls and assurances for each risk. The 'Risk on a Page' report (Appendix 2) provides a summary of the key changes since the last review cycle. The high scoring partner risks are highlighted in Appendix 4.

There are 17 risks on the Leeds place risk register:

- Ten risks are aligned to the Quality and People's Experience Committee
- Five risks are aligned to the Finance and Best Value Committee
- Two risks are aligned to both the Quality and People's Experience Committee and Finance and Best Value Committee

The following changes have taken place in Cycle 2, 2025/26:

- Nine high scoring risks (15+ in risk score)
- One new risk
- Two risks have decreased in risk score

3.3 **High level risks**

There are nine high level risks (risk score 15+) on the Leeds place risk register in cycle 2, 2025/26:

Risk	Sub-Committee Alignment	Cycle 2 2025/26	Update for Cycle 2 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 Committee	20 (I5xL4)	Update – static 1 cycle This was added on the risk register in Cycle 1, 2025/26. The risk owner has added additional assurance, but the risk score remains at 20 in Cycle 2. Regular monthly budget holder and finance meetings in place to address shifts in position.

Risk	Sub-Committee Alignment	Cycle 2 2025/26	Update for Cycle 2 2025/26
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 Committee	16 (I4xL4)	Update – static 1 cycle The infrastructure investment challenges remain due to delays in funding. The risk score remains the same.
2529 - There is a risk that the ICB in Leeds will not deliver the 2025/26 financial requirement of break even (as submitted to NHS England on 27 March 2025). This is due to the significant level of risk contained within ICS organisational plans (including a £33.2m 'system risk' value, currently held within the ICB in WY), and the fact that delivery is predicated on delivering efficiencies of £429m of efficiencies (6.6% of allocation). Failure to deliver a break even position will result in:	Finance and Best Value Committee	16 (I4xL4)	Update – static 1 cycle Financial challenges remain, the risk score remains the same for Cycle 2.

Risk	Sub-Committee Alignment	Cycle 2 2025/26	Update for Cycle 2 2025/26
- 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).			
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	16 (I4xL4)	Update – Decreasing The risk score has decreased in cycle 2, from 20(L4xI5) to 16 (L4xI4). The risk owner has reported improved partnership working when a children and young person presents with escalating needs, there is good planning and solutions for discharge which is being agreed and implemented sooner, therefore the risk score has reduced from 20 to 16.
2480 - There is a risk that our current commissioned Tier 3 weight management service will not have sufficient capacity to meet demand due to limited local budget and workforce and the introduction of new drugs for weight management and associated NICE technology appraisals increasing demand and legal obligations. This could result in an increased number of	Quality and People's Experience Committee	16 (I4xL4)	Update – static 2 cycles The NICE Technology Appraisal (TA) medicines policy and funding variation was reviewed at the Transformation Committee in July 2025. Also in place are feasibility studies for four models of primary care delivery of Tirzepatide. Risk score remains the same for Cycle 2.

Risk	Sub-Committee Alignment	Cycle 2 2025/26	Update for Cycle 2 2025/26
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.			
2414 - There is a risk that measures being taken to control expenditure in Leeds City Council will have an impact on other place partners, due to the financial pressures being experience by most councils across West Yorkshire and their statutory 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 (I4xL4)	Update – static 5 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	Quality and People's Experience Committee	16 (I4xL4)	Update – static 8 cycles The risk score remains the same for Cycle 2. Current controls are still not sufficient to reduce the risk when there is exceptionally high demand on the system

Risk	Sub-Committee Alignment	Cycle 2 2025/26	Update for Cycle 2 2025/26
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.			
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 Finance Sub-Committee / Leeds Committee	15 (I3xL5)	Update – static 9 cycles The risk remains at the same rating with significant financial risk to the ICB. The WY Commissioning Policy being developed and out for consultation over Q2, 2025/26. A deep dive took place at the Quality and People's experience committee on 16 July 2025. A detailed explanation of the issues around spend and value in the provision of diagnostic assessment and support was presented. The group discussed the importance of a strong plan with detailed evaluation built in to test whether the new approaches being tested are providing better outcomes and improving inequalities, recognising the importance of poverty, deprivation, ethnicity and other factors that may impact on accessing diagnosis and support.

Risk	Sub-Committee Alignment	Cycle 2 2025/26	Update for Cycle 2 2025/26
			The group understood that the new models would take significant time to reverse the risks in the spend but welcomed the focused attention. They asked for more detailed modelling work to be completed once the initial evaluation data has started to come through for the adult ADHD pathway.
2301 - There is a risk of CYP being unable to access a timely diagnostic service for neurodevelopmental conditions (Autism and ADHD) due to rising demand for assessments and capacity of service to deliver this (ICAN for under 5, CAMHS for school age). In addition, with the focus on diagnosis and the associated costs of referrals, there is less opportunity to resource additional needs led provision over and above what we already locally provide to meet the escalation of needs. The delays in access to timely diagnosis may impact upon children's outcomes, access to other support services across health, education and social care, and also compliance with NICE standards for assessment within 3 months from referral.	Quality and People's Experience Committee	15 (I3xL5)	Update – static 10 cycles The risk description has been reviewed and amended with focus on access to diagnosis and support which is also a risk. The development of WY hub has commenced and locally the team are engaged and supporting this.

3.4 **New risks**

There is one new risk in Cycle 2, 2025/26:

Risk	Sub-Committee Alignment	Cycle 2 2025/26	Update for Cycle 2 2025/26
2550 - There is a risk that initial health assessments for children in care, will not be completed within the statutory time frames. This is primarily due to ongoing capacity difficulties in children's social care and our community provider to ensure timely referrals to the health team. This could result in health needs assessments of Children in Care being delayed and the health needs of these vulnerable children not being met, which could impact upon longer term outcomes.	Quality and People's Experience Committee	12 (I3xL4)	New risk. A new risk has been added to place risk registers (Leeds, Wakefield, Kirklees and Bradford District and Craven) in relation to the impact of the delays in initial health assessments for looked after children. There are robust systems in place that give live information of clinic availability and waiting times and escalation process is in place to notify head of service should there be children or young person waiting for IHNA appointments.

3.5 **Increase in risk score**

None.

3.6 **Decrease in risk score**

Two risks have reduced in risk score during Cycle 2, 2025/26. Risk 2494 has reduced in risk score which is highlighted above in section 3.5. The following additional risk has reduced in risk score:

Risk ID	Risk score Cycle 1	Risk score Cycle 2	Sub-Committee	Risk Description	Reason for change
2415	16 (I4xL4)	12 (I4xL3)	Quality and Finance Sub-Committee /	There is an increasing risk of widening health inequalities and poorer health outcomes across Leeds due to the reduction	This risk has reduced from 16 to 12.

Risk ID	Risk score Cycle 1	Risk score Cycle 2	Sub-Committee	Risk Description	Reason for change
			Leeds Committee	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.	Work being progressed to align future funding of Third Sector in Leeds with principles set out in the position statement around joint commissioning and longer-term contract arrangements. There is ongoing work to build Third Sector into Neighbourhood Health Model.

3.7 **Closed risks**

None.

4. Emerging risks

4.1 The following risks are being developed on the WY ICB corporate risk register in relation to the WY ICB organisational change:

- Risk to being able to deliver statutory functions in respect of quality and safety including safeguarding
- Financial risk due to lack of funding for staff redundancy costs and exit packages
- Risk of prolonged distraction, disruption and people starting to disengage impacting on the ICB's core activities
- Risk of increased turnover of staff and wellbeing concerns for staff due to the organisational change programme and the development of the ICB operating model.
- The risk on industrial action will also be reviewed due to recent strike action by resident doctors (previously referred to as Junior Doctors) and the possibility of strike action by nursing colleagues.

5 Board Assurance Framework (BAF) update for Cycle 2 2025/26

5.1 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.

5.2 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.**

5.3 The Board Assurance Framework reviewed in Cycle 2 2025/26 is attached at Appendix 3 and the review for Cycle 2 is highlighted using blue font.

5.4 The table below shows key changes which has been made to the BAF following review by Leeds senior managers during Cycle 2, 2025/26;

BAF risk	Cycle 4, 2024/25	Cycle 2 2025/26	Reason for change
2.4 There is a risk that our infrastructure (estates, facilities, digital) hinders our ability to deliver consistently high-quality care.	12	16	The delays with the construction of the Leeds Teaching Hospital Trust has increased this risk therefore the current risk score has been reviewed and increased from 12 to 16.

6 Next Steps

6.1 The risks will be carried forward to the next risk review cycle which will commence after the WY ICB Board meeting on 23 September 2025.

6.2 Subsequent to that meeting, any closed risks will be archived and open risks carried forward to the next risk review cycle.

7 Recommendations

The Leeds ICB Committee is asked to review the risks aligned to the Committee and:

- **RECEIVE** and **NOTE** the High-Scoring Risk Report as a true reflection of the risk position in Leeds following any recommendation from the relevant sub-committees.
- **CONSIDER** whether it is assured in respect of the effective management of the risks and the controls and assurances in place.

- **RECEIVE** and **NOTE** the Board Assurance Framework for Cycle 2 2025/26

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 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. 9. Identified cash releasing efficiency schemes in place. 10. New PHB Payroll and Direct Payment Managed Bank Account provider in position which has enabled use of superior software supporting transparency of accounts.	1. Regular data cleansing activity in place to assure financial data held is accurate and up to date 2. All staff aware of responsibilities in regard to Scheme of Delegation 3. Decision - Makers re eligibility and commissioning decisions are fully aware of Commissioning Principles and how to implement 4. PHB Audit and 'claw-back' processes in place and in operation. 5. Packages of care to be delivered via PGH Direct Payment are carefully considered in terms of statutory duties of the ICB to deliver.	1. Spend on PHB Direct Payment budgets is subject to misuse and mis-management 2. Potential for inappropriate decisions made on PHB packages of care following historical agreements. 3. Overdue reviews lead to potential lack of up to date needs and care plan, or costs for care. 4. Local Councils responsible for agreeing uplifts and rates for non-eligible individuals, with differing level of assurance/authority to act/evidence of 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 increases in costs can occur at any time. 7. The uncertainty around ICB organisational change increases the risk of losing experienced staff or losing grip due to the actual restructure process.	Static - 1 Archive(s)
2530	14/04/2025	Finance and Best Value Committee	Enhance productivity and value for money	16	(I4xL4)	9	(I3xL3)	Matthew Turner	Alex Crickmar	There is a risk that the needs and demands for NHS infrastructure investment in West Yorkshire is greater than the resources being made available to the ICB/ICS. This is due to the specific environmental and building issues prevalent in the West Yorkshire system and the finite capital resource being made available This could result in poor quality estate and equipment, with resultant risks to safety, quality, experience and outcomes.	1. Oversight at WY ICS Finance Forum, supported by Capital Working Group 2. Utilisation of organisational and place / system risk registers to generate action 3. Risk based approach to prioritisation of operational capital (within our envelope) 4. Risk based approach to lobbying for strategic capital 5. Development of an infrastructure strategy for West Yorkshire (completed July 2024) 6. Establishment of an ICS Infrastructure Strategy Oversight Group	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	Static - 1 Archive(s)
2529	14/04/2025	Finance and Best Value 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)	Static - 1 Archive(s)
2494	25/03/2025	Quality and People's Experience Committee	Improve healthcare outcomes for residents	16	(I4xL4)	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 All are ongoing.	Opportunity for greater connectivity between local controls and pressures including in Health/LA & Provider Collaborative where appropriate No 'spare' capacity is available to meet the needs of all children in crisis at all times	1. Actions agreed and implemented from meetings and escalations 2. When a young person placed is 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 1/7 Partners are now escalating cases much sooner to allow for the planning and solutions to be made and agreed. recruitment of Positive Support Service underway to help provide capacity for more proactive work	Timely escalation - without delays 1/7 Identification of placements can be a challenge if the CYP becomes looked after whilst in hospital 1/7 Lack of providers that match the needs of the CYP	Decreasing
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 will not have sufficient capacity to meet demand due to limited local budget and workforce and the introduction of new drugs for weight management and associated NICE technology appraisals increasing demand and legal obligations. This could result in an increased number of referrals to right to choose providers and associated expenditure and potential detrimental impact on the quality and suitability of services for the population in Leeds.	1. Revised contract and specifications to help future planning facilitated by funding (ICB Leeds) 2. Recovery plans and efficiency plans in place 3. Leeds Specialist Weight Management service reopened to referrals in July 2024 4. Ongoing work to develop new model of delivery - SPA/front door in collaboration with Leeds Specialist Management service and Leeds GP confederation 5. NICE TA medicines policy and funding variation for agreement at Transformation Committee in July 6. Right to choose monitoring 7. Feasibility studies for four models of primary care delivery of Tirzepatide	1. Awaiting guidance from NHSE 2. Awaiting guidance and support from WY core team 3. Limited ability to mitigate referral to Right to Choose - clear legal advice required 4. Media influence and public demand 5. No local governance contract mechanisms with national right to choose provider(s)	1. Currently discussed and reviewed via Leeds long term conditions population board with updates to Leeds Scrutiny committee and Leeds LMC 2. Local service offer in place in Leeds 3. Quality measures in place of the local offer	See above	1. Not receiving quality data from right to choose (only referral numbers received) 2. Gaps in data from Leeds data model	Static - 2 Archive(s)
2414	20/03/2024	Finance and Best Value Committee	Enhance productivity and value for money	16	(I4xL4)	6	(I3xL2)	Matthew Turner	Alex Crickmar	There is a risk that measures being taken to control expenditure in Leeds City Council will have an impact on other place partners, due to the financial pressures being 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. Regular meetings with LCC and through ICE where financial position and risks are shared.	Close working relationships between the NHS and councils in place and representation of councils on system partnership board	Lack of medium term plan to understand how recurrent financial balance position can be achieved.	Static - 5 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 through Active System Leadership Structures System Escalation Actions and Processes revised continuously Integrated OPEL Framework 2024/26 published in Oct 24. Communications work with Public to suggest alternatives to ED Investment in HomeFirst services and in assessment capacity through Better Care Fund Winter capacity plans in place to support discharge capacity Improvements in pathways, processes and in hospital waiting times for social workers and care act assessments have reduced the length of time people wait on pathways 1 & 3 where a care act assessment is required for long-term care. Improved capacity for Same Day Emergency Care at St James's and virtual ward capacity significant improvements in waiting time for rehab beds driven by major productivity gains LTHT internal improvement plan to reduce delays in care Home First 2 Intermediate Care workstream, with particular focus on P3	Key controls in place responding to high levels of demand. Current controls are still not sufficient to reduce the risks when there is exceptionally high demand on the system or where outflow is constrained While occupancy has improved, this isn't always correlated with a reduction in people spending a long time in ED - in part because the bed availability doesn't always match the specialty that is in demand delivery plans of all partners not yet sufficient to reduce occupancy levels, and funding constraints mean that where beds are released there is financial pressure to close them rather than reduce occupancy levels	Health & Social Care Command & Control Groups: Active System Leadership,Active System Leadership Executive Group (Silver) Integrated Commissioning Executive Home First Programme Board Quality and Performance Committee System Visibility Dashboard is in place to support assurance and decision making	Bi-weekly meeting in place for services to report on capacity /demand (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 and HF 2 programme being finalised Improvements in SW staff retention 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. Lack of an agreed plan to improve flow out of Stroke wards SW capacity, recruitment and retention remain a key risk alongside groups such as therapists	Static - 9 Archive(s)
2354	14/08/2023	Quality and Finance Sub-Committee / Leeds Committe	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.	Team now in place offering needs led assessment of all local ADHD adult referrals on behalf of primary care. This will help us understand the volume of people who meet the threshold for a diagnosis, but also the most effective way to provide support for needs related to suspected neurodiversity. 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. WY accredited provider list will be increased from August 2025 which will help improve quality and reduce 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. 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. Trying to reinforce data capture requirements via accreditation and other lead commissioners, but needs national push too to improve tracking and understanding WY Commissioning Policy being developed and out for consultation over the summer	Spend is driven by the high numbers of people already in the system. 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 Awaiting proposal from LYPFT about their proposals for their ongoing service There is no ring-fenced investment/funding into ADHD or autism development. Data collection by all 15 providers remains patchy which makes it impossible to really track referral demand or how current needs are being met The increased supply of diagnostic capacity is making it difficult to shift investment into support offers without commissioning policy difficult to require referrers to use front door offer demand into ADHD pilot offer already significantly higher than anticipated, so would need more funding to cover Autism referrals too	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 summer - National Task Force set up, but potentially then risks local solution development as people wait for national steer	Static - 9 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). In addition, with the focus on diagnosis and the associated costs of referrals, there is less opportunity to resource additional needs led provision over and above what we already locally provide to meet the escalation of needs. The delays in access to timely diagnosis may impact upon children's outcomes, access to other support services across health, education and social care, and also compliance with NICE standards for assessment within 3 months from referral.	1. Development of "ND - thinking differently case" presented to PEG in March 2024 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. 2. Working with cluster leads in the highest RTC referring areas, identifying what needs led provision is already provided and what additional support is required to meet the need of children in the cluster area. (7/7/25) 3. 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. 4. 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 focused time out in October 2025. System wide workshop undertaken, headed by senior leaders and action plan particular relating to education developed. Needs a refresh as due to education leaders absence, planned in the next coming weeks (Aug 2025) 5. Funding has moved to LCH to outsource assessments for our most vulnerable cohorts. 6. 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 7. Refreshed framework for accreditation of providers to secure face to face capacity has been published which will help with QA of providers and also aims to increase medication initiation capacity	1. Escalating increase in choice referrals due constrained local capacity, but long waits for other providers too and not all offer access to medication 2. Available funding and workforce will make rapid improvements difficult. 3. Staff availability with appropriate skills remains a key risk nationally and locally 4. Lack of update from national Task Force. Pace of change required to shift from diagnosis led to needs led transformation	1. Data from LCH on waiting times. Working group established this will report regularly to SEND Partnership board and CYP population board 2. Meeting in place with ICB, LCH and LCC to determine development plan and shared position statement. Engagement with Education underway. Action plan re workshop outcomes - being refreshed and relaunched. Development of WY hub provision and place provision at cluster level being developed	1. Capacity in IS confirmed for highest risk cases 2. ICB establishing a clinical reference group to support model design 3. Written to all families on the waiting list to sign post to additional resources that will offer support - need to progress work on contacting everyone on the SPA backlog. Data relating to wait times more readily available and referral numbers to Right to Choose being used to model some of the cluster offer proposals.	Trying to balance risks to individual children and families of not receiving a diagnosis, with the costs of the diagnostic capacity and the need to provide support not just diagnosis	Static - 10 Archive(s)
2550	28/07/2025	Quality and People's Experience Committee	Improve healthcare outcomes for residents	12	(I3xL4)	6	(I3xL2)	Angela Dillon	Jo Harding	There is a risk that initial health assessments for children in care, will not be completed within the statutory time frames. This is primarily due to ongoing capacity difficulties in children's social care and our community provider to ensure timely referrals to the health team. This could result in health needs assessments of Children in Care being delayed and the health needs of these vulnerable children not being met, which could impact upon longer term outcomes.	1. On LCH Risk Register and updates given to quarterly Safeguarding Committee. 2. Standing Operating Procedures (SOP's) across West Yorkshire to be standardised (2025/26) 3. Risk escalated to children's commissioners at Place. Regular meetings take place between commissioner provider and DN. One off extra clinic capacity commissioned to reduce backlog. Completed May 25. 4. Risk communicated to Place based Corporate Parenting Board (CPB) and updates given quarterly. 5. Demand and capacity assessment undertaken and current capacity would meet demand if WNB is reduced. 6. Work with stakeholders completed to assess barriers to attendance of IHNA's 7. Plan in place to overcome barriers and reduce WNB. 8. Nurse oversight of cases waiting for IHNA consent. Ensure CYP are registered with GP. 9. LCH looking to build resilience into clinic capacity to cover holiday/sickness. 10. Robust weekly escalation in place between health and CSWS to speed up consent for IHNA. This has scrutiny from CPB.	1. Timeliness of requests for IHNA from CSWS.	1. Monthly performance data produced by LCH business support showing IHNA delivery against KPI's. 2. DN accesses LA and Health data monthly to gain assurance of data congruence. 3. Robust systems in place that give live information of clinic availability and waiting times. Escalation process in place to notify head of service should there be CYP waiting for IHNA appointments. 4. Quarterly data is shared by LCH with NHSE and this data is collated into WYICB dashboard which is shared at the WY CIC group for oversight. 5. Ensure regular review of the WY ICB corporate risk at the bi-monthly WY CIC group meeting. 6. Ensure regular reporting into place provider Safeguarding Committees, Corporate Parenting Boards and WY ICB Safeguarding Oversight and Assurance Partnership for oversight. 7. Connecting with relevant Regional and National Groups	See assurance on controls.	1. Assurance that LCH has resilience of clinic capacity to cover holiday/sickness.	New - Open
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. There is a significant additional risk that patients will not have the advocacy they need to go through the process due to a lack of commissioned resource. In addition to the above, there is reduced capacity within the court of protection which has meant that applications may have to be redone to ensure they are completed within the timescales given by the courts. This could result in a risk of unauthorised and unlawful deprivation of liberty.	1. Monthly meetings held to review caseload, update ADASS Priority Tool, and identify any immediate risks to safety and welfare. 2. Review of care and support plans, engagement with patients and their families/representatives. 3. MCA Specialist Practitioner / Lead in place to ensure clinical team are clear on roles and responsibilities in the CHC process to support necessary CoP applications. 4. Good relationship with Local Council in CoP processes, including where joint responsibility in place. 5. Clear arrangements for local implementation for joint and fully funded individuals dependent upon residence	1. Lack of required resource at a Clinical Lead level to review and quality assure care and support plans to ensure CoP - ready 2. Lack of sufficient MCA/DoLS Lead resource at Place 3. Risk of increased legal fees due to lack of Team resource to undertake majority of workload 4. Increased costs associated with 1.2 representatives where individual resides 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. 6. LCH provide performance reports, highlighting the current position. 7. The ICB Mental Capacity Act Lead meets with LCH quality Leads and Beachcroft solicitors quarterly to track progress and unpick any delays or performance issues 8. The AACC Service has agreed a joint commissioning of an advocacy service for Leeds residents which is now live.	1. Updates provided regularly at a number of senior operational meetings 2. Place lead fully involved in WY discussions and updates. 3. 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. 5. Adam (CHC System) has been updated to record DoLS, enabling improved monitoring and recording of DoLS	1. Gap relates to workforce as identified. 2. The uncertainty around ICB organisational change increases the risk of losing experienced staff or losing grip due to the actual restructure process.	Static - 1 Archive(s)
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	Static - 1 Archive(s)
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. Contribution 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.	Static - 1 Archive(s)
2415	21/03/2024	Quality and Finance Sub-Committee / Leeds Committe	Tackle inequalities in access, experience, outcome	12	(I4xL3)	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 08/07/2025 Recent Third Sector State of the Sector report is indicative to lower the current likelihood of the risk. The latest position statement and working with the Third Sector across the ICB in Leeds to understand the current position. Work being progressed to align future funding of Third Sector in Leeds with principles set out in position statement around joint commissioning and longer term contract arrangements. Ongoing work to build Third Sector into Neighbourhood Health Model.	Need to develop broader partnership overview in Leeds at the moment still too fragmented so assurance is limited.	Decreasing
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 recruiting additional housing and discharge coordinators to help be more proactive in managing discharges LYPFT/LTHT working group reviewing processes around supporting people waiting for assessment and admission in ED	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 and the data flows to LYPFT around callers will be strengthened 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 and 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 daily OPEL data is flowing so visibility of key measures	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- Improving MH Flow Programme -in place and governance being further refreshed, including review of membership of Discharge Workstream. LYPFT reviewing configuration of community offers to help reduce barriers between teams. Complex rehabilitation work has seen good results in reducing inpatient stays	Access to urgent crisis assessment within the MH trust within 4hrs whilst improved remains below target. Ongoing challenges in embedding the pathways with the provider of 111 Mental health and the data flows required to support people then accessing ongoing support in Places . 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 - 4 Archive(s)
2531	14/04/2025	Finance and Best Value 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 would 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	Static - 1 Archive(s)
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. 7. Complete place mapping for end of life palliative care (2025/26)	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. 5. Uncertainty concerning where actions align given ICB reorganisation; central WY coordination versus place.	1. Financial audits: Work with finance teams to monitor and evaluate the impact of the tax increase on Hospice finances and assess the effectiveness of mitigation measures 2. Hospice performance reviews: Reviews of service delivery metrics to ensure patient care and service standards are maintained 3. Collect feedback from patients, families, carers and staff 4. End of Life Population Care Board: Regular reporting to ensure governance and accountability in managing the risk 5. Regular reporting to the group Quality sub committee 7. West Yorkshire Palliative End of Life Care Steering Group: Regular reporting to the group	See above	None identified at this stage.	Static - 2 Archive(s)

WY ICB Leeds Place, Cycle 2 - 2025/26
Risk on a Page Report

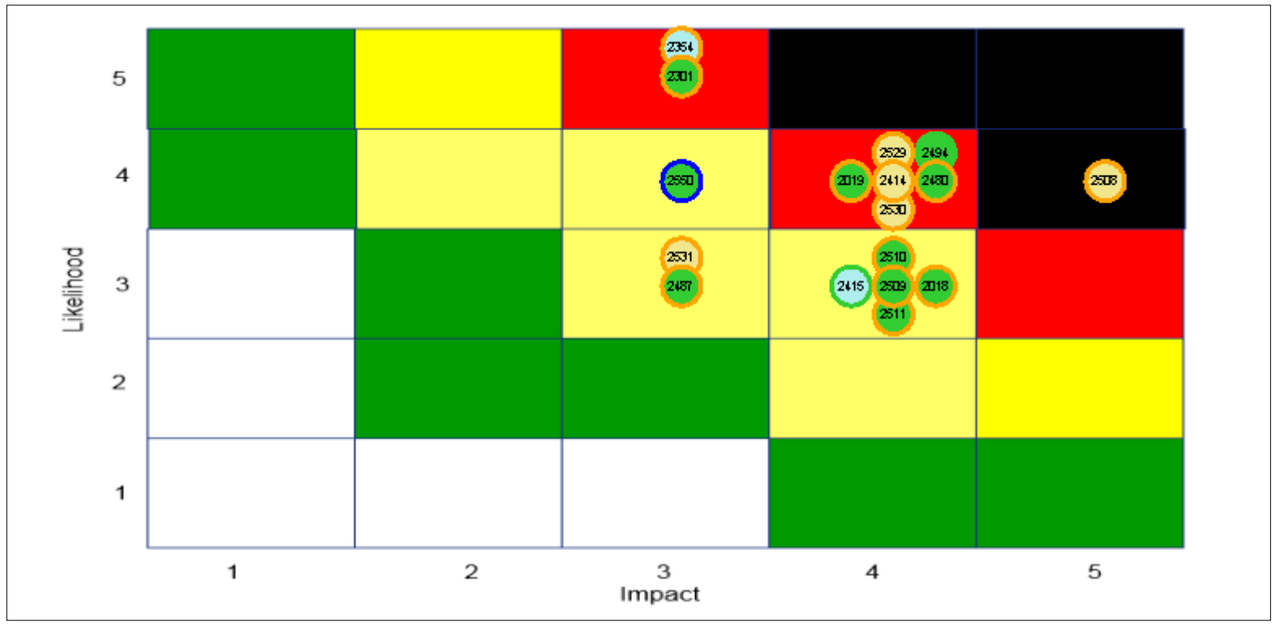
Leeds Health & Care Partnership

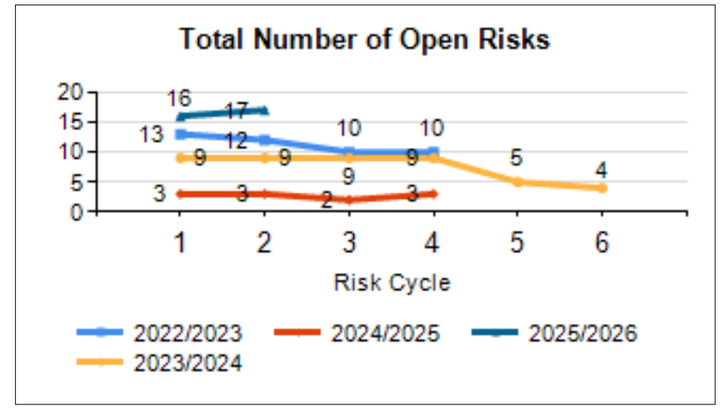
NHS West Yorkshire Integrated Care Board

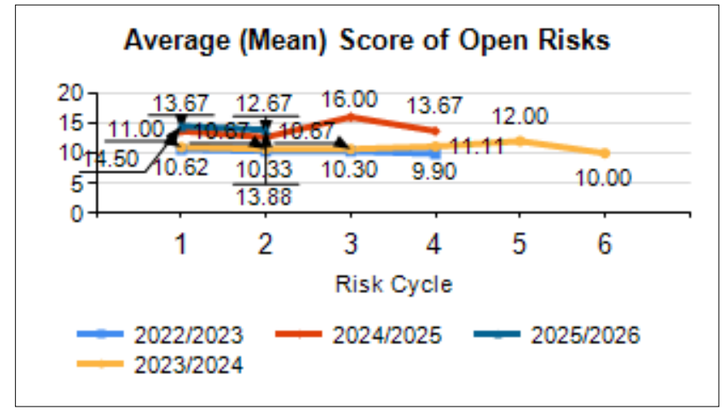
Total Risks	17
Finance & Performance	5 risks
Quality	10 risks
Finance and Quality	2 risks

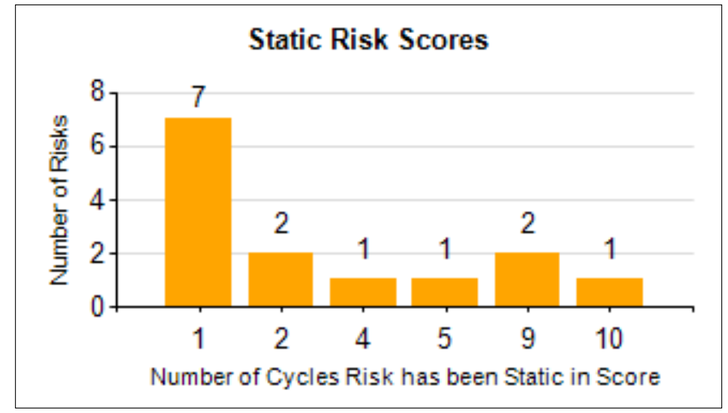
Movement of Risks		Risk Score Increasing	0
New	1	Risk Score Decreasing	2
Marked for Closure	0	Risk Score Static	14

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

West Yorkshire Integrated Care Board - Board Assurance Framework - Guidance notes for completion *(version 11, Sept 2025)*

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

https://www.wypartnership.co.uk/application/files/7017/5395/3821/Risk_Management_Framework_v4.0.pdf

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

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

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

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

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

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

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

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

Definitions of impact:

Risk impact	Insignificant	Minor	Moderate	Major	Catastrophic
	1	2	3	4	5
Purpose					
Achievement of the ICB mission	A decision affecting contracts finance, collaborations, quality or governance has no impact on the ICB mission.	A decision affecting contracts finance, collaborations, quality or governance does not support the ICB mission.	A decision affecting contracts finance, collaborations, quality or governance delays the achievement of the ICB mission.	A decision affecting contracts finance, collaborations, quality or governance impedes or significantly delays the achievement of the ICB mission.	A decision affecting contracts finance, collaborations, quality or governance majorly impedes and/or delays the achievement of the ICB mission.
Health outcomes and life	Marginal reduction to health	Minor reduction to health	Moderate reduction in health	Significant reduction in health	Major reduction in health outcomes and/or life expectancy for

Health outcomes and life expectancy	outcomes and/or life expectancy for >5% of a given population.	outcomes and/or life expectancy for >15% of a given population.	outcomes and/or life expectancy for >30% of a given population.	outcomes and/or life expectancy for > 50% of a given population.	Major reduction in health outcomes and/or life expectancy for >75% of a given population.
Health inequalities	Marginal increase in the health inequality gap in up to all six of most deprived Local Care/Community Partnerships (PCNs)	Minor increase in the health inequality gap in up to all of the six most deprived Local Care/Community Partnerships (PCNs) and / or a minor increase in the number of deprived Local Care/Community Partnerships (PCNs)	Moderate increase in the health inequality gap in up to all of the six most deprived Local Care/Community Partnerships (PCNs) and / or a moderate increase in the number of deprived Local Care/Community Partnerships (PCNs)	Significant increase in the health inequality gap in up to all of the six most deprived Local Care/Community Partnerships (PCNs) and / or a significant increase in the number of deprived Local Care/Community Partnerships (PCNs)	Major increase in the health inequality gap in up to all of the six most deprived Local Care/Community Partnerships (PCNs) and / or a major increase in the number of deprived Local Care/Community Partnerships (PCNs)
Service quality and performance (includes patient experience, safety and clinical effectiveness)	Informal complaint	Formal complaint Local resolution	Investigation by Health Service Ombudsman Minor out-of-court settlement	Multiple complaints Judicial review Litigation expected Civil action – no defence	Litigation certain Criminal prosecution
	Negligible effect on quality of clinical care	Noticeable effect on quality of care Single failure to meet internal standards Minor implications for patient safety if unresolved	Significant effect on quality of care / significantly reduced effectiveness Repeated failure to meet internal standards Major patient safety implications of findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved.	Totally unacceptable level or quality of treatment / service Gross failure of patient safety if findings not acted on Gross failure to meet national standards
	Commissioned local or national targets not achievable – single episode	Commissioned local or national targets not achievable – 1-3 episodes	Repeated failure to meet commissioned local or national targets > 3 episodes	Commissioned national targets not achieved resulting in involvement of external bodies / regulator	Commissioned national targets not achieved resulting in special measures
Financial efficiency	Small loss	Loss of 0.1–0.25 per cent of budget	Loss of 0.25–0.5 per cent of budget	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget	Non-delivery of key objective/ Loss of >1 per cent of budget
Capability					
Compliance (includes H&S and other legal or governance factors such as procurement, information governance etc.)	Negligible injury or ill health requiring no absence from work. Negligible damage to equipment or property. No or minimal impact or breach of guidance / statutory duty.	Minor injury or ill health requiring up to 2 days absence from work. Minor damage to equipment or property. Breach of statutory legislation Reduced performance rating if unresolved	Moderate injury or illness resulting in the submission of a RIDDOR report. Moderate damage to equipment or property. Single breach in statutory duty Challenging external recommendations / improvement notice	Single fatality. HSE improvement notice received. Major damage to property Enforcement action Multiple breaches in statutory duty Improvement notices Low performance rating Critical report	Multiple fatalities HSE or police investigation resulting in imprisonment of Chief Executive or other implicated staff Multiple breaches in statutory duty Prosecution Complete system s change required Zero performance rating Severely critical report

Descriptors for risk likelihood:

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

Overall risk matrix scoring (= impact x likelihood):

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

West Yorkshire Integrated Care Board - Board Assurance Framework - Summary						Version: 11	Date: Sept 2025
Mission		**Strategic risk**	**Risk appetite**	**Target WY score**	**Current WY score**	**Lead director(s) / board lead**	**Lead committee / board**
(1) Reduce inequalities	1.1	There is a risk that our local priorities to narrow inequalities are not delivered due to the impact of wider economic social and political factors.	Bold	16	20	Ian Holmes	ICB Board
	1.2	There is a risk that operational pressures and priorities impact on our ability to target resources effectively towards improving outcomes and reducing inequalities for children and adults.	Open	9	16	Ian Holmes / Jonathan Webb	Finance, Investment and Performance Committee
	1.3	There is a risk that we fail to join up services in our communities which means that we do not improve outcomes and reduce health inequalities.	Open	8	12	Ian Holmes	ICB Board
(2) Manage unwarranted variation in care	2.1	There is a risk that our inability to collectively recruit and retain staff across health and care impacts on the quality and safety of services.	Open	8	16	Kate Sims	Transformation Committee
	2.2	There is a risk that as a system we fail to innovate, learn lessons and share good practice that allows us to respond to service pressures resulting in widening variations across our footprint.	Open	6	8	James Thomas	Quality Committee
	2.3	There is a risk that we are unable to measure and assess performance across the system in a timely and meaningful way, which impacts on our ability to respond quickly as issues arise.	Open	6	9	Lou Auger	Finance, Investment and Performance Committee
	2.4	There is a risk that our infrastructure (estates, facilities, digital) hinders our ability to deliver consistently high quality care.	Open	9	16	Jonathan Webb / Shaukat Ali Khan	Finance, Investment and Performance Committee.Transformation Committee for Digital
	2.5	There is a risk of an inability to deliver routine health and care services due to the emergence of a future pandemic leading to substantial loss of life and failure to deliver key functions and responsibilities.	Averse	16	16	Lou Auger	ICB Board
(3) Use our collective resources wisely	3.1	There is a risk that we do not invest resources in a way which prioritises community, primary and prevention programmes and so doesn't maximise value for money.	Open	6	12	Jonathan Webb	Finance, Investment and Performance Committee
	3.2	There is a risk that we don't operate within our available system and organisational resources (revenue and capital) and so breach our statutory duties.	Cautious	9	20	Jonathan Webb	Finance, Investment and Performance Committee
	3.3	There is a risk that ICB capacity and infrastructure is not sufficient nor targeted effectively towards key priorities.	Open	9	12	Rob Webster	ICB Board
(4) Secure benefits of investing in health and care	4.1	There is a risk that partnership working on wider societal issues is deprioritised in order to meet current operational pressures.	Open	8	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	Lou Auger / Shaukat Ali Khan	Transformation Committee
	4.4	Due to climate change, there is a risk of increased demand for health and care services and disruption to the provision of services. This will result in health and care services that cannot effectively meet population needs.	Open	12	16	Ian Holmes	Transformation Committee

West Yorkshire Integrated Care Board - Board Assurance Framework - Heat map			Version 11													
Mission		Strategic risk	WYICB and 5 Places	West Yorkshire		Bradford District and Craven		Calderdale		Kirklees		Leeds		Wakefield	
			Risk appetite (All)	Target score (WYICB)	Current score (WYICB)	Target score (BD&C)	Current score (BD&C)	Target score (Cald'e)	Current score (Cald'e)	Target score (Kirk's)	Current score (Kirk's)	Target score (Leeds)	Current score (Leeds)	Target score (Wake'd)	Current score (Wake'd)
Reduce inequalities	1.1	There is a risk that our local priorities to narrow inequalities are not delivered due to the impact of wider economic social and political factors.	Bold	16	20	16	20	16	20	16	20	16	20	16	20
	1.2	There is a risk that operational pressures and priorities impact on our ability to target resources effectively towards improving outcomes and reducing inequalities for children and adults.	Open	9	16	9	12	6 ↓	9	6	12	9 ↓	16	9	16
	1.3	There is a risk that we fail to join up services in our communities which means that we do not improve outcomes and reduce health inequalities.	Open	8	12	8	12	8	12	8	12	8	12	8	12
Manage unwarranted variation in care	2.1	There is a risk that our inability to collectively recruit and retain staff across health and care impacts on the quality and safety of services.	Open	8	16	8 ↑	16 ↑	8	12	8	16 ↑	9	12	8	12
	2.2	There is a risk that as a system we fail to innovate, learn lessons and share good practice that allows us to respond to service pressures resulting in widening variations across our footprint.	Open	6	8	4	9 ↑	4	6	4	8	4	12	4	12
	2.3	There is a risk that we are unable to measure and assess performance across the system in a timely and meaningful way, which impacts on our ability to respond quickly as issues arise.	Open	6	9	2	4	2	6	2	8	2	6	2	6
	2.4	There is a risk that our infrastructure (estates, facilities, digital) hinders our ability to deliver consistently high quality care.	Open	9	16	9	16	9	16	9	16	9	16 ↑	9	12
	2.5	There is a risk of an inability to deliver routine health and care services due to the emergence of a future pandemic leading to substantial loss of life and failure to deliver key functions and responsibilities.	Averse	16	16	Not required	Not required	Not required	Not required	Not required	Not required	Not required	Not required	Not required	Not required
Use our collective resources wisely	3.1	There is a risk that we do not invest resources in a way which prioritises community, primary and prevention programmes and so doesn't maximise value for money.	Open	6	12	4	12	4	12	4 ↓	12	4	9	4	12 ↑
	3.2	There is a risk that we don't operate within our available system and organisational resources (revenue and capital) and so breach our statutory duties.	Cautious	9	20	9 ↑	20	9 ↑	20	9 ↑	20	9 ↑	20	9 ↑	20
	3.3	There is a risk that ICB capacity and infrastructure is not sufficient nor targeted effectively towards key priorities.	Open	9	12	4	12	4	16	4	12	4	16	4	12
Secure benefits of investing in health and care	4.1	There is a risk that partnership working on wider societal issues is deprioritised in order to meet current operational pressures.	Open	8	8	8	8	8	8 ↓	8	12	8	12	8	8
	4.2	There is a risk that we are unable to achieve our ambitions on equality diversity and inclusion due to ingrained attitudes that persist in society and across our health and care organisations.	Bold	8	12	8	12	8	12	8	12	6 ↓	9	8	12
	4.3	There is a risk that threats to our people and physical and digital infrastructure, e.g. from cyber-attacks, terrorism and other major incidents, prevents us from delivering our key functions and responsibilities.	Averse	9	12	Not required	Not required	Not required	Not required	Not required	Not required	Not required	Not required	Not required	Not required
	4.4	Due to climate change, there is a risk of increased demand for health and care services and disruption to the provision of services. This will result in health and care services that cannot effectively meet population needs	Open	12	16	Not required	Not required	Not required	Not required	Not required	Not required	Not required	Not required	Not required	Not required

WYICB - Board Assurance Framework - ICB and places							Version: 11	22 April 2025
Mission 1	Failure to manage strategic risk could result in a failure to **REDUCE INEQUALITIES**						**Lead director(s) / board lead**	Ian Holmes
Strategic risk 1.1	There is a risk that our local priorities to narrow inequalities are not delivered due to the impact of wider economic social and political factors.						**Lead committee / board**	ICB Board (linked to place committees)
ICB risk appetite	**ICB risk scores**						**Rationale for current ICB score**	
	Target (ICB)			**Current (ICB)**			Inequalities have widened in recent years due to broader social and economic factors. Our health and care partnership will make a positive contribution on these issues, there are a range of factors outside of our control that are likely to make narrowing inequalities more challenging.	
BOLD	**Likelihood**	**4**	**16**	**Likelihood**	**5**	**20**		
	Impact	**4**		**Impact**	**4**			

	Key controls *(What helps us mitigate the risk?)*	**Mitigating actions** *(What more are we/should we be doing at ICB level?)*
1	ICS Five Year Strategy, including the 10 Big Ambitions, focusing on health inequalities and wider economic, social and political factors.	(1) Development of granularity of data to have full insight across different inequalities and impact across different populations. This is aimed for completion by the end of 2025/26.
2	Health Inequalities Steering Group oversees spend of funding on specific initiatives to address inequalities.	
3	An MOU with WYCA setting out shared priorities, working and governance arrangements.	
4	Team working across health inequalities, with an in-house ICB team together with shared posts with WYCA.	

	Sources of assurance *(Where is the evidence that the controls work?)*	**Links to ICB risk register** *(Reference numbers/brief description)*
1	Integrated Care Partnership Board - agenda items, discussions, evidenced by minutes	**2120** - reduction/loss of VCSE services; **2437** - GP collective action; **2402** - access GP services; **2267** - maternity services; **2106** - Cancer health inequalities;
2	ICB Board - four deep dives into health inequalities during 2024/25 - agenda and minutes	
3	ICB Board - six monthly performance dashboard metrics against 10 Big Ambitions - agenda and minutes	
4	System Oversight and Assurance Group - rolling programme of metrics reported - agenda and minutes	
5	WYCA / ICB Quarterly Leadership Team meeting to oversee MOU	
6	Internal Audit review of Health Inequalities Partnering Arrangements - Significant Assurance (June 2024)	**Positive Assurance** - see separate log

Bradford District and Craven (BD&C)	**Place lead:**	**Therese Patten**	**Nominated lead for <u>this</u> risk:**	**Sohail Abbas (26.06.25)**

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

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

	Sources of assurance *(Where is the evidence that the controls work?)*	
1	Reducing inequalities alliance - regular meetings - Papers and Mins	
2	Health and Wellbeing Board - Papers and Mins	
3	The Core20Plus5 and health inequalities premium dashboards	
4	Outcomes focused performance report for HCP Board capturing health inequalities	**Links to Place Risk Register**
		2317, 2386, 2477, 2418, 2221

Calderdale	**Place lead:**	**Robin Tuddenham**	**Nominated lead for <u>this</u> risk:**	**Neil Smurthwaite (17.07.2025)**

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (Calderdale)			**Current (Calderdale)**			As WYICB outlines above. The CCPB focuses regularly on health inequalities. Presentation due in September 2025 Committee on latest intelligence and how we will using linked data sets to provide greater insight into the Integrated Neighbourhood Health work.
BOLD	**Likelihood**	**4**	**16**	**Likelihood**	**5**	**20**	
	Impact	**4**		**Impact**	**4**		

	Key controls *(What helps us mitigate the risk?)*	**Mitigating actions** *(What more are we/should we be doing at place?)*
1	We have a shared set of priorities set by Calderdale Health and Wellbeing Board - local plan feeds into ICB / ICP 5-year strategy forward plan	1. Calderdale council run a cost of living programme (2022 - ongoing) 2. Public have produced population data packes for each PCN and Integrated Neighbourhood health team.
2	Reducing inequalities is a key ambition of the partnership	
3	Council Director of Public Health is lead for health inequalities work across Calderdale	

	Sources of assurance *(Where is the evidence that the controls work?)*	
1	Progress against the ICB metrics on inequalities is reviewed regular by HWBB and CCPB	
2	Local JSNA	
3	Council Director of Public Health- attends Partnership Board	**<u>Links to Place Risk Register;</u>** 2224, 2476, 2149, 1998, 1493, 62, 2469, 2484,

Kirklees	**Place lead:**	**Vicky Dutchburn**	**Nominated lead for <u>this</u> risk:**	**Steve Brennan (27.06.2025)**

ICB risk appetite	**Place risk scores**		**Rationale for current place score**
	Target (Kirklees)	**Current (Kirklees)**	Recognise that addressing inequalities will take time and there are factors beyond our

BOLD	Likelihood	4	16	Likelihood	5	20	control, however the partners are committed to addressing this through the work that they do.
	Impact	4		Impact	4		

Key controls *(What helps us mitigate the risk?)*	Mitigating actions
1 Kirklees Health and Wellbeing strategy	1. Progressing on the work of the inclusive community framework (one of top tier partnership strategy) Power of one, power of many, working other for equity and fairness linked to the inclusive communities framework (2025/26)
2 Health and Wellbeing Plan	2. The Kirklees ICB committee committed to continue with their work and actions were agreed as part of this work (November 2025)
3 Kirklees Economic, Environment and Inclusive Communities Strategies.	3. Focus on addressing inequalities is key to how we deliver the Kirklees Healthy Working Life programme (for example the VCSE sector has a prominent role in helping to deliver this) 2025/26
Sources of assurance *(Where is the evidence that the controls work?)*	
1 Regular reports to Health and Wellbeing Board	**Links to place risk register:**
2 Regular reports to Partnership Forum / ICB committee/ and other place governance	2475, 2240, 2445
3 Project reports	

Leeds — **Place lead:** Tim Ryley — **Nominated lead for this risk:** Nick Earl 27.06.25

ICB risk appetite	Place risk scores						Rationale for current place score
	Target (Leeds)			Current (Leeds)			Inequalities continue to widen in Leeds due to wider social and economic factors. LHCP has a strong and continued focus to address these disparities through our operating framework. Risk score remains the same.
BOLD	Likelihood	4	16	Likelihood	5	20	
	Impact	4		Impact	4		

Key controls *(What helps us mitigate the risk?)*	Mitigating actions *(What more are we/should we be doing at place?)*
1 Partnership Leadership Team and Health and Wellbeing Board meetings in Leeds - allow influence of wider	1. Continued participation and support for Leeds City Council's Marmot City ambition
2 The Delivery and Inequalities Sub-Committee - highlighting impact of wider factors	2. Leveraging ICB's role at place as a (small) anchor institution, and influence over other (larger) anchor institutions (NB this may not take place during vacancy freeze/restructure)
3 Marmot City Programme - provides joint working mechanism to address wider determinants	
4 Ongoing contracting with the third sector - provide additional resource flow into local economy and areas of need	**Links to place risk register:**
	2415, 2354, 2301, 2018
Sources of assurance *(Where is the evidence that the controls work?)*	
1 Minutes from PLT / HWB meetings, particularly sessions with a wider strategic focus	
2 Minutes from Delivery and Inequalities Sub-Committee	
3 Programme reports from the Marmot city programme	
4 Financial accounts recording proportion of spend in this area	

Wakefield — **Place lead:** Mel Brown — **Nominated lead for this risk:** Ruth Unwin, Amrit Reyat (14.07.25)

ICB risk appetite	Place risk scores						Rationale for current place score
	Target (Wakefield)			Current (Wakefield)			Local position reflects the WYICB position. Current likelihood is high due to significant pressures in the system.
BOLD	Likelihood	4	16	Likelihood	5	20	
	Impact	4		Impact	4		

Key controls *(What helps us mitigate the risk?)*	Mitigating actions *(What more are we/should we be doing at place?)*
1 Healthy Standard of Living for All is one of the four priorities in the Health and Wellbeing Strategy	1. A further community of practice event has been planned for November 2025
2 Economic Strategy is in place led by the local authority. Elements that impact on health inequalities are reported to Health and Wellbeing Board	2. The work to develop the place response to reducing economic inactivity is currently taking shape (2025/26)
3 Joint post working across health and the Local Authority addressing inequalities is in place	3. Wakefield is working with funding from Health Determinants Research Collaborative (HDRC) to establish research capacity around health inequalities (2025/26)
4 Joint Steering Group established	4. The development of our integrated neighbourhood health model (2025/26)
5 We are now established as a enabler programme in our transformation and delivery collaborative	
6 Community of Practice event being took place in May 2025	
7 Some of our uncommitted core spend for 2025/26 will be focusing on COPD	
8 The economic accelerator programme is now established.	
9 Development of a district plan	
Sources of assurance *(Where is the evidence that the controls work?)*	
1 Regular reports such as Bi-monthly public health profiles addressing inequalities are presented to the Health and Wellbeing Board and to the Wakefield District Health and Care Partnership	
2 Wakefield Joint Strategic Needs Assessment	**Link to Place Risk Register**
4 Report to WDHCP Committee in November 2024 on the evaluation and principles of allocation of resource for CORE20PLUS	2481

WYICB - Board Assurance Framework - ICB and places							Version 11	Date: 12 June 2025
Mission 1	Failure to manage strategic risk could result in a failure to **REDUCE INEQUALITIES**						**Lead director(s) / board lead**	Ian Holmes / Jonathan Webb
Strategic risk 1.2	There is a risk that operational pressures and priorities impact our ability to target resources effectively towards improving outcomes and reducing inequalities for children and adults.						**Lead committee / board**	Finance, Investment and Performance Committee
ICB risk appetite	**ICB risk scores**						**Rationale for current ICB score**	
	Target (ICB)			**Current (ICB)**			Significant financial and operational pressure continues to impact on our ability to deliver wider ambitions. The organisational change process and capacity will impact on the operational pressure.	
OPEN	**Likelihood**	**3**	**9**	**Likelihood**	**4**	**16**		
	Impact	**3**		**Impact**	**4**			

Key controls *(What helps us mitigate the risk?)*		**Mitigating actions** *(What more are we/should we be doing at ICB level?)*
1	Clear, agreed plans that deploys £10.75m Health Inequalities funding across all Core 20PLUS5 priorities - specific workstream headed by Improving Population Health (IPH) Board with remit to recommend allocation of specific funding across the ICS	1. EQIA process on any proposed service change and commissioning policy change (2025/26).
2	The first 3 ambitions in our Strategic Plan relate to inequalities. Plans for these are set out in the Joint Forward Plan which provides the foundation to prioritisation by the ICB Board. The Plan has a refreshed set of metrics to ensure that a difference can be made and measured.	
3	Measurement of inequalities relating to key operational priorities - such as elective recovery and ambulance waiting times.	
4	Board approved WY ICS Finance Strategy confirms importance of health inequalities as key element of how deploy resources.	
5	Committee overview of commissioning policies and quality impact by the Transformation Committee and Quality Committee respectively.	
6	Inclusion Health Unit, whose focus is on the sustainability of inclusion health services, supporting the system to improve the health of population groups.	

Sources of assurance *(Where is the evidence that the controls work?)*		**Links to ICB risk register** *(Reference numbers/brief description)*
1	Partnership Board focus on 10 big ambitions	**Risk 2309** - demand for CYP mental health services; **2451** - Delays in gender identity specialist services; **2400** - delays in health assessments of CiC; **2479** - children's hospice care;
2	ICB Board - performance dashboard and deep dives into health inequalities	
3	SOAG updates against 10 big ambitions	**Positive Assurance: see log**
4	ICB Annual Report summarises work on improving outcomes and reducing inequalities	
5	Internal Audit 'Health Inequalities Partnership Working' review - Significant Assurance - June 2024	

Bradford District and Craven (BD&C)	**Place lead:**	**Therese Patten**	**Nominated lead for this risk:**	**Sohail Abbas (26.06.25)**

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (BD&C)			**Current (BD&C)**			There are higher levels of inequality in BDC as compared to other places. The organisational changes and wider environments makes it difficult to reduce inequalities. The risk score remains the same for this cycle.
OPEN	**Likelihood**	**3**	**9**	**Likelihood**	**3**	**12**	
	Impact	**3**		**Impact**	**4**		

Key controls *(What helps us mitigate the risk?)*		**Mitigating actions** *(What more are we/should we be doing at place?)*
1	QEIA assessments in routine use	1. Work is ongoing on population needs assessment and using population health management principles to identify population cohorts for targetting interventions (2025/26)
2	Prioritising action plans to address the main causes of death, inequalities and poor health across BDC HCP (place) within the new Closing the Gap programme. Leadership group has been set up for implementing Core20PLUS5 for the ICS and BDC HCP (place). Targeting reduction of health inequalities by working closely with PCNs and Community Partnerships (and with Local Authority Area teams)	2. We are in the process of developing our health and care strategies in place together with our partners which will meet our ambitions around improving outcome and reducing inequalities. This work is being led by the Director of partnership and place (2025/26)
3	Closing the gap programme has segmented the population and examines trends on health needs against expenditure, and high impact evidence based interventions to reduce inequalities and address pressure points locally.	3. Alongside the strategy development we are developing our intent around neighbourhood health and have events in the diary both with practices but also as part of our Listen In engagement schedule across our communities to ensure we are developing services in partnership (2025/26)
4	Inequalities toolkits have been used by our 13 Community Partnerships to guide commissioning (with guidance and separate intelligence packs itemising outliers). Primary care practice priorities have been aligned to Core20 priorities via the health inequality practice premium.	4. QEIA assessments in routine use (process being refined and reviewed 2025) to ensure that the impact of proposed decisions does not move resource away from critical areas of health inequality (2025/26)
5	Priority boards maintain a key focus on inequalities through their programmes of work	5. Economic evaluation of our health inequalities programme is undergoing which will help us deliver financial case for reducing inequalities (2025/26)
6	Developing a System approach to reducing inequalities via improved collaboration between Inequalities, EDI, Research and Prevention programmes (included board readiness toolkit & development sessions to embed work to reduce inequalities through the governance structure).	

Sources of assurance *(Where is the evidence that the controls work?)*		**Links to Place Risk Register**
1	BDC Partnership Board and Exec receive full papers and briefings on progress within the Priorities and Enablers alongside system based committees which provide oversight and assurance on our outcomes.	
2	Inequalities are embedded into our transformation work with Population Health Management (PHM) data identifying key areas of focus for priority. Priority Boards providing ownership of transforming services across all place based partners	
3	Outcomes focused performance report for HCP Board capturing health inequalities	
		2386, 2227, 2039, 2221

Calderdale	**Place lead:**	**Robin Tuddenham**	**Nominated lead for this risk:**	**Neil Smurthwaite (17.07.2025)**

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (Calderdale)			**Current (Calderdale)**			Risk score reflects operational performance on NHS targets. There are pressures in the system but it's not impacting on our ability to deliver Core 20+5. There is a significant risk on future finances and the overall change programme announced in March 25 could result in inequalities being impacted. Score will be continually monitored. Reviewed target score and reduced this from 9 to 6, due to a OPEN risk appetite.
OPEN	**Likelihood**	**2**	**6**	**Likelihood**	**3**	**9**	
	Impact	**3**		**Impact**	**3**		

Key controls *(What helps us mitigate the risk?)*		**Mitigating actions** *(What more are we/should we be doing at place?)*
1	Clear plan for place share of £12m led by DPH, reports to HWBB.	1. The data model is being developed to help analyse the use of urgent care to help address and ensure that out-of-hospital services do not create health inequalities - Population health tool is being developed - local drop in sessions will take place with discussion at Board level in 2025-26.
2	Tackling inequalities is a core requirement of all papers to comment upon, particularly contract awards / service improvement.	2. Financial pressures continue to be monitored and savings identified recurrently to ensure undelrying position does not deteriorate.
3	Measurement of health inequalities for elective recovery has been key component for CHFT and its delivery of its waiting lists.	3. Change programme and new ICB operating model will impact on this risk and will be monitored.

Sources of assurance *(Where is the evidence that the controls work?)*		**Links to Place Risk Register:**
1	Regular report to HWBB (as above) and CCPB.	2224, 1338, 2476, 2149, 1998, 1493, 62, 2092
2	Joint Forward Plan will include health inequalities.	
3	Transformation delivery plan signed off by Board on 5 September 2024, one of the key ambitions in reduction in health inequalities	

Kirklees	**Place lead:**	**Vicky Dutchburn**	**Nominated lead for this risk:**	**Vicky Dutchburn (25.06.2025)**

ICB risk appetite	Place risk scores						Rationale for current place score
	Target (Kirklees)			Current (Kirklees)			
OPEN	Likelihood	2	6	Likelihood	3	12	Outcomes Framework, indicators and proxy indicators, establish network, align core 20 plus 5 , strengthen reporting through PMO and align approaches to VCSE investment and Inclusive communities framework. The elective performances is included in the bi-monthly performance committee. There have been deep dive reports and discussions with our health and care partnership board specifically on child and adult mental health and neurodiversity assessment, there is an action plan. The core 20+5 schemes have been reviewed and built in as business as usual as an outcome of that review. The rigour of internal processes with regards to prioritisation and reviews of all contracts which are due to expire March 2026 - the governance timeline complete until the end of October 2025.
	Impact	3		Impact	4		

Key controls *(What helps us mitigate the risk?)*	
1	Health and Wellbeing Strategy
2	Health and Wellbeing Plan
3	Outcomes Framework
4	Deep dive reports on high risk areas e.g. child & adult mental health, neurodiversity assessments.
5	Completed review of the children and young people's mental health model (Kirklees Keeping In Mind) implementation commenced April 2025.

Sources of assurance *(Where is the evidence that the controls work?)*	
1	Regular reporting into Health and Wellbeing Board
2	Regular reporting into place governance such as the Kirklees Quality Committee
3	PMO reports on projects
4	Reports and action plans to Transformation Committee

Mitigating actions *(What more are we/should we be doing at place?)*

1. Agreed that Kirklees place will develop an action plan on children and young people's neurodiversity to sign off by April 2025 - action plan has been completed and submitted as part of the SEND review - June 2025.
2. Expecting final SEND report end of August 2025 and implementing review actions from Q3, 2025/26
3. Establishment of transformation dashboard as per annual review recommendation (Q2, 2025/26)

Links to place risk register:
2240

Leeds	Place lead:	Tim Ryley	Nominated lead for this risk:	Nick Earl 27.06.2025

ICB risk appetite	Place risk scores						Rationale for current place score
	Target (Leeds)			Current (Leeds)			
OPEN	Likelihood	3	9	Likelihood	4	16	Current reduction in ICB resources and associated restructure will be presenting notable challenges to driving work in this area (alongside existing operational pressures - particularly during Winter). Reviewed target risk score in light of a open risk appetite (willing to take reasonable risks and is tolerant to some uncertainty), agreed to reduce the target risk score from 12 to 9.
	Impact	3		Impact	4		

Key controls *(What helps us mitigate the risk?)*	
1	Local strategy with a focus on health inequalities (Healthy Leeds Plan), with key data cut by IMD and other relevant HI metrics.
2	Local governance structures with a focus on inequalities - Delivery and Inequalities sub-committee, Health Inequalities Oversight Group and specific sessions at Partnership Leadership Team
3	Leeds financial planning process includes mechanisms to minimise impact on inequalities as well as QEIA assessments in routine use (and published)
4	All delivery plans have a clear focus on addressing inequalities within existing resources.
5	Inequalities / Core20+5 / transformation funding as part of general practice incentive scheme (GPOP)

Sources of assurance *(Where is the evidence that the controls work?)*	
1	HLP document and access to PowerBI reporting
2	Minutes and terms of reference for Delivery Sub-Committee, HIOG and PLT
3	Online QEIA resource
4	Business reporting to Leeds Director Team
5	GPOP scheme documents

Mitigating actions *(What more are we/should we be doing at place?)*

1. Partnership focus in 25/26 on programme benefits quantification should support greater assessment of potential HI impact
2.Review approach to incentives in line with strategic commissioning role towards the end of this financial year
3. Provide both challenge and support to emerging HealthCare Inequalities Oversight Group, which has a partnership focus across providers

Links to place risk register:
2354, 2301, 2480

Wakefield	Place lead:	Mel Brown	Nominated lead for this risk:	Ruth Unwin, Amrit Reyat (14.07.25)

ICB risk appetite	Place risk scores						Rationale for current place score
	Target (Wakefield)			Current (Wakefield)			
OPEN	Likelihood	3	9	Likelihood	4	16	Reflects the Integrated Care Board position. Local places have limited powers to reduce likelihood.
	Impact	3		Impact	4		

Key controls *(What helps us mitigate the risk?)*	
1	Allocation of CORE20plus5 monies
2	Healthy Sustainable Communities Oversight Group established for CORE20plus5 and reports through the governance structure
3	Place Outcomes Framework currently in development
4	Tackling inequalities is a priority of the Health and Wellbeing Board and associated work programmes
5	Established CORE20plus5 strategic group which oversees the evaluation of funded programmes. Developed a evaluation framework which will support targeted interventions

Sources of assurance *(Where is the evidence that the controls work?)*	
1	Health and Wellbeing Board Outcomes Framework - reports to the Health & Wellbeing Board - annually
2	Performance Report to Integrated Assurance Committee - bi-monthly
3	Performance Report to Wakefield District Health and Care Partnership - quarterly

Mitigating actions *(What more are we/should we be doing at place?)*

1. Working with the data team to do more deeper evaluation of our CORE20plus funded programmes (2025/26)
2. Working through the investment panel process to secure funding (2025/26)

Link to Place Risk Register
2128

WYICB - Board Assurance Framework - ICB and places							Version: 11	22 April 2025
Mission 1	Failure to manage strategic risk could result in a failure to **REDUCE INEQUALITIES**						**Lead director(s) / board lead**	Ian Holmes
Strategic risk 1.3 (previously 1.4)	There is a risk that we fail to join up services in our communities which means that we do not improve outcomes and reduce health inequalities.						**Lead committee / board**	ICB Board *(linked to place committees)*
ICB risk appetite	**ICB risk scores**						**Rationale for current ICB score**	
	Target (ICB)			**Current (ICB)**			Integrated care in communities is fundamental to our strategy for improving outcomes and tackling inequalities and a priority for all places. We have made good progress in some areas, but progress has been variable and there is still significant work to be done.	
OPEN	**Likelihood**	**2**	**8**	**Likelihood**	**3**	**12**		
	Impact	**4**		**Impact**	**4**			

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

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

Bradford District and Craven (BD&C)	**Place lead:**	**Therese Patten**	**Nominated lead for this risk:**	**Sohail Abbas (26.06.25)**

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

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

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

Calderdale	**Place lead:**	**Robin Tuddenham**	**Nominated lead for this risk:**	**Neil Smurthwaite (17.07.2025)**

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

Key controls *(What helps us mitigate the risk?)*		**Mitigating actions** *(What more are we/should we be doing at place?)*
1	Calderdale Cares Community Programme Board is in place for integrating services and community.	1. Looking to utilise data over coming year to ensure efficiency and effectiveness of services to ensure out of hospital care reduces inequalities, there is a programme of work ongoing (Quality group) 2025/26 2 Place Partnership Review (led by Anthony Kealy) and ICB letter March 25 regarding Provider Collaboration will support further development of Place model including provider collaboratives and integration in Places. The ICB's response to the running cost reduction will need to consider the findings of this review in the context of significantly reduced capacity. 3. National focus on integrated neighbourhood health as part of the new Government's 10 year plan create greater focus. This will influence ICB planning for 2025/26 and beyond. The ICB has identified integrated neighbourhood health as a key priority lead by Places. 4. Consideration made for national programme for Integrated Neighbourhood Health, however due to uncertain times first phase application not proceeded with. Further strengthening of data and resource needed for future waves **Links to Place risk register:** 2476, 2163, 1493, 62, 1977, 2469, 2484, 2092
2	Tranformation deliver plan has integrated neighbourhood team as key objective for the partnership board	
3	Calderdale Community Collaborative Programme board in placed led by PCN Directors.	
4	Senior leadership meeting in July 2024, discussion on integrated neighbourhood teams	
5	There are variety of governor forums and enabler groups that bring partners across the health and care partnership together to address issues relating to issues in a joined up way	

Sources of assurance *(Where is the evidence that the controls work?)*	
1	A year end report will be presented to the partnership board on the tranformation delivery plan for which integrated neighbourhood is the key priority
2	Joint Forward Plan being developed.
3	Calderdale Community Collaborative Programme board in place led by PCN Directors. Terms of Reference and mins.

Kirklees	**Place lead:**	**Vicky Dutchburn**	**Nominated lead for this risk:**	**Catherine Wormstone (30.06.2025)**

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (Kirklees)			**Current (Kirklees)**			While a strategy is in place, there is a need to focus on the delivery of transformation and improvements across all nine integrated neighbourhood teams and to ensure adequate capacity is freed up by system partners. Risk score remains the same.
OPEN	**Likelihood**	**2**	**8**	**Likelihood**	**3**	**12**	
	Impact	**4**		**Impact**	**4**		

Key controls *(What helps us mitigate the risk?)*		**Mitigating actions** *(What more are we/should we be doing at place?)*
1	Core20+5 is being lead by the Public Health team on behalf of the Partnership	1. Programme plan in place to fully implement integrated neighbourhood teams and improve integrated neighbourhood health in line with 2025/26 planning guidance

2	Addressing inequalities is and will continue to be written into the scope and terms of reference for all place based work areas, to ensure that the focus on inequalities is a common theme to all our work
3	INT data packs developed and data sharing agreements in place
4	A number of services including VCSE already aligned around communities

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

improve integrated neighbourhood health in line with 2025/26 planning guidance
2. Business case developed for accessing West Yorkshire SDF funds (non-recurrent) to assist with accelerating pace of implementation
3. Identified accelerator site to commence first INT on 2 July 2025, system partners are ready to facilitate engagement and support for accelerator site.
4. Regular fortnightly call in place with SROs for 6 core components of integrated neighbourhood health
5. Workshop held on 27 June 2025 to co-design OD support for system leaders and integrated neighbourhood teams. Next steps will be to share draft programme with stakeholders (2025/26)
6.Planned refresh of the objective within the health and care plan (2025/26)
7. Neighbourhood level data being extracted from primary care and supported by linked data sets to facilitate a population health management approach. Next steps to share with accelerator site and other INTs (2025/26)

Links to place risk register
2475

Leeds **Place lead:** **Tim Ryley** **Nominated lead for this risk:** **Helen Lewis (23.06.25)**

ICB risk appetite	Place risk scores					
	Target (Leeds)			Current (Leeds)		
OPEN	Likelihood	2	8	Likelihood	3	12
	Impact	4		Impact	4	

Rationale for current place score
Strong work plans already within the Leeds Health and Care Partnership, within LCP areas and in key areas such as frailty, mental health and transfer of care. More to do, and the impacts of getting it wrong for individuals remain high but good progress.

Key controls *(What helps us mitigate the risk?)*	
1	Strong LCPs and PCNs.
2	All relevant data displayed by IMD and other key variables linked to inequalities.
3	Population and care delivery board structures in place, with increasing access to data that enables analysis of issues at very local levels, add neighbourhood health is one of the partnership leadership priorities and programme is reviewed regularly and overseen by partnership leadership team

Sources of assurance *(Where is the evidence that the controls work?)*	
1	Access to Leeds data model/power BI platforms, and RAIDR to review data sets.
2	Notes of LCP/PCN meetings.
3	All LHCP programmes pay due attention to joining up services, demonstrated via minutes.

Mitigating actions *(What more are we/should we be doing at place?)*
1. Developing (integrated neighbourhood clinics are in place and considering further developments) (2025/26)
2. LCH and GP confederation looking at neighbourhood integration opportunities as part of the system neighbourhood health model (2025/26)
3. LCH and Leeds City Council rolling out their active recovery offer to improve integration (2025/26)
4. Community mental health programme engaging all relevant partners to improve service integration and focus on those people most at risk (new contract with VCSE 2025/26)

Positive Assurance
Data available at PCN level is already driving the delivery plans of PCNs working in partnership with statutory and VCSE partners in each footprint to support change and integration on the ground.

Link to place Risk Register
2415

Wakefield **Place lead:** **Mel Brown** **Nominated lead for this risk:** **Ruth Unwin, Amrit Reyat (14.07.25)**

ICB risk appetite	Place risk scores					
	Target (Wakefield)			Current (Wakefield)		
OPEN	Likelihood	2	8	Likelihood	3	12
	Impact	4		Impact	4	

Rationale for current place score
There is limited opportunity for place to influence the impact of inequalities but reducing inequalities is a priority for the Health and Wellbeing Board and the Wakefield District Health and Care Partnership.

Key controls *(What helps us mitigate the risk?)*	
1	Wakefield Transformation and Delivery Collaborative established supported by a network of Provider Alliances with responsibility for joining up services and addressing inequalities
2	Core Senior Leadership team established across Wakefield place with distributed leadership responsibilities
3	Action plan to address the gaps following the publication of the Fuller report
4	This work is connected to the work to develop a neighbourhood model

Sources of assurance *(Where is the evidence that the controls work?)*	
1	Transformation and Delivery Collaborative Chair's report to Wakefield District Health and Care Partnership highlights key discussions - bi monthly
2	Provider Alliance deep dive regarding progress against priorities reported to Transformation and Delivery Collaborative - monthly
3	Medical Director for Integrated Community Services attends Fuller Board

Mitigating actions *(What more are we/should we be doing at place?)*
1. The development of a neighbourhood model enables a targeted and more planned approach to care (2025/26)
2. The reducing healthcare inequalities steering group is connected into the VCSE collaborative which is taking forward the development of the VCSE strategy for the district (2025/26)
3. The work to develop the place response to reducing economic inactivity is currently taking shape (2025/26)

Positive Assurance
An update report was provided to the health and wellbeing board on the 30 January 2025 regarding the development of the VCSE strategy.

Links to Place Risk Register
2397, 2429

WYICB - Board Assurance Framework - ICB and places							Version: 11	Date: 8 April 2025
Mission 2	Failure to manage the strategic risk could result in a failure to **MANAGE UNWARRANTED VARIATION IN CARE**						**Lead director(s) / board lead**	Kate Sims
Strategic risk 2.1	There is a risk that our inability to collectively recruit and retain staff across health and care impacts on the quality and safety of services.						**Lead committee / board**	Transformation Committee
ICB risk appetite	**ICB risk scores**						**Rationale for current ICB score**	
	Target (ICB)			**Current (ICB)**			Workforce recruitment and retention remains a challenge across the system. The current workforce reduction programmes within both the ICB and provider Trusts will impact on the ability to attract and retain staff across the workforce. In addition, the system awaits further detail in relation to any potential growth as part of the NHS long term workforce plan and Adult Social Care workforce strategy.	
OPEN	**Likelihood**	**4**	**8**	**Likelihood**	**4**	**16**	Risk score- increased impact from 3 to 4 for this quarter - increased from 12 to 16.	
	Impact	**2**		**Impact**	**4**			

Key controls *(What helps us mitigate the risk?)*		**Mitigating actions** *(What more are we/should we be doing at ICB level?)*
1	WY People Board (multi-sector) oversight of priority programmes, The ICB EMT organisational change programme board - a system wide overview of the responses to the workforce challenges under the West Yorkshire People Plan	(1) WY People Strategy is being refreshed during 2025. (2) The ICB received detail from each NHS provider of their current workforce planning and control mechanisms. These will be used to help monitor each Trusts workforce position against its operating planning submission (2025/26) (3) Workforce Strategy and Planning Team - primary agenda is aligned with Strategic Workforce Transformation Forum, and as this develops they will provide a level of workforce transformation capacity. (4) One of the agreed terms of reference for the Strategic Workforce Transformation Forum centres on influencing regionally and nationally. The Forum has now agreed its core 4 priorities with delivery groups established to respond to each - 2025/26 (5) The ICB has commenced a review of its operating model (Apr 2025) in response to the further targetted reduction of 50% of costs. There will be a large scale organisational change programme to deliver the required response to this announcement. (6) NHS providers across West Yorkshire are also required to review their growth in corporate service costs since 2019/2020 and reduce these by 50%. This is in addition to the workforce reductions indicated within the operating planning submission.
2	WY Mental Health and Well Being Hub - a system wide offer to all staff across the WY partnership to ensure that access to Mental Health Wellbeing is available to all - with regular reporting into People Board	
3	WY Strategic Workforce Transformation Forum established (system wide) to have strategic overview to ensure readiness against long term workforce plan and adult social care workforce strategy	
4	Workforce Place Leads and place-based plans (for further details, see Place BAF below)	
5	Creating Global partnerships for the supply of International recruits into challenged areas - to ensure ethical and sustainable international recruitment, education pathway and to offer system support. Dedicated global team working directly with NHS England.	
6	Active leadership on workforce part of annual operating plan cycle, with ongoing assurance through Finance Investment and Performance Committee, Transformation Committee and ICB Board.	

Sources of assurance *(Where is the evidence that the controls work?)*		**Links to ICB risk register** *(Reference numbers/brief description)*
1	Transformation Committee; Strategic Workforce Forum; People Board - agenda, papers and minutes	**2296** - YAS workforce; **2108** - cancer workforce; **2324** - ICB workforce; **2402** - general practice workforce; **2512** - ICB workforce
2	Place leads meet with local NHS providers to ensure progress is monitored across WY against the operating planning submission. WY People Team actively attend Place workforce committees. Director of People is a member of Yorkshire and Humber Workforce Steering Group for adult social care.	
3	NHS sickness absence and turnover is reported to ICB Board via Integrated Performance Report.	
2	Active data flow across wider People agenda, which is presented to the People Board and Strategic Workforce Transformation Forum.	
3	(NHS specific) Staff Survey annual results	**See the separate Positive Assurance Log**

Bradford District and Craven (BD&C)	**Place lead:**	**Therese Patten**	**Nominated lead for this risk:**	**Andrew Milner 27.06.2025**

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (BD&C)			**Current (BD&C)**			The workforce challenges remain across both health and social care within the public and independent sector. Additionally, there are similar challenges within the voluntary, community and social enterprise sector where issues around living wage and competition from larger employers is cited as a particular challenge. Within health, retention remains a signficant challenge. Current financial and organisational circumstances mean recruitment across healthcare organisations is extremely limited. Risk score increased from 12 to 16. Discussed target score as the appetite is currently cautious, agreed to increase the target risk score from 6 to 8 due to limited tolerance.
CAUTIOUS	**Likelihood**	**4**	**8**	**Likelihood**	**4**	**16**	
	Impact	**2**		**Impact**	**4**		

Key controls *(What helps us mitigate the risk?)*		**Mitigating actions** *(What more are we/should we be doing at place?)*
1	BDC HCP System Finance and Performance Committee (System FPC) – led by an independent NED chair who champions the agenda at the BDC Partnership Board. Broad based senior participation including care sector and primary care. Quarterly review of the detailed workforce dashboard with a view to identifying workforce risks and issues.	1 We have made progress in supporting the social care workforce with initiatives to help retain staff. As a part of the health and work accelerator programme multiple interventions including the provision of mental health and physiotherapy support are being commissioned to support the social care workforce. This builds upon learning from successful employee assistance programmes operating within our NHS provider organisations. We are building on this by working with the Bradford Care Association. 2. Delivery of the workforce priority programme at place with emphasis on building recruitment pipelines for health and social care staff specifically through the development of a consolidated entry level recruitment programme run via Skills House within Bradford Metropolitan District Council (Ongoing 2025/26) 3. Working across the system within partners including Higher Education Institutions to develop a pipeline for registered health and care roles (Ongoing 2025/26)
2	BDC HCP People Plan has been refined to ensure alignment with the priorities of partner organisations and the partnership more broadly. As a part of this, particular focus has been placed upon capacity and ability to deliver.	
3	'People' is one of five strategic priorities for BDC HCP which means that additional focus and resource applied to delivery of the People Plan. Reported on at Partnership Leadership Executive and Partnership Board. With CEO lead Foluke Ajayi in place.	

Sources of assurance *(Where is the evidence that the controls work?)*		**Links to Place Risk Register**
1	Triple A report from SFPC to Partnership Board	
2	Highlight reports from the People Programme through a Programme Board	
3		2386, 2227, 2477, 2434, 2422, 2420, 2418, 2417, 2215, 2421,

Calderdale	**Place lead:**	**Robin Tuddenham**	**Nominated lead for this risk:**	**Neil Smurthwaite (17.07.2025)**

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

Key controls *(What helps us mitigate the risk?)*		**Mitigating actions** *(What more are we/should we be doing at place?)*
1	West Yorkshire plans reflected at place.	1. Provider workforce plans led by Acute and Primary Care leads 2025/26 2. Local group looks at recruitment and development 2025/26
2	Operating model is in place	

Sources of assurance *(Where is the evidence that the controls work?)*		**Links to Place Risk Register;**
1	Update to the partnership board	2224, 1338, 2149, 1493, 62, 1977, 2092

Kirklees	**Place lead:**	**Vicky Dutchburn**	**Nominated lead for this risk:**	**Steve Brennan (25.06.2025)**

ICB risk appetite	**Place risk scores**		**Rationale for current place score**
	Target (Kirklees)	**Current (Kirklees)**	Whilst workforce data shows that generally the workforce is increasing at a modest rate, it is not

CAUTIOUS	Likelihood	4	8	Likelihood	4	16	in line with growth targets and therefore workforce challenges still remain across all sectors of Health and Social Care. The workforce controls around the 2025/26 planning round makes this challenging. Some of the challenges are structural [such as rates of pay within social care and potential changes for international staff particularly in the independant care sector and recent NI changes] and therefore are difficult to address in the short term. Current ongoing changes to where the responsibility for strategic workforce planning sits within the NHS make this more challenging. The workforce challenges with Kirklees are in line with those across West Yorkshire as a whole, and therefore our risk scores are in line with those for the wider West Yorkshire ICB. Risk score increased from 12 to 16 in line with WY ICB.
	Impact	2		Impact	4		

Key controls *(What helps us mitigate the risk?)*		**Mitigating actions** *(What more are we/should we be doing at place?)*
1	Kirklees actively engaged in West Yorkshire arrangements.	1 We have made progress in supporting the social care workforce with initiatives to help recruit staff. We are building on this by working with the Kirklees and Calderdale Care Association, for example, to support staff wellbeing within care homes roadshow which took place in May 2025. Compassionate cultures conference took place in June 2025, supporting staff with health and wellbeing. However, this is an area where we continue on supporting staff health and wellbeing. 2 We want to develop approaches to building training capacity in non-acute settings, but this will take time. Working as part of the WY placement expansion work with a focus on placements in care home settings (2025/26) 3 We also want to build more on the opportunities created by working with the University of Huddersfield, particularly around the new Health Innovation Campus, Health and Wellbeing Academy, and Leadership Development. Recently established a partnership board to oversee this work (2025/26) for example the development of new Radiography course.
2	Workforce arrangements well established within Kirklees for working with health and care providers and sectors including the VCSE and social care. We have an agreed integrated workforce approach with Calderdale which focuses on 3 pillars (1. Looking after our people, 2. Recruiting and retaining our people, and 3. Developing our people together). We have a system Senior Responsible Officer in place and a joint Workforce Steering Group which is supported by a Working Group for each of the 3 pillars.	
3	Placement work on pharmacy is now complete, the placement arrangements and systems will continue 2025/26	
Sources of assurance *(Where is the evidence that the controls work?)*		**Link to place risk register:** 2498
1	Evidence on the impact of projects and initiatives is monitored within the appropriate Working Group for each of the pillars.	
2	Each of the 3 Working Groups reports into our Joint Workforce Steering Group to present evidence of impact of their projects and initiatives.	
3	Regular updates on the Joint Workforce Programme are reported into the Kirklees Partnership Forum, which is part of our overall place governance arrangements. Updates are also presented to other governance forums when required such as the Kirklees Transformation sub-committee.	

Leeds	**Place lead:**	**Tim Ryley**	**Nominated lead for this risk:**	**Kate O'Connell (02/07/2025)**

ICB risk appetite	Place risk scores						Rationale for current place score
	Target (Leeds)			Current (Leeds)			
CAUTIOUS	Likelihood	3	9	Likelihood	4	12	The current risk score reflects the scale of unfilled vacancies across the vast majority of employers in the context of a tight labour market. Although targeted activity has reduced some vacancies, the financial pressures have created recruitment controls and so notable risk remains. There has been a shift in focus from recruitment to retention. Current pressures on services and the cost of living increase creates significant risk of retention, particularly for the lowest paid staff, many of whom are in the third sector. Existing mitigations are unlikely to resolve the scale and nature of these challenges in the short term.
	Impact	3		Impact	3		

Key controls *(What helps us mitigate the risk?)*		**Mitigating actions** *(What more are we/should we be doing at place?)*
1	The Leeds One Workforce Strategy has been refreshed, continuing to providing a cohesive, prioritised approach for the city's health and care partners and a clearly defined programme of work.	1. Continue to identify and secure diverse funding which supports collaborative recruitment and retention. The Leeds Health and Care Academy leads this on behalf of the city and income is assessed annually. The last review took place on April 2025. The next review will take place in April 2026. 2. Continue to increase and diversify student placement opportunities and experience, and support transition from education to employment. This is a priorty strategic project in the Leeds One Workforce Programme due for review in November 2025. 3. Health and growth accelerator programme providing additional support to retain staff in work (2025/26)
2	Leeds City Resourcing Group (LCRG) guide and monitor the collective impact of workforce recruitment and retention activity across Leeds Health and Care Partnership.	
3	Leeds H&W Community of Practice (CoP) collaborates on city-wide funding and services for H&SC staff.	
Sources of assurance *(Where is the evidence that the controls work?)*		**Link to place risk register:** None.
1	Minutes from Leeds One Workforce Strategic Board (LOWSB), LCRG and Leeds H&W CoP	
2	Academy Steering Group quarterly reports	
3	Leeds One Workforce City Risk profile	

Wakefield	**Place lead:**	**Mel Brown**	**Nominated lead for this risk:**	**Dominic Blaydon/ Philip Marshall 01.07.25**

ICB risk appetite	Place risk scores						Rationale for current place score
	Target (Wakefield)			Current (Wakefield)			
CAUTIOUS	Likelihood	4	8	Likelihood	4	12	The current likelihood and impact scores recognise the work underway as part of the implementation and delivery of The Wakefield People Plan. The Plan consists of 6 Pillars, all aligned to supporting staff health and wellbeing, retention and recruitment included in Pillar 1 'Looking after our People' and Pillar 5 'Growing and Developing Our Workforce. These programmes will support partnership and collaborative initiatives. It also includes commitment to the Memorandum of Understanding (MoU) and Operational Template to support the deployment of staff between organisations. This MoU will mitigate any future impact of operational and process challenges with recruitment and retention of staff at an organisational level. Currently there is a significant risk to the workforce as a result of the 50% reduction in ICB funding however, in Wakefield we are to some extent protected from this because of the way the PMO is currently funded. There is still residual risks to the social care workforce associated with a lack of the national strategy and funding arrangements.
	Impact	2		Impact	3		

Key controls *(What helps us mitigate the risk?)*		**Mitigating actions** *(What more are we/should we be doing at place?)*
1	Wakefield People Alliance oversight of priority programmes - a system wide overview of the responses to the workforce challenges under the Wakefield People Plan	The Wakefield People Alliance's Pillar 5 Programme adopts a comprehensive approach to tackling workforce risks through strategic recruitment initiatives. These initaitives mitigate workforce risks associated with recruitment and retention of staff across the health and care system. Initiatives include: (timescale - 2025/26) 1. Hyperlocal Recruitment Programme, which focuses on attracting talent from within the local community. By partnering with local organisations and offering tailored recruitment opportunities, this programme supports the development of a diverse workforce that is connected to local communities. 2. School Engagement Programme, which fosters early career awareness by engaging students and raising the profile of the full range of careers available in our sector. This initiative not only encourages the pursuit of healthcare careers but also strengthens the pipeline of future professionals. 3. The Student Placement Framework further enhances workforce sustainability by providing students with hands-on experience within the Wakefield health and care sectors, helping to
2	Mental Health and Well Being Hub - a system wide offer to all staff across the West Yorkshire partnership to ensure that access to Mental Health Wellbeing is available to all.	
3	The Wakefield People Plan has 6 Pillars within it, each with two Pillar Leads, supported by a Programme Manager to plan, lead the delivery of each Programme	
4	Wakefield Workforce Project Management Office established across the Wakefield system	
Sources of assurance *(Where is the evidence that the controls work?)*		
1	Access and analysis of workforce sector data to inform the development of a Workforce Plan dashboard to be reported through to Integrated Assurance Committee.	
2	Wakefield has been supported via system-wide funding/workstreams including staff training and support, coaching and mentoring, money buddies, physical health checks.	

	Positive Assurance The current Programme within the Wakefield People Plan focuses on the following priorities: - Community Career Events co-designed by the Community delivered by all health and social care providers across Place and hosted in Community Anchors. Hyper local recruitment in place with job interviews on the day and roles offered to community members. This is an evolving programme which will be delivered across all localities. - System approach to the pooling of the apprenticeship levy and developing resources specifically for young people to increase the number of apprenticeships in the system and grow our own from the future generation - Working with the social care independent sector to support their key challenges identified and co-design solutions, which include system offers on training, well-being and local recruitment. - Strong place-based governance arrangements are in place to support the delivery of the programmes, including a well-developed People Alliance, dedicated System Workforce Programme Management Office and Wakefield Health and District Partnership People Hub. - Recently launched economic accelerator programme that supports people in the current workforce who are at risk of becoming economically inactive. Commissioned a range of services to support this cohort.	bridge the gap between academic learning and real-world application. The Wakefield People Alliance addresses retention through its Pillars 1-3 Programmes. Initiatives include: (timescale - 2025/26) 1. The Wakefield Health and Care Learning Portal supports continuous development by offering accessible training and development resources for current staff, promoting career growth within the sector. 2. The Compassionate Leadership Programme cultivates empathetic leadership to create supportive working environments, while The Leading Wakefield Together training builds collaborative leadership skills across the workforce. 3. Coaching and Mentoring Hubs provide personalised support to staff, helping them navigate career challenges and fostering long-term engagement. Continues for 2025/26.
		Links to Place Risk Register
		2129

WYICB - Board Assurance Framework - ICB and places							Version: 11	Date: 19 March 2025
Mission 2	Failure to manage the strategic risk could result in a failure to **MANAGE UNWARRANTED VARIATION IN CARE**						**Lead director(s) / board lead**	James Thomas
Strategic risk 2.2	There is a risk that as a system we fail to innovate, learn lessons and share good practice that allows us to respond to service pressures resulting in widening variations across our footprint.						**Lead committee / board**	Quality Committee
ICB risk appetite	**ICB risk scores**						**Rationale for current ICB score**	
	Target (ICB)			**Current (ICB)**			More formal assurance is needed through Transformation Committee and Partnership Board. Significant work has taken place over the last 12 months. Digital is a risk in terms of separation with the new leadership arrangements however this is being focused on, this will continue in 2025/26. Uncertainty around the implications of current changes with ICBs and the impact on the WY ICB research function, risk scores may change by the end of Cycle 1 2025/26.	
OPEN	**Likelihood**	**2**	**6**	**Likelihood**	**2**	**8**		
	Impact	**3**		**Impact**	**4**			

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

Bradford District and Craven (BD&C)	**Place lead:**	**Therese Patten**	**Nominated lead for this risk:**	**Phillipa Hubbard (30.06.2025)**

ICB risk appetite	**Place risk scores**						**Rationale for current place score**	
	Target (BD&C)			**Current (BD&C)**			Recognise the requirement to implement the BDC HCP strategy and 'inverting the power to act' at locality level - this is ongoing through Healthy Communities and Living Well Programmes. Risk score increased from 6 to 9 due to work needing to be undertaken with regards to digital upgrade for systems and software. Business case approved but not implemented to date. Primary care impact is on new approach to shared care protocols/ agreement still to be signed off.	
OPEN	**Likelihood**	**2**	**4**	**Likelihood**	**3**	**9**		
	Impact	**2**		**Impact**	**3**			

Key controls *(What helps us mitigate the risk?)*		**Mitigating actions** *(What more are we/should we be doing at place?)*
1	Committee structure in place including BDC HCP System Quality Committee which oversees the process of mutual assurance of quality of care delivered by local providers, which identifies issues, and supports improvement. In addition we have Priority and Enabler Programme Boards that provide ownership to transforming services across all place based partners. The system quality insight and assurance group meets monthly to triangulate themes, intelligence and learning which then reports into the System and Quality Committee. The SQC reports quarterly into place partnership board and WY Quality Committee and Quality Group.	1.The Quality Team input into BDC priorities and transformation programmes and patient safety/ quality is taken into account when responding to financial pressures (Work ongoing 2024/25-2026) 2. Development of the dashboard to include patient outcomes to be used as a source of assurance operational is ongoing (2024/25 - 2026) 3. Work is progressing on the BDC clinical strategy to support and streamlining of clinical pathways which supports the work of the place based clinical forum. (September 2025) Governance system structures and alignment to support the wider collaborative have been revised including workstreams for integrated neighbourhood health.
2	The Innovation Hub working alongside the development of improves as one portal and accompanying process identifies proven best practice and supports local teams to adopt and adapt across the BDC HCP	
3	Model of Distributive leadership in place in Bd&C with HCP for Chief Nurse which provides opportunities to provide assurance and oversight, share best practice, learning and improvement opportunities between partner organisations	**Links to Bradford place risk register:**
4	Prioritisation framework and WY ICB wide QEIA process has been implemented alongside strategic principles that have been produced by the BDC System Strategy working group to try and narrow the gap	2419
5	Quality requirements are represented with all providers and monitored through the contract management process	
Sources of assurance *(Where is the evidence that the controls work?)*		
1	Assurance through Internal Audit of our transformation programmes and via ongoing reporting and challenge through individual Programme Boards, Partnership Board, Clinical Forum and SQC/SQG and ICB governance structures - through AAA updates from assurance and governance committees (combined F&PC SQC and meet monthly) and priority and enabler programmes.	
2	Redeveloped model/way of working for the Place (Bd&C) System Quality Committee (SQC) including the provision of governance and assurance and sharing of best practice through the work of sub-groups and the reporting structure. Terms of Reference and Minutes.	
3	The Innovation Hub networked to all other parts of our BDC governance structure, including whole system enabling strategy groups for population health management, workforce, digital, estates, and communication & engagement. Supported by shared system committees for Finance and Performance, Quality and Safety, and our Clinical Forum. The Hub maintains strong links with Bradford Institute of Health Research (BIHR), Yorkshire & Humber AHSN, Yorkshire and Humber Improvement Academy (IA) and the University of Bradford (UoB). Terms of Reference and Meeting Minutes.	
4	Recommendations on investment / dis-investment take into account EQIAs/QEIAs, output from the prioritisation tool and demonstrate strategic fit.Equity, Quality Impact Assessment (EQIA) / Quality, Equality Impact Assessment (QEIA) embedded.	

Calderdale	**Place lead:**	**Robin Tuddenham**	**Nominated lead for this risk:**	**Neil Smurthwaite (17.07.2025)**

ICB risk appetite	**Place risk scores**						**Rationale for current place score**	
	Target (Calderdale)			**Current (Calderdale)**			Governance arrangements are continually reviewed locally. Development time dedicated at Partnership Board to discuss key issues as a system. Clear weakness in WY data/analytics for system overview. No significant resource locally to compare with other resource. Recognise work ongoing to produce consistent WY data.	
OPEN	**Likelihood**	**2**	**4**	**Likelihood**	**2**	**6**		
	Impact	**2**		**Impact**	**3**			

Key controls *(What helps us mitigate the risk?)*		**Mitigating actions** *(What more are we/should we be doing at place?)*
1	Place-based Quality Group established to ensure we continue to share lessons and good practice.	1. Calderdale lead on a number of WY elective recovery programmes, ensuring greater consistency in single contracts, to help avoid variation. Consistent Independant Sector waiting times recently agreed across WY.
2	Clinical and Professional Forum currently being reviewed with a aim to link the output of the forum to our transformation priorities and financial position	
3	Primary Care Strategy Group meets quarterly and reports to the partnership board.	

4	Urgent care model has been developed that will help UECB and Community programmes joined up impactful initiatives.

Sources of assurance *(Where is the evidence that the controls work?)*

1	Regular reporting to Calderdale Care Partnership Board.

Links to Place risk register;
1338, 2476, 2163, 2149, 1493, 62, 1977, 2092

Kirklees	Place lead:	Vicky Dutchburn	Nominated lead for this risk:	Vicky Dutchburn (25.06.2025)

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

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

1	Kirklees ICB Transformation Sub-Committee, supported by the Kirklees Delivery Collaborative as mechanism to enable shared learning across providers
2	Working across places and with WY programmes to share learning and experience, identify variation, and opportunities for improvement
3	Clear governance around Quality oversight in place with providers, working collaboratively to share learning and report via System Quality Group and ICB Quality Sub-Committee
4	Active participation in WY networks and programmes with evidence of having shared learning from Kirklees, and adopted it from elsewhere.

Mitigating actions *(What more are we/should we be doing at place?)*

1. Increase visibility and understanding of the West Yorkshire Innovation Leadership Collaborative and the interface between this network and place (Review 2025/26)
2. Establish clearer connections between the WY ICB and the West Yorkshire Innovation Leadership Collaborative (Review 2025/26)
3. Chief Digital and Information Officer attending Kirklees Board Development Session to share learning, next steps (Q2, 2025/26)

Sources of assurance *(Where is the evidence that the controls work?)*

1	Evidence of early adoption and innovation in place e.g. UCR, Lung Health Checks, approach to neighbourhood working.
2	Reports to Kirklees Sub-Committees demonstrating provider collaboration, examples of innovation and shared learning. Papers and Mins.
3	System Quality Group and ICB Quality Sub-Committee. Papers and Mins.

Link to place risk register:
2445

Leeds	Place lead:	Tim Ryley	Nominated lead for this risk:	Jason Broch (26.06.2025)

ICB risk appetite	Place risk scores						Rationale for current place score
	Target (Leeds)			Current (Leeds)			
OPEN	Likelihood	2	4	Likelihood	3	12	Earlier in the year the Leeds governance arrangements were established with a wide range of stakeholders, these were relatively new and establishing a rhythm and recognition of function. Throughout the last Quarter of 2024/25 and into 2025/26 there is a continual improvement approach to the Leeds governance and priortisation. Our partnership governance arrangements have become more mature and we have identified some priority areas to collectively focus on as part of the Healthy Leeds plan. The biggest barriers to progress in these programmes tend to be digital and this is complex across competing providers with different needs as well as the Leeds digital infrastructure being a challenge when compared with the WY strategic approach.
	Impact	2		Impact	4		

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

1	Clear governance arrangements in place to provide assurance to the Leeds Committee of the ICB. Place partners working collaboratively through the Assurance Sub-Committees (Quality & People's Experience and Finance & Best Value).
2	Regular contribution and representation at the ICB Quality Committee and System Quality Group
3	Regular contribution and representation at the WY ICB Safeguarding Oversight and Assurance Partnership
4	Leeds Academic Health Partnership membership with representation at Board and implementation levels.
5	As a partner with Leeds Academic health partnership identifying opportunities from health professionals,
6	The Clinical Professional Executive Group (CPEG) meet monthly and has been reviewing a system approach to risk and learnings from escalated cases to make sure there is a Leeds based approach to those learnings and that partners can better manage system risk collectively

Mitigating actions *(What more are we/should we be doing at place?)*

1. There has been a lot of progress amongst senior clinical leaders to understand the wide range of interface issues in the city and a programme has been established to try and manage some of these better (2025/26)
2. Leeds partnership has appointed a Lead Chief digital information officer (CDIO) from one of the partners to oversee partnership development work and facilitate integration. New governance around this is being developed to be in place by 2025/26. Although these governance arrangements are starting to become clearer they are also highlighting some of the competing ambitions between different partners. They are not yet in a clearer enough form for senior leaders to prioritise. There is a piece of work to look at developing provider collaborative in line with the direction the government is taking the NHS and in line with the ICB blue print which will hopefully address some of the digital issues.
3. All Leeds partnership across Leeds health and social care were working collaboratively with the University of Leeds to develop a research project (SEISMIC) to bring academic rigour to system improvements and integration for people with long term conditions and mental illness, facilitating the use of innovative technology. Unfortunately Leeds was unsuccessful in the bid but there is ongoing conversation to see how the partnership can capitalise on the work so far anyway.

Sources of assurance *(Where is the evidence that the controls work?)*

1	Regular arrangements to evaluate the effectiveness of the Sub-Committees.
2	Emerging system-wide networking between Quality Improvement leaders across the partnership.
3	WY ICB Safeguarding Oversight and Assurance Partnership. Papers and Mins
4	ICB Quality Committee and System Quality Group. Papers and Mins
5	West Yorkshire clinical and professional forum (monthly) - representation from Leeds
	The Clinical Professional Executive Group (CPEG) meet monthly
6	

Link to place risk register:
2480, 2487

Wakefield	Place lead:	Mel Brown	Nominated lead for this risk:	Penny McSorley (30.06.25)

ICB risk appetite	Place risk scores						Rationale for current place score
	Target (Wakefield)			Current (Wakefield)			
OPEN	Likelihood	2	4	Likelihood	3	12	WDHCP governance arrangements are now well established and relationships strengthened. Examples of sharing and learning across key forums in the ICB and wider partners. Governance is in place with connection to West Yorkshire System Quality Group and WY Quality Committee. Risk score remains the same until the release of the 10 year plan.
	Impact	2		Impact	4		

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

1	Clear governance around quality, safety and patient experience with regular reports through to Integrated Assurance Committee, Wakefield District Health and Care Partnership and People Panel
2	Experience of Care Network - sharing good practice following feedback from service users
3	Transformation and delivery committee established to which shares good practice and focus on improving services
4	Patient safety priorities, development of place quality priorities, and alignment with West Yorkshire quality priority areas in place
5	Shared quality frameworks in place

Mitigating actions *(What more are we/should we be doing at place?)*

Timescale 2025/26:
1. District plan has been agreed
2. Clinical and professional engagement takes place and is collated and monitored.
3. Wakefield and district health and care partnership have commenced a neighbourhood health programme of work focusing on the 6 key elements of neighbourhood health in preparation for the 10 year plan (2025/26)

Sources of assurance *(Where is the evidence that the controls work?)*

1	Reports provided of quality across the WDHCP of areas of transformation and improvement
2	Minutes of meetings from multiple governance forums
3	Recommendations and action plans from Care Quality Commission inspections and quality visits
4	Local perfomance dashbords and improvement plans

Links to Place Risk Register
None.

WYICB - Board Assurance Framework - ICB and places		Version: 11	Date: 12 March 2025
Mission 2	Failure to manage the strategic risk could result in a failure to **MANAGE UNWARRANTED VARIATION IN CARE**	**Lead director(s) / board lead**	Lou Auger
Strategic risk 2.3	There is a risk that we cannot measure and assess performance across the system in a timely and meaningful way, which impacts our ability to respond quickly as issues arise.	**Lead committee / board**	Finance, Investment and Performance Committee

ICB risk appetite	**ICB risk scores**						**Rationale for current ICB score**
	Target (ICB)			**Current (ICB)**			
OPEN	**Likelihood**	**2**	**6**	**Likelihood**	**3**	**9**	The current likelihood is **possible,** given the limited business intelligence capacity in the ICB, limited access to near real-time performance data and lack of a comprehensive, shared performance dashboard. Failure to control this risk will lead to **moderate** impact on system performance. We could see a failure to meet national standards, a failure to address unwarranted variation, an inability to provide mutual aid in a timely way and regulatory breaches.
	Impact	**3**		**Impact**	**3**		

Key controls *(What helps us mitigate the risk?)*		**Mitigating actions** *(What more are we/should we be doing at ICB level?)*
1	A comprehensive performance dashboard and exception report shared by the Board and its committees	1. Development of Business intelligence (BI) capacity across the ICB (Q3, 2025/26).
2	A system co-ordination centre is live to consolidate information and action on UEC pressures. The SCC meets the revised national specification.	
3	Securing access to, and review of, comprehensive, up-to-date management data	
4	System-wide meetings to share intelligence, review risk and agree mitigating actions	
5	UEC-Raidr app is active and continues to be developed	

Sources of assurance *(Where is the evidence that the controls work?)*		**Links to ICB risk register** *(Reference numbers/brief description)*
1	Minutes of Board and committee meetings	None identified
2	Minutes and action logs of System Oversight and Assurance Group (SOAG) and other system groups	
3	Evidence of access by system leaders to UEC app and national data sources	
4	3 x daily SCC reports to NHSE Regional Team and shared with senior leaders	**See the separate Positive Assurance Log**

Bradford District and Craven (BD&C)	**Place lead:**	**Therese Patten**	**Nominated lead for this risk:**	**Sohail Abbas and Kerry Weir (26.06.25)**

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (BD&C)			**Current (BD&C)**			
OPEN	**Likelihood**	**1**	**2**	**Likelihood**	**2**	**4**	Good processes and systems in place to monitor performance and capacity across providers and BD&C place . Performance dashboards which are regularly taken to System committees and transformation programmes. Ability to pull out performance data quickly on an ad-hoc basis when required.
	Impact	**2**		**Impact**	**2**		

Key controls *(What helps us mitigate the risk?)*		**Mitigating actions** *(What more are we/should we be doing at place?)*
1	BDC HCP (place) governance assurance through sub-committees System Finance and Performance Committee to the Partnership Board	Partnership Board level outcomes report has been developed and includes health and inequalities metrics (control) 1. Reviewed governance arrangements, which will help to triangulate performance across the range of areas (2025/26) # Control Finance, performance and quality forum (inbetween the FIPC and QC quaterly meetings) performance reported monthly to the extended leadership team (ELT)
2	BDC HCP (place) governance assurance through sub-committees System Quality Committee to the Partnership Board	
3	HCP programme boards	

Sources of assurance *(Where is the evidence that the controls work?)*		**Links to Place Risk Register**
1	Performance dashboard at System Finance and Performance Committee and robust processes in place to review performance (range of dashboards, reports to SF&P and HCP board)	2168, 2423
2	Sub Committee of Quality committee receives performance dashboard focussing on patient experience and outcomes and statutory requirements, issues discussed at Quality Committee	
3	Regular update on performance provided to WYICB to support development of SOAG report	
4	3 times weekly system resilience dashboard circulated across HCP partners	
5	Regular Performance reports to HCP programme boards and ICB executive meeting	
6	Core 20+5 and health inequality premium performance reporting	
7	Triple A reports from finance and quality committees to Health and Care Partnership Board	
8	Core 20+5 and health inequality premium performance reporting (assurance)	

Calderdale	**Place lead:**	**Robin Tuddenham**	**Nominated lead for this risk:**	**Neil Smurthwaite (17.07.25)**

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (Calderdale)			**Current (Calderdale)**			
OPEN	**Likelihood**	**1**	**2**	**Likelihood**	**2**	**6**	Established performance monitoring process across commissioners and providers. Recognise we have potential BI capacity issues but we are currently performing as expected.
	Impact	**2**		**Impact**	**3**		

Key controls *(What helps us mitigate the risk?)*		**Mitigating actions** *(What more are we/should we be doing at place?)*
1	Oversight framework used as base of performance monitoring at CCPB.	(See WY response above regarding BI) 1. Calderdale has good oversight on the key national performance metrics and out perfoms in a number of areas. 2. Joint UECB across CHFT footprint monitoring urgent care performance, including winter, discharge and ambulance performance.
2	Working with partners to provide singular view at WY and place level.	

Sources of assurance *(Where is the evidence that the controls work?)*		**Links to Place Risk Register;**
1	Performance monitoring at CCPB. Papers and Minutes.	2476, 2149, 62

Kirklees	**Place lead:**	**Vicky Dutchburn**	**Nominated lead for this risk:**	**Vicky Dutchburn (25.06.2025)**

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (Kirklees)			**Current (Kirklees)**			
OPEN	**Likelihood**	**1**	**2**	**Likelihood**	**2**	**8**	Kirklees has processes in place that monitor the current performance with main providers and as a Kirklees position. This is reported to the Kirklees Finance and Performance Sub-Committee. A local framework for daily escalations and service capacity is in place and monitored through our CHFT/ MYTT silver escalations.
	Impact	**2**		**Impact**	**4**		

Key controls *(What helps us mitigate the risk?)*		**Mitigating actions** *(What more are we/should we be doing at place?)*
1	Detailed performance reports presented to Kirklees Finance and Performance Sub-Committee and ICB	1. The local dashboard and indicators will transition into the new national RAIDR KPIs when signed off (2025/26) 2. Data sharing agreement across primary and secondary care with regards to integrated neighbourhood team development (100% by Q2, 2025/26)
2	Partnership processes for sharing timely data across the system partners	
3	Speciality level reports at Elective Care and Urgent Care Boards	
4	A Urgent and Emergency Care Board (UECB) has a system dashboard	
5	Community service and primary care performance indicators now in place in a local dashboard (reviewed daily)	

Sources of assurance *(Where is the evidence that the controls work?)*		**Link to place risk register:**
1	Minutes of Finance and Performance Sub-Committee and Kirklees Health and Care Partnership Board	None.
2	Action logs and performance slide packs from Elective Boards	
3	Minutes from system silver escalation calls	
4	Review the UECB dashboard and agree actions	
5	Data sharing agreement by the end of Q1, data flow is 80% and by the end of Q2, 100%	

Leeds	**Place lead:**	**Tim Ryley**	**Nominated lead for this risk:**	**Richard Irvine (23.06.2025)**

ICB risk appetite	Place risk scores						Rationale for current place score
	Target (Leeds)			Current (Leeds)			Reasonable oversight already of activity, capacity and performance via excellent place based relationships and working arrangements. Continues to be timely, automated and wide availability of data. Risk score remains.
OPEN	Likelihood	1	2	Likelihood	2	6	
	Impact	2		Impact	3		

Key controls *(What helps us mitigate the risk?)*	
1	System Resilience Operational and Coordination groups in place, and daily pressures meeting.
2	Daily data shared via Opel System gives good oversight of volumes of attendances and pressures across sectors.
3	Regular feedback from Trust Boards about performance risks and issues feeding local dashboards and delivery groups.
4	The system visibility tool/ dashboard to support daily oversight of capacity and demand around system flow is in place and is mature
5	The Opel dashboard is also available across the Leeds system, harnessing data from UEC-RAIDR and supplementing it with data from Leeds City Council/ Adult Social Care. Across the Leeds system all partners have access to this data and alerts our providers where thresholds are exceeded

Sources of assurance *(Where is the evidence that the controls work?)*	
1	Minutes of meetings.
2	Partner Board reports demonstrate tight tracking on behalf of the system via their IQPRs.
3	The use of data and insight (as evidence) is fast becoming central to a number of governance boards. For example, the Population and Care Delivery Boards have a compelling score card that describes performance for each population segment.

Mitigating actions *(What more are we/should we be doing at place?)*

1. There is a wider set of dashboards, metrics and indicators that have been developed and are used to track both operational and transformational activity across Leeds. All data that feed the various dashboards in Leeds have been automated and all dashboards are accessible to individuals across a range of organisations as per access controls. Individuals and organisations (including the Population and Care Delivery Boards) use these data to manage strategic risk of unwarranted variation of care.
2. During Q1 2025/26, the Opel dashboard has been improved and General Practice data flows are being included (2025/26). The audience has widened and this dashboard provides timely awareness of pressures right across Leeds. The dashboard has high use with almost 100 managers and service leaders across Leeds accessing this on a daily basis.

Link to place risk register:
None

Wakefield	Place lead:	Mel Brown	Nominated lead for this risk:	Natalie Tolson (14.07.25)

ICB risk appetite	Place risk scores						Rationale for current place score
	Target (Wakefield)			Current (Wakefield)			Good processes and systems in place. Performance dashboards which are regularly taken to Integrated Assurance Committee. Responsive narrative on a monthly basis to central core team. Ability to pull out performance data quickly on an ad-hoc basis when required. Risk score remains the same in Cycle 2.
OPEN	Likelihood	1	2	Likelihood	2	6	
	Impact	2		Impact	3		

Key controls *(What helps us mitigate the risk?)*	
1	Wakefield District and Health Care Partnership Committee, Integrated assurance committee and Transformation and Delivery Collaborative receives activity and performance report at each of its meetings
2	System Outcomes Framework in place and is being re-evaluated as part of a new District Plan.
3	Each transformation programme has it's own performance dashboard or a dashboard is in development which tracks performance, progress and supports evaulation
4	MYTT share daily sit-rep data (DSIT) with the ICB BI team so we are sighted on current performance
5	Investment in Business Intelligence, including the shared PowerBI tenancy with MYTT allows colleagues with easy access to performance information and 'live' performance information from within the Trust
6	Recently appointed Data & Analytic Business Partners to support collaberative performance reporting / analytics across the Wakefield system / MYTT

Sources of assurance *(Where is the evidence that the controls work?)*	
1	Minutes and papers from the Wakefield District and Health Care Partnership Committee, Integrated assurance committee and Transformation and Delivery Collaborative
2	Tracking of key consitutional and local priority metrics through dashboards and reports - presented to Integrated Assurance Committee, Transformation Delivery Collaberative, Transformation programmes and Wakefield District Health and Care Partnership.
3	The system visibility of tools/reports to support daily oversight of capacity and demand around system flow is in place and is mature (one suite of reports shared across ICB/MYTT)
4	Use of RAIDR UEC Dahboard, OPEL information and feedback from System Meetings (to support on call and system command)
5	Through collaberative working / shared BI roles across ICB/MYTT, the ICB is kept informed of any upcoming or changes to risks to performance and reporting.

Mitigating actions *(What more are we/should we be doing at place?)*

1 Currently working on the flow of community data to extend the OPEL framework to incorporate community services (2025/26)
2 Continue to strengthen collaberative / joint working between ICB BI and MYTT BI to support the efficient sharing of performance information, single version of the truth, access to live data and removal of duplication. MYTT will migrate to PowerBI across 2025 which will improve the accessibility of live information across the system - supporting the ability to make rapid decision making based on live data and intelligence (by March 2026)
3. Mid Yorkshire Teaching Hospital are actively engaging with the national federated data platform, adopting a number of applications that suppport performance delivery and access to timely data to support daily decision making (OPTICA, shared Patient Treatment List) Ongoing development 2025/26

Link to Place Risk Register
None

WYICB - Board Assurance Framework - ICB and places		Version: 11	Date: 10 June 2025
Mission 2	Failure to manage the strategic risk could result in a failure to **MANAGE UNWARRANTED VARIATION IN CARE**	**Lead director(s) / board lead**	Jonathan Webb / Shaukat Ali Khan
Strategic risk 2.4	There is a risk that our infrastructure (estates, facilities, digital) hinders our ability to deliver consistently high quality care.	**Lead committee / board**	Finance, Investment and Performance. Transformation Committee - for Digital.

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

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

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

Bradford District and Craven (BD&C)	**Place lead:**	**Therese Patten**	**Nominated lead for this risk:**	**Robert Maden (01.07.2025)**

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (BD&C)			**Current (BD&C)**			For digital, investment in AFT, BDCT will move us to a higher level of digital maturity over the next 18 months 2025/26. However, we have investment challenges in Primary Care persisting due to limited primary care capital. For estates, even allowing for investment in the Airedale Hospital development and Lynfield Mount, significant backlog maintenance remains an issue, both for the acute estate and the primary and community estate. Significant affordability issues remain in relation to primary care developments. The utilisation and modernisation fund for primary care has the potential to mitigate some of these issues, but funding for year 2 onwards remains to be confirmed, risk score will remain the same in this cycle.
OPEN	**Likelihood**	**3**	**9**	**Likelihood**	**4**	**16**	
	Impact	**3**		**Impact**	**4**		

Key controls *(What helps us mitigate the risk?)*		**Mitigating actions** *(What more are we/should we be doing at place?)*
1	Programme Boards established to take forward the business cases for the new hospital at AFT and for the redevelopment of Lynfield Mount.	1. The existing WY digital strategy is undergoing review across the ICS. Each organisation will review and update its own digital strategy and plan alongside (2025/26) 2. Place health and wellbeing strategy has been developed which will shape the development of the new hospital at Airedale to support the shift of services into the community and deliver an affordable solution. This will also support the development of neighbourhood health services for BDC localities. 3. Initial Place Based Capital Infrastructure Strategy completed and will continue to be developed to ensure that our estate planning across health and care reflects changing service delivery models and supports safe and innovate service provision that is targeted at the areas of highest population need. Implementation will be overseen by the Strategic Estates Group on an ongoing basis. Ongoing. 4. More emphasis on the better use of our existing estate as opposed to looking at new build solutions, unless there is no alternative option (2025/26) 5. Access to the utilisation and modernisation fund for primary care has outlined in the planning guidance for 2025/26. This provides a specific funding for addressing primary care capacity issues.
2	Estates is an enabler in BDC HCP (place) operating model and is key to supporting the shift of services into the community.	
3	BDC HCP continues to be supported by the BDC Digital Programme Board and meets bi-monthly. It reports into BDC executive. Digital programme of work in place with formal workstreams identified, inclusive of partnership representation (Cyber Security, Work as One, Shared Care Records, workforce, Digital Inclusion). Additional subgroups focus on infrastructure and services, research and business intelligence linked to priority programmes.	

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

Calderdale	**Place lead:**	**Robin Tuddenham**	**Nominated lead for this risk:**	**Neil Smurthwaite (17.07.2025)**

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

Key controls *(What helps us mitigate the risk?)*		**Mitigating actions** *(What more are we/should we be doing at place?)*
1	Regular round-table on financing of CHFT reconfiguration.	1. Need to be able to identify capacity and capability to support further estates and digital transformation - Operating Model clearly identified risks around estates and digital capacity gaps due to affordabililty. This hasn't been addressed fully. Local support purchased to enable invovlement in WY Infrastructure Strategy for primary care (2025/26) 2. Work still ongoing to identify local capacity for estates going forward (2025/26) 3. Digital need to be addressed by new Digital Director (2025/26) 4. Recruitment for CKW GP estates post hampered due to cost control (2025/26) and business case approved to use external company to support bids for national capital pot.
2	Calderdale is a member of: ICS Capital Infrastructure Board; Finance Forum; Digital Strategy Board	
3	General practice PCN estate strategies in plan with support procured from external organisation for national bids.	

Sources of assurance *(Where is the evidence that the controls work?)*		**Link to place risk register**
1	Reports to Committee	None

Kirklees	**Place lead:**	**Vicky Dutchburn**	**Nominated lead for this risk:**	**Alison Needham (02.07.2025)**

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (Kirklees)			**Current (Kirklees)**			Place is refreshing Estates and IT strategies to understand the infrastructure needs of the wider system. Currently, constraints in both funding and resources have resulted in lower investment into
	Likelihood	**3**	**9**	**Likelihood**	**4**	**16**	

OPEN	Impact	3		Impact	4		the Kirklees Estates, which will create unwarranted variation of services for the Kirklees place.

Key controls *(What helps us mitigate the risk?)*	
1	Estates Strategy
2	IT Strategy
3	Estates and IT leads
4	Kirklees - one public estates forum now established
5	

Sources of assurance *(Where is the evidence that the controls work?)*	
1	Estates Forums
2	IT and Digital Groups
3	Reports to Committee
4	Kirklees Estates Forum (partnership with providers) monthly
5	Meeting with senior leaders to discuss CHFT reconfiguration

Mitigating actions *(What more are we/should we be doing at place?)*

1. Estates lead continues to focus on key developments in estates within the place and wider ICB. However, potential estates operational support is currently provided by independant consultant. This contract has ended June 2025. Paper has gone to panel to extend this support (2025/26)
2. Support Primary Care to understand the need to develop and support services from an IT and an Estates perspective. Explore creative solutions with other public sector partners, particularly to develop primary care estate 2025/26.
3. Ensure funding available flows into the Kirklees place.
4. Work with partners and stakeholders to access capital resources to support development in primary care (2025/26)
5. On going round table meeting of senior leaders to support the ongoing development of the CHFT reconfiguration

Link to place risk register:
None.

Leeds **Place lead:** **Tim Ryley** **Nominated lead for this risk:** **Tim Ryley 26.06.2025)**

ICB risk appetite	Place risk scores					
	Target (Leeds)			Current (Leeds)		
OPEN	Likelihood	3	9	Likelihood	4	16
	Impact	3		Impact	4	

Rationale for current place score

The new hospitals scheme for Leeds General Infirmary rebuild is critical to the transformations in the Leeds Health and Care system. Currently we have only limited assurance that, despite all the processes completed to secure NHSE approval to proceed, the scheme will be allowed to finally proceed. Primary Care expansion of roles and the ambition for a neighbourhood health model is placing greater strain on estates in Primary Care with little access to capital. Risk score increased from 12 to 16 due to delayed funding for LTHT scheme.

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

Sources of assurance *(Where is the evidence that the controls work?)*	
1	Providers have strong infrastructure to manage capital planning and building.
2	Minutes of Strategic Estates and Programme Boards.

Mitigating actions *(What more are we/should we be doing at place?)*

1. LTHT working through medium term alternatives to the Leeds Way due to national delays until 2030 and beyond, this includes working with Leeds City Council to consider alternatives to the innovation hub.
2. Exploring innovative joint ventures/schemes and strenghten a one city estates strategy across NHS and Local Authority and cutting-edge digital solutions with detailed plans in place by March 2026
3. City Wide Digital and Estates Strategies linked to our wider H&WB plans (2025/26)

Link to place risk register:
2530

Wakefield **Place lead:** **Mel Brown** **Nominated lead for this risk:** **Colin Speers (02.07.2025)**

ICB risk appetite	Place risk scores					
				Current (Wakefield)		
OPEN	Likelihood	3	9	Likelihood	3	12
	Impact	3		Impact	4	

Rationale for current place score

There is currently no process or forum for bringing together a total estates strategy across Wakefield Place. There is no identified capital resources for any estates across the sectors.
The Digital Strategy is in delivery phase for place. The major programme of works is MYTT EPR procurement which is nationally and regionally assured, therefore there is no change to the risk score in Cycle 2.

Key controls *(What helps us mitigate the risk?)*	
1	Wakefield Place Digital Strategy in place and now being aligned across partners
2	Wakefield Place Finance Working Group linking into the West Yorkshire Integrated
3	Leads at Place that are fully involved in the Integrated Care Board strategy meetings

Sources of assurance *(Where is the evidence that the controls work?)*	
1	Minutes from Digital Programme Board
2	Place nominated lead on West Yorkshire groups
3	Digital maturity assessments (annually) - national programme

Mitigating actions *(What more are we/should we be doing at place?)*

1. Place digital forum brings together all sector and it delivers on the place digital strategy (2025/26) Both business as usual replacement and innovation investment.

Link to place risk register:
2481, 2440

WYICB - Board Assurance Framework - ICB (no requirement for places to complete)							Version: 11	Date: 12 March 2025
Mission 2	Failure to manage the strategic risk could result in a failure to **MANAGE UNWARRANTED VARIATION IN CARE**						**Lead director(s) / board lead**	Lou Auger
Strategic risk 2.5	There is a risk of an inability to deliver routine health and care services due to the emergence of a future pandemic leading to substantial loss of life and failure to deliver key functions and responsibilities.						**Lead committee / board**	ICB Board
ICB risk appetite	**ICB risk scores**						**Rationale for current ICB score**	
	Target (ICB)			**Current (ICB)**			The likelihood of a future pandemic is certain; the scale, severity and impact is unknown. This risk is based on the potential impact of a serious pandemic, based on learning from Covid. The scoring mirrors the regional NHS England score of 16 (4Lx4I).	
AVERSE	**Likelihood**	**4**	**16**	**Likelihood**	**4**	**16**		
	Impact	**4**		**Impact**	**4**			

Key controls *(What helps us mitigate the risk?)*		**Mitigating actions** *(What more are we/should we be doing at ICB level?)*
1	Surveillance systems	1. Awaiting findings of the national Covid inquiry to incorporate learning into plans. Specific recommendations around the NHS are due by June 2025.
2	Pandemic Plan	
3	Exercises	
4	Business Continuity Plans	
5		
Sources of assurance *(Where is the evidence that the controls work?)*		**Links to ICB risk register** *(Reference numbers/brief description)*
1	EPRR Core Standards and assurance process provide evidence that plans are in place and tested - this is reported to the ICB Board annually	**2456** - Health protection
2	Local Health Resilience Partnership meets quarterly to review learning from incidents and	
3	Local Resilience Forum (multi agency) meets quarterly	**Positive Assurance (see log)**

WYICB - Board Assurance Framework - ICB and places							Version: 11	Date: 12 June 2025
Mission 3	Failure to manage the strategic risk could result in a failure to **USE OUR COLLECTIVE RESOURCES WISELY**						**Lead director(s) / board lead**	Jonathan Webb
Strategic risk 3.1	There is a risk that we do not invest resources in a way which prioritises community, primary & prevention programmes and so doesn't maximise value for money.						**Lead committee / board**	Finance, Investment and Performance Committee
ICB risk appetite	**ICB risk scores**						**Rationale for current ICB score**	
	Target (ICB)			**Current (ICB)**			There has been a disproportionate increase of resource in recent years into acute hospital services in West Yorkshire and no clear plan to remedy this.	
OPEN	**Likelihood**	**2**	**6**	**Likelihood**	**4**	**12**		
	Impact	**3**		**Impact**	**3**			

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

Bradford District and Craven (BD&C)	**Place lead:**	**Therese Patten**	**Nominated lead for <u>this</u> risk:**	**Karen Parkin (30.06.2025)**

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

Key controls *(What helps us mitigate the risk?)*		**Mitigating actions** *(What more are we/should we be doing at place?)*
1	Section 75 and Better Care Fund arrangements in place reporting to planning and commissioning forum which is embedded within our governance arrangements between NHS and Local Authority for Bradford district	1. Development of Better Care Fund benchmarking across West Yorkshire during 2025/26 subject to capacity. 2. Implemention of a integrated neighbourhood health West Yorkshire Board to oversee the distribution of £5m funding in order to accelerate integrated neighbourhood health teams. 3. Bradford District Care Trust are part of the community services review which is being led by an external partner. This wil enable better collection of activity information and a comparison across West Yorkshire and nationally. 4. There is now a new governance framework across BDC with three priority programmes, one is Airedale Bradford Collaboration of Acute Services (ABCAS), second is implementation of integrated neighbourhood health and the third is corporate services review and progressing with closing the gap. All of these have efficiency saving targets to meet.
2	A new established governance framework which includes relevant committees and business meetings. This has a clear reporting structure.	
3	All VCSE sector awarded 25/26 uplift factor to help with sustainability. In addition, hospice sector allocated an extra £2m funding.	
Sources of assurance *(Where is the evidence that the controls work?)*		**<u>Link to Place risk register:</u>**
1	Better Care Fund submission 2025/26 and monitoring overseen by the Planning and Commissioning Forum	2447, 2386, 2227, 2486, 2040
2	Much tighter monitoring arrangements for effiency savings, closing the gap and difficult decisions. All Bradford and Craven NHS organisations have robust monitoring frameworks in place.	
3	New priority programmes established and regular reports to those business meetings.	

Calderdale	**Place lead:**	**Robin Tuddenham**	**Nominated lead for <u>this</u> risk:**	**Neil Smurthwaite (17.07.2025)**

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (Calderdale)			**Current (Calderdale)**			Significantly pressured financial environment with acute hospital in deficit. This means lack of resources to move funds to invest in other areas or services. Current allocations suggest we are utilising more financial resource than we should, therefore not able to invest new money in additional areas to integrate services. Development of Provider collaboration in its infancy and with 10 year plan we should be able to develop strategies for more proportionate distribution of funding.
OPEN	**Likelihood**	**2**	**4**	**Likelihood**	**4**	**12**	
	Impact	**2**		**Impact**	**3**		

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

Kirklees	**Place lead:**	**Vicky Dutchburn**	**Nominated lead for <u>this</u> risk:**	**Alison Needham (02.07.2025)**

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (Kirklees)			**Current (Kirklees)**			The planning guidance and funding allocations does not allow for significant investment within primary care and the community. As stated in the WY narrative, funding is heavily weighted to the acute sector. Kirklees place whilst working collaboratively across the system, due to these challenges and the contractual form does not allow funding to flow around the system to allow services to align and increase investment in those areas. Review of target score against risk appetite, agreed to reduce the target risk score from 8 to 4 as the place is willing to take reasonable risks and tolerant of a certain amount of uncertainty.
OPEN	**Likelihood**	**2**	**4**	**Likelihood**	**3**	**12**	
	Impact	**2**		**Impact**	**4**		

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

Leeds	**Place lead:**	**Tim Ryley**	**Nominated lead for <u>this</u> risk:**	**Nick Earl 27.06.2025** **Cycle 3 review will be undertaken by Alex Crickmar**

ICB risk appetite	Place risk scores						Rationale for current place score
	Target (Leeds)			Current (Leeds)			Despite progress for a more integrated approach to financial planning across LHCP there remain challenges based on organisational boundaries and ongoing financial pressures. Additional challenges in Q3 and Q4 anticipated given reduction in ICB resources and associated restructure.
OPEN	Likelihood	2	4	Likelihood	3	9	
	Impact	2		Impact	3		

Key controls *(What helps us mitigate the risk?)*	
1	Integrated finance reports through LHCP governance - Leeds Finance and Best Value Committee oversees Leeds System Financial and Commissioning positions.
2	Analysis of spend through lens of populations and sub-groups as well as service lines.
3	Strategic Finance Executive Group and Joint Planning Process across the partnership
4	Finance sub-committee oversees financial planning and decisions.
5	Regular attendance of DOFs at LHCP Partnership Exec Group and guiding priority programme ambition

Sources of assurance *(Where is the evidence that the controls work?)*	
1	Finance sub-committee receives financial planning and decisions. Papers and Minutes
2	DOFs at LHCP Partnership Exec Group. Papers and Minutes
3	Benefits realisation assessments for priority programmes

Mitigating actions *(What more are we/should we be doing at place?)*

1. A programme of work is underway to continue to develop our joint approach to financial planning and decision-making to allow us to make the most value-driven decisions on resource allocation across the LHCP. To be actioned within the medium term financial plans (2025/26)
2. Increasing focus on quantifying impact for and transformational change for larger partnership programmes and release of benefits (alongside their quantification)

Links to Place Risk Register

2414

Wakefield **Place lead:** **Mel Brown** **Nominated lead for this risk:** **Jenny Davies (26.06.25)**

ICB risk appetite	Place risk scores						Rationale for current place score
	Target (Wakefield)			Current (Wakefield)			Continued development of the Wakefield Place working together, investment in services, greater understanding required of service join-up within Place in order to invest more wisely. Greater involvement of system partners in decision making, for example - voluntary sector. A requirement for more robust return on investment modelling within place. Risk score increased from 9 to 12 in line with WY ICB.
OPEN	Likelihood	2	4	Likelihood	4	12	
	Impact	2		Impact	3		

Key controls *(What helps us mitigate the risk?)*	
1	Partnership Committee comprises of partner organisations and Integrated Assurance Committee looks in more detail at financial decision making
2	The Wakefield Place Finance Leaders meeting is now established, forming a wider financial strategy, including the voluntary sector and local authority.
3	Each place finance lead closely connected with director of finance for Integrated Care Board therefore strategies aligned.
4	Shared posts across partner organisations - link services together to make more informed decisions around
5	A framework for investment decisions agreed and implemented
6	Financial Plan in place

Sources of assurance *(Where is the evidence that the controls work?)*	
1	Minutes from meetings (TDS and Wakefield management meetings)
2	Honorary contracts in place
3	Regular reporting mechanisms for quality, performance and finance in place
4	Monthly review at Wakefield Senior Leadership Team meeting

Mitigating actions *(What more are we/should we be doing at place?)*

1. Within Wakefield place, there is Transforming Development Collaborative (TDC) whereby they engage with all parties to ensure there is investment in the right areas and in 2025/26 planning there will be a commitment to increase investment within primary care. A balanced financial plan was submitted, monitoring continues on a monthly basis (2025/26).

Links to Place Risk Register

None.

WYICB - Board Assurance Framework - ICB and places							Version: 11	Date: 12 June 2025
Mission 3	Failure to manage the strategic risk could result in a failure to **USE OUR COLLECTIVE RESOURCES WISELY**						**Lead director(s) / board lead**	Jonathan Webb
Strategic risk 3.2	There is a risk that we don't operate within our available system and organisational resources (revenue and capital) and so breach our statutory duties.						**Lead committee / board**	Finance, Investment and Performance Committee
ICB risk appetite	**ICB risk scores**						**Rationale for current ICB score**	
	Target (ICB)			**Current (ICB)**			Despite a number of years of strong performance as an ICS, the 2024/25 position and 2025/26 plan were only balanced after receipt of significant non-recurrent financial support from NHS England, and as such there is a challenging plan to deliver this year and risks are materialising.	
CAUTIOUS	**Likelihood**	**3**	**9**	**Likelihood**	**4**	**20**		
	Impact	**3**		**Impact**	**5**			

Key controls *(What helps us mitigate the risk?)*		**Mitigating actions** *(What more are we/should we be doing at ICB level?)*
1	Financial Framework document agreed by FIPC	(1) ICB Board sponsored across all places and organisations to improve financial underlining positions. (2) Development of a robust and credible medium term financial plan.
2	All Plans are signed off by the organisational Boards	
3	Escalation and joint approach with NHS England for Trusts in NOF3	
4	Finance Forum, SOAG, FIPC, EMT and Board all have oversight	
5	Place Committees and their finance sub-committees have oversight and provide assurance upwards	
Sources of assurance *(Where is the evidence that the controls work?)*		**Links to ICB risk register** *(Reference numbers/brief description)*
1	Quarterly review meetings with NHS England and outcome letters	**2431** - managing within capital limits; **2430** - financial breakeven
2	Agendas, reports and minutes of all meetings above	
3	Internal Audit and External Audit	
4	External review commissioned into Finance by WYAAT (July 2024) and across the ICS (November 2024).	**Positive Assurance Log -** see separate

Bradford District and Craven (BD&C)	**Place lead:**	**Therese Patten**	**Nominated lead for this risk:**	**Karen Parkin (30.06.2025)**

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (BD&C)			**Current (BD&C)**			Due to the current financial pressures there is a significant risk that Bradford and Craven will fail to operate within current resource envelopes. Target risk score increased from 6 to 9 due to cautious risk appetite.
CAUTIOUS	**Likelihood**	**3**	**9**	**Likelihood**	**4**	**20**	
	Impact	**3**		**Impact**	**5**		

Key controls *(What helps us mitigate the risk?)*		**Mitigating actions** *(What more are we/should we be doing at place?)*
1	System Finance & Performance Committee oversight of Place financial position	1. Implementation of closing the gap programme now included within the corporate services priority programme. 2. Difficult decisions list established and being prioritised 3. Robust and regular monitoring of all Bradford and Craven NHS organisations by the ICB and by NHSE. All frameworks and monitoring processes have been strengthened and implemented. Actions to de-risk efficiency saving plans are being developed. 4. Development of plans for the further stretch of £12m is underway with the establishment of the new priority programmes as part of the new governance structure.
2	BDC follows the West Yorkhire established principles and process.	
3	Regular detailed review of in-year financial performance by Place DoFs with full transparency of cost pressures and sources of mitigation.	
3	Ongoing closing the gap programme reports to Place Leadership and Partnership Board	
4	Overaching programme board which oversees the three priority programmes	
5	Organisations under regulatory scrutiny meet monthly by ICB/ NHSE	
Sources of assurance *(Where is the evidence that the controls work?)*		**Alignment to place risk register:**
1	SF&PC minutes. Place financial performance reported to System F&P on a regular basis and key messages reported to BDC Health and Care Partnership Board.	2433, 2337, 2314, 2039, 2047
2	Strategic Partnering Agreement updated January 2025.	
3	Programme Board minutes	
4	NHSE letters of assurance following scrutiny visits.	
5	BDC system F&P committee approved financial and operating plans in April 2025. Regular monthly monitoring of financial and operating plans.	

Calderdale	**Place lead:**	**Robin Tuddenham**	**Nominated lead for this risk:**	**Neil Smurthwaite (17.07.2025)**

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (Calderdale)			**Current (Calderdale)**			As a place we are in deficit due to acute pressures. Whilst we are assessing the risk at place level a lot of this is controlled via WY working at DoF level and little influence on this via ICB place team. Its monitored and understood but difficult to influence for the BAF. Target risk score increased from 6 to 9 due to cautious risk appetite.
CAUTIOUS	**Likelihood**	**3**	**9**	**Likelihood**	**4**	**20**	
	Impact	**3**		**Impact**	**5**		

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

Kirklees	**Place lead:**	**Vicky Dutchburn**	**Nominated lead for this risk:**	**Alison Needham (02.07.2025)**

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (Kirklees)			**Current (Kirklees)**			Due to the current financial pressures there is a real risk that Kirklees Place will fail to operate within current resource envelopes. Target risk score increased from 6 to 9 due to cautious risk appetite.
CAUTIOUS	**Likelihood**	**3**	**9**	**Likelihood**	**4**	**20**	
	Impact	**3**		**Impact**	**5**		

Key controls *(What helps us mitigate the risk?)*		**Mitigating actions** *(What more are we/should we be doing at place?)*
1	Financial Strategy	1. Engage in WY-wide work to drive transformation and efficiency, including leading efficiency programmes undertaken on a WY footprint (2025/26) 2. Develop priority setting of resources within Kirklees place (2025/26) 3. We have developed a long list of difficult decisions around contracts and services that could be paused/ stopped/ slowed down across the Kirklees place. Ensuring decisions made align with West Yorkshire principles, and consider the prioritisation and disinvestment / decommissioning framework across the place (2025/26) 4. We have developed a working group across Kirklees place and neighbouring partners to review all services and spend that can improve the financial position of the Kirklees system (2025/26) 5. Review of all contracts commissioned by the ICB as to whether they can be stopped
2	Review of Financial position and plans by Kirklees Finance Sub-Committee and ICB Committee, both locally and at a West Yorkshire level.	
3	Kirklees & Calderdale Recovery group	
4	Collaborative meetings to discuss how services can be undertaken differently to maximise resources	
5	Utilisation of the cross- partner Finance Forum to strengthen ownership of place based solutions.	
Sources of assurance *(Where is the evidence that the controls work?)*		
1	Financial plan will be signed off by the ICB Committee and risks identified	
2	PMO function to support financial recovery for the ICB and its wider system	

3 Aligned to West Yorkshire ICB approach to planning and final plan signed off by WY Committees	or reduced (2025/26) 6. We have developed a PMO process to develop recurrent efficiency schemes to improve the financial sustainability within the current year and future (2025/26) **Link to place risk register:** 2533

Leeds	**Place lead:**	**Tim Ryley**	**Nominated lead for this risk:**	**Alex Crickmar (reviewed 23.06.25)**

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (Leeds)			**Current (Leeds)**			
CAUTIOUS	**Likelihood**	**3**	**9**	**Likelihood**	**4**	**20**	Due to the current financial pressures there is a significant risk that Leeds Place will fail to operate within current resource envelopes. Target risk score increased from 6 to 9 due to cautious risk appetite.
	Impact	**3**		**Impact**	**5**		

Key controls *(What helps us mitigate the risk?)*		**Mitigating actions** *(What more are we/should we be doing at place?)*
1	Leeds Finance, Investment and Best Value Committee oversees Leeds System Financial and Commissioning positions.	(1) Development of a number of key transformation business cases for change aimed at changing suboptimal care pathways with potential for significant savings longer term (timing: ongoing and part of planning for 25/26) (2) Review of potential opportunities and mitigating financial actions within each organisation and across Place, including delaying/stopping spend, focus on efficiencies and productivity (3) Integrated Commissioning Executive share plans between LCC and NHS and present jointly to Adults and Health Scrutiny (ongoing).
2	Strategic Finance Executive Group	
3	Financial Framework and controls within each organisation at Place	
4	Robust Budget setting and financial planning	
5	Leeds Health and Care Partnership Committee oversight of City wide statutory duties on behalf of the WY ICB.	
Sources of assurance *(Where is the evidence that the controls work?)*		
1	Agendas, reports and minutes of all meetings above	
2	External Review of system finances (PwC report)	
3	Internal and External Audit	
4	Fortnightly meetings between DoFs to review position	
5	Budgets/Financial plans set	
6	PMO functions within each org	**Links to Place Risk Register**
		2530

Wakefield	**Place lead:**	**Mel Brown**	**Nominated lead for this risk:**	**Jenny Davies (26.06.25)**

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (Wakefield)			**Current (Wakefield)**			
CAUTIOUS	**Likelihood**	**3**	**9**	**Likelihood**	**4**	**20**	Due to the current financial pressures there is a real risk that Wakefield Place will fail to operate within current resource envelopes. Target risk score increased from 6 to 9 due to cautious risk appetite.
	Impact	**3**		**Impact**	**5**		

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

WYICB - Board Assurance Framework - ICB and places		Version: 11	Date: 10 March 2025
Mission 3	Failure to manage the strategic risk could result in a failure to **USE OUR COLLECTIVE RESOURCES WISELY**	**Lead director(s) / board lead**	Rob Webster
Strategic risk 3.3	There is a risk that ICB capacity and infrastructure is not sufficient nor targeted effectively towards key priorities.	**Lead committee / board**	ICB Board

ICB risk appetite	ICB risk scores						Rationale for current ICB score
	Target (ICB)			Current (ICB)			
OPEN	Likelihood	3	9	Likelihood	3	12	We have developed the new operating model which clarifies roles and responsibilities and ensures capacity in the right areas. Ongoing demands following new Government ambitions coupled with reductions in staffing means difficult choices continue to be made.There is recognition of additional uncertainty through NHSE reduction in staff and the ICB organisational change programme which may impact on the ICB's ability to deliver.
	Impact	3		Impact	4		

Key controls *(What helps us mitigate the risk?)*	**Mitigating actions** *(What more are we/should we be doing at ICB level?)*
1 An agreed operating model, approved through the Board and set out in the constitution and handbook	1. Place Partnership Delivery (led by Anthony Kealy) to support the development of Place model and infrastructure will be implemented by September 2025. 2. Ongoing organisational development work across Executives to support level of agility required in current context.
2 Agreed objectives for all directors, including places, cascaded throughout the ICB	
3 Business planning processes that align capacity to our plans	
4 Place partnership review concluded in March 2025.	
5 MAUs with provider collaboratives specifying their responsibilities for delivery	
Sources of assurance *(Where is the evidence that the controls work?)*	**Links to ICB risk register** *(Reference numbers/brief description)*
1 Annual business plan approved by the Executive and ICB Board	**2165** - insufficient IT team capacity to deliver digitial priorities
2 CEO and director appraisals, with outcome reported to Remuneration and Nominations Committee	
3 Annual review of governance and statement of internal control, reported through Audit to Board	**See the separate Positive Assurance Log**

Bradford District and Craven (BD&C)	**Place lead:**	**Therese Patten**	**Nominated lead for this risk:**	**Matt Sandford (26.06.2025)**

ICB risk appetite	Place risk scores						Rationale for current place score
	Target (BD&C)			Current (BD&C)			
OPEN	Likelihood	1	4	Likelihood	3	12	The move to a new Operating Model, where BDC significantly reduced its capacity is still embedding, along with current vacancy controls due to the financial challenges, means that, similar to other Places, Bradford place is carrying a number of vacancies. A further impact will be felt following the organisational change by Q3. Bradford is utilising partnership relationships to help boost that capacity by building on current joint roles, to identify opportunities for further targeted shared and aligned resources across our Place so they can continue to deliver against both local and national standards and priorities.
	Impact	4		Impact	4		

Key controls *(What helps us mitigate the risk?)*		**Mitigating actions** *(What more are we/should we be doing at place?)*
1	The Partnership Leadership Executive oversee the deployment of resources (including ICB capacity) in pursuit of the BDC HCP strategy agreed by the Partnership Board	1. Utilise strength of our Health and Care Partnership, building on current joint roles, to identify opportunities for further targeted shared and aligned resources across Place (February – September 2025) 2. Annual business planning process to align resources to required activity/ priorities (April/ May 2025) 3. Priority Programme and Programme Board oversight of key system transformation plans (including workforce) and related activity, to review resource requirements against transformation delivery plans (February – September 2025) 4. Place level 'difficult decisions' programme to target resources at activity that delivers strategic and financial priorities (February – Apr 2026) 5. Adoption of WY Vacancy Control measures into Place level governance to ensure grip and control, alongside overarching understanding of Place resource requirements (already in place - ongoing) 6. Developed Health, Care and Wellbeing strategy (clinical strategy) at Place in full co-production with partners including citizens and our workforce. The strategy focuses on clear alignment of services, pathways and models of care driven by population health needs. This strategy will enable us to target and deploy resources in the most effective way. Three strategy delivery boards are being established focused on integrated acute services, integrated neighbourhood services and integrated corporate services, these are our core priorities for delivery and resource management 7. Specific Integrated Neighbourhood Team (INT) development work is underway across the BDC system is ongoing (2025/26) 8. Work has begun locally on the development of a BDC provider collaborative approach to be implemented by September 2025 (2025/26). 9. Developed Healthcare and Wellbeing strategy (clinical strategy) at place in full co-production with partners such as citizens and our workforce. The strategy focuses on clear alignment of services, pathways and models of care driven by population health needs. This strategy will enable us to target and deploy resources in the most effective way. Three strategy delivery boards are being established focused on integrated acute services, integrated neighbourhood services and integrated corporate services, these are our core priorities for delivery and resource management **Link to place risk register** 2447
2	System transformation priorities and enablers established through our operating model using a distributed leadership approach	
3	Place based lead influence deployment of ICB resource for BDC HCP	
4	Closing the Gap programme – already established – with widened scope to incorporate Investment/ Business Case review	
5	Difficult Decisions programme has commenced and incorporates all partners across the system. This provides targeted focus on delivery of our efficiency programme whilst identifying risks associated with capacity.	
6	Place Clinical Strategy; and Place Financial Recovery Plan – providing greater oversight of resource	
7	3 x Strategic Delivery Group meetings (Integrated Acute Care; Integrated Neighbourhood Health & Care; Integrated Corporate Support & Closing the Gap will bring together all partners across the system to provide greater oversight on delivery of the core priorities we have set out in our health, care and wellbeing strategy.	
Sources of assurance *(Where is the evidence that the controls work?)*		
1	An agreed BDC HCP operating model approved by the PLE and the PB within the BDC HCP governance handbook	
2	Priority Programmes in place including: access; healthy communities; healthy minds; workforce and children and young people improvement. Enablers in place including: reducing inequalities alliance; digital, data, intelligence and insight; living well; and Estates. All priorities and enablers report into PLE	
3	ICB SORD sets out place role within both the WY ICB SORD (WY Governance Handbook) and BDC HCP Strategic Partnering Agreement and Governance Handbook set our the way we work, including our operating model, SORD and Terms of Reference.	
4	Closing the Gap programme – Partnership led and supported – Reviewed via System Finance and Performance Committee, PLE and Partnership Board.	

Calderdale	**Place lead:**	**Robin Tuddenham**	**Nominated lead for this risk:**	**Neil Smurthwaite (17.07.2025)**

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

Key controls *(What helps us mitigate the risk?)*	**Mitigating actions** *(What more are we/should we be doing at place?)*
1 Work undergoing with neighbouring places to ensure resilient finance function.	1. Transformation delivery plans list seven key priorities and discussions are ongoing at operational and senior leadership meetings (2025/26) 2. Senior Leadership team continue to monitor risks relating to resource, intensified given NHS changes and 50% cuts. 3. Working collaboration with KW partners on sharing resource in difficult situation of zero recruitment and future reduced resource. **Link to place risk register:** 1998, 2484
2 Partnership board regularly conducts deep dives for tranformational priorities.	
3 Prioritisation takes place on a weekly basis to assess place workload and ability to respond to asks.	
Sources of assurance *(Where is the evidence that the controls work?)*	
1 Tranformation delivery plan approved by Calderdale Care Partnership Board.	
2 Prioritisation process as part of annual planning round.	

Kirklees	**Place lead:**	**Vicky Dutchburn**	**Nominated lead for this risk:**	**Vicky Dutchburn (25.06.2025)**

ICB risk appetite	Place risk scores		Rationale for current place score
	Target (Kirklees)	Current (Kirklees)	There are specific challenges in Kirklees place related to leadership changes in several

OPEN	Likelihood	1	4	Likelihood	3	12
	Impact	4		Impact	4	

parts of the health and care partnership and the transition period could lead to uncertainty. Time will have to dedicated to establish new working relationships when leadership changes take effect. The impact of the operating model changes are still being felt and challenges remain in some functions.

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

1. Weekly SLT meetings to discuss current priorities and ensure capacity is dedicated to the right areas
2. Health & Care Executive to support cross sector prioritisation within the Health & Care Partnership
3. Business planning processes to support confirmation of priorities

Sources of assurance *(Where is the evidence that the controls work?)*

1. Clear examples of where capacity is being used to best effect by sharing teams with other places, in particular Calderdale (where there is a history of shared teams) and increasingly with Wakefield. Examples of capacity from across the partnership (not just the ICB) supporting our work e.g. Place Director of Finance role. Other examples of programme leadership from beyond the ICB team in place.
2. Staff survey results relating to the ability of individuals to undertake their role within their designated hours, clarity of objective setting and additional hours worked.The action plan agreed to respond to findings of staff survey.
3. Agreement from the Kirklees ICB Committee as to our shared priorities, supported by teams within partner organisations dedicating capacity to these priorities (e.g. Discharge, community services transformation)

Mitigating actions *(What more are we/should we be doing at place?)*

1. Organisational change review ongoing will include a Kirklees integrator function to be consulted on (Q3, 2025/26)
2. Ongoing development prioritisation and review within and across Teams in Kirklees (2025/26)
3. Specific Integrated Neighbourhood Team (INT) development work across Kirklees system (2025/26)
4. Ongoing local development of the Kirklees provider collaborative approach by September 2025.

Link to place risk register:
None

Leeds **Place lead:** Tim Ryley — **Nominated lead for this risk:** Sabrina Armstrong (30.06.2025)

ICB risk appetite	Place risk scores	Target (Leeds)		Current (Leeds)		
OPEN	Likelihood	1	4	Likelihood	4	16
	Impact	4		Impact	4	

Rationale for current place score

The move to a new Operating Model in April 2024, where Leeds reduced its capacity by 20% was still bedding in when the national announcement was made for reduction in ICB staff by 50%. Leeds was holding a number of vacancies whilst it settled and due to vacancy control they can no longer be filled. The latest organisational change programme is likely to exacerbate this issue. Failure to address these issues is likely and this could lead to a failure to meet national standards, broadening of inequalities, financial distress and regulatory breaches in line with the definitions. Risk score remains the same.

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

1. Agreed Operating Model with WY ICB and Leeds Health & Care Partnership
2. Capacity aligned to Healthy Leeds Plan and LHCP objectives
3. Director accountabilities finalised and objectives set by end of April

Sources of assurance *(Where is the evidence that the controls work?)*

1. Healthy Leeds Plan and Business Plan reviewed monthly in line with LHCP priority work
2. Ongoing appraisal throughout year with all directors in place
3. Staff Survey results

Mitigating actions *(What more are we/should we be doing at place?)*

1. The ICB in Leeds has agreed a number of city priorities with partners in the Leeds Health and Care Partnership (LHCP). The ICB in Leeds needs to ensure that the majority of its capacity is working on these priority areas. Apr - Mar 2026
2. Refreshed OD priorities in place to support staff within the ICB in Leeds to deliver the capabilities needed to deliver the above priorities. However the OD plan has been extended to provide support and resilience training to staff during the organisational change (2025/26)
3. ICB in Leeds Business Plan for 25/26 in place, outlining the BU actions to deliver the LHCP priority programmes and work has been prioritised to take account of diminishing capacity due to both people leaving and people working on the organisational change
4. Action plan on staff survey results most pertinent to Leeds, 2025/26
5. Leeds Directors will continue to review capacity and reprioritise as necessary (2025/26)

Link to place risk register:
None

Wakefield **Place lead:** Mel Brown — **Nominated lead for this risk:** Mel Brown 27.06.2025

ICB risk appetite	Place risk scores	Target (Wakefield)		Current (Wakefield)		
OPEN	Likelihood	1	4	Likelihood	3	12
	Impact	4		Impact	4	

Rationale for current place score

The current likelihood is possible, given the movement to a new operating model for the NHS and the Integrated Care Board. Failure to control this risk will lead to major impact on a number of financial, quality, operational and people fronts. We would see a failure to meet national standards, broadening of inequalities, financial distress and regulatory breaches in line with the definitions. Wakefield place are working with other places and the strategic commissioning functions between June and September 2025 to mobilise a new operating model to go live in April 2026.

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

1. Agreed operating model in place aligned to Integrated Care Board structures and went live in April 2024, some reviews have been underway due to leadership changes
2. Agreed objectives for all directors
3. Wakefield place plan agreement in May 2025, signed off objectives and plans for Wakefield district
4. Business planning processes that aligns both to the WY ICB 10 ambitions and the Wakefield district plan (annual review)
5. Developed a new business planning process that aligns with our Integrated Care System strategy and place delivery plan in line with national guidance
6. Some Directors have previously undertaken leadership roles with partner organisations, these directors are now working full time for the ICB, such as Director of Nursing and Director of Strategy.

Sources of assurance *(Where is the evidence that the controls work?)*

1. Delivery plan approved including Outcomes Framework.
2. The Mutual Accountability meetings chaired by Rob Webster, quarterly meetings, these provide assurance of the progress against the functions in Wakefield place.
3. Director appraisals conducted and regular one to ones are mobilised across the Wakefield district, this ensures flexibility in responding to new work that emerges from WY ICB.
4. Contribute to the annual governance review.
5. Regular one to ones between Accountable officer and Cheif Executive WY ICB

Mitigating actions *(What more are we/should we be doing at place?)*

1. Continue to review gaps in strategic capacity across the leadership team at Wakefield and confirm these objectives through PDR processes in the summer of 2025
2. Working with partner organisations across Wakefield district to maximise capacity to and to deliver objectives in 2025/26
3. Reviewing everyones PDR objectives to ensure any areas that need capacity are appropriately addressed such as EDI leadership (End of Summer 2025)
4. Contributing to the organisational change programme in place across WY ICB to shape the integrator teams

Links to Place Risk Register

None.

WYICB - Board Assurance Framework - ICB and places							Version: 11	22 April 2025
Mission 4	Failure to manage the strategic risk could result in a failure to **SECURE BENEFITS OF INVESTING IN HEALTH AND CARE**						**Lead director(s) / board lead**	Ian Holmes
Strategic risk 4.1	There is a risk that partnership working on wider societal issues is deprioritised to meet current operational pressures.						**Lead committee / board**	ICB Board
ICB risk appetite	**ICB risk scores**						**Rationale for current ICB score**	
	Target (ICB)			**Current (ICB)**			Wider societal issues contribute significantly to health, wellbeing and inequalities. Working with partners to address these is a key part of our health and care strategy. We have dedicated capacity supporting this work which we will protect through the business planning process. The key is ensuring sufficient leadership focus.	
OPEN	**Likelihood**	**2**	**8**	**Likelihood**	**2**	**8**		
	Impact	**4**		**Impact**	**4**			

	Key controls *(What helps us mitigate the risk?)*	**Mitigating actions** *(What more are we/should we be doing at ICB level?)*
1	ICS strategy and 10 big ambitions will be used to create priority and focus on these issues. These will be tracked annually via an outcomes framework and associated integrated dashboard.	1. Economic Inactivity Accelerator work to be delivered throughout 2025/26 ensuring dedicated capacity and the establishment of a programme board with WY Combined Authority to oversee it.
2	We have established dedicated capacity working on these issues at WY level, together with appropriate programme boards, working with the Combined Authority - focusing on issues such as poverty, climate change, violence reduction, housing and employment	
3	Business planning process describes how we use our capacity to support delivery of all ambitions.	
4	Memorandum of Understanding with WY Combined Authority which describes shared priorities, capacity and ways of working.	
5	Consultant in Population Health appointment ensures focus on wider societal issues.	
5	Director objectives, subsequently cascaded to teams, reflect partnership working.	

	Sources of assurance *(Where is the evidence that the controls work?)*	**Links to ICB risk register** *(Reference numbers/brief description)*
1	Progress against the strategy and 10 big ambitions is overseen by the Partnership Board, together with deep dives - evidenced in agenda and minutes	None identified
2	ICB Board receives six monthly updates on 10 big ambitions - agenda / minutes	
3	SOAG - minutes evidence review of progress against 10 big ambitions	**See the separate Positive Assurance Log**

Bradford District and Craven (BD&C)	**Place lead:**	**Therese Patten**	**Nominated lead for this risk:**	**Helen Farmer, 23.06.2025**

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (BD&C)			**Current (BD&C)**			Challenging financial circumstances for all partner organisations may increase likelihood of retrenchment into siloed, short term approaches, emphasising direct operational delivery over longer term outcome focused system thinking, which evidence shows will have a bigger impact on the determinants of health and wellbeing outcomes.
OPEN	**Likelihood**	**2**	**8**	**Likelihood**	**2**	**8**	
	Impact	**4**		**Impact**	**4**		

	Key controls *(What helps us mitigate the risk?)*	**Mitigating actions** *(What more are we/should we be doing at place?)*
1	Our BDC health and care strategy localises the WY strategy and clearly establishes the focus on the wider contribution of the health and care system to the determinants of health, and encourages stewardship for the future as well as short term delivery focus.	1. All district partners (including those outside health and care) will sign up to a new district strategy to improve the wellbeing, both health and economically in Bradford district (2025 - 2028) 2. Our reducing inequalities alliance continues to lead the way in identifying our wider determinants and mitigating the impact, including leading on our economic accelerator programme 3.,The BD&C HC&P has now finalised the healthcare and wellbeing strategy and we are moving to implementation through our new governance arrangements. This jointly agrees the safe and sustainable service models and pathways across all partners, driven by the health and care needs of our population, ensuring a holistic approach to delivery (2025/26)
2	The Wellbeing Board (HWB for Bradford District) is comprised of the leaders of all local strategic partnerships and all local anchor organisations. Its focus is firmly on the 'wider determinants'. The BDC Partnership Board and its Committees have broad based participation across VCSE, Local Government and Care sectors. Our approach is to engage with communities through locality based **Listen In** visits and to take our Partnership Board meetings into communities, to understand the strengths and challenges of communities and what will help - which includes focus on the 'wider determinants' - e.g. development session on sustainability, Partnership Board papers on anti poverty actions etc.	
3	Our closing the gap business case appraisal process takes into account impact on wider health and care and public sector and population including health inequalities, social value etc (ongoing)	**Link to place risk register:** 2317, 2386, 2221
4	People priority include focus on inclusive community recruitment.	
5	Our partnership work is focused on five Strategic Priorities and four key Enablers. This includes a prevention focus through Living Well, Reducing Inequalities, an asset based approach to Healthy Communities, and a focus on net zero and local economic development through our partnership Estates work.	

	Sources of assurance *(Where is the evidence that the controls work?)*
1	See strategy and closing the gap process on partnership website https://bdcpartnership.co.uk/
2	Wellbeing Board (Bradford district) on the BMDC wellbeing web page https://bdp.bradford.gov.uk/about-us/health-and-wellbeing-board/ See partnership governance structure, TORs, meeting papers including Listen In reports - on website
3	See priorities and enablers scoping documents on partnership website https://bdcpartnership.co.uk/our-strategic-priorities-re-set-programme/

Calderdale	**Place lead:**	**Robin Tuddenham**	**Nominated lead for this risk:**	**Neil Smurthwaite (17.07.2025)**

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (Calderdale)			**Current (Calderdale)**			Wider societal issues contribute significantly to health, wellbeing and inequalities. Working with partners to address these is a key part of our health and care strategy. Risk score reduced from 12 to 8.
OPEN	**Likelihood**	**2**	**8**	**Likelihood**	**2**	**8**	
	Impact	**4**		**Impact**	**4**		

	Key controls *(What helps us mitigate the risk?)*	**Mitigating actions** *(What more are we/should we be doing at place?)*
1	Joint membership of HWBB and CCPB by each chair to ensure societal issues continue across.	1. The Transformation delivery plans list seven key priorities, these aim to address wider societal challenges in Calderdale, there is ongoing work at senior leadership level to ensure governance arrangements align with the transformational priorities (2025/26)
2	ICS strategy and 10 big ambitions will be used to create priority and focus on these issues. These will be tracked annually. We also have Health and Wellbeing Strategy, monitored via HWBB.	
3	Business planning process will describe how we use our capacity to support delivery of all ambitions.	**Link to place risk register:** None
4	The senior leadership group terms of reference refers to operational delivery as a "must do" so that our transformational plans are able to flourish	

	Sources of assurance *(Where is the evidence that the controls work?)*
1	Progress against health and wellbeing priorities is undertaken at every meeting. Evidenced by papers and minutes.
2	We also have an inclusive economy strategy led by the local authority.
3	

Kirklees	**Place lead:**	**Vicky Dutchburn**	**Nominated lead for this risk:**	**Steve Brennan (25.06.2025)**

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (Kirklees)			**Current (Kirklees)**			As Kirklees place we have signed up to 4 top tier strategies that cover areas of joint working beyond just health and care, including the wider societal issues. These are: 1. Health and Wellbeing Strategy 2. Inclusive Communities Framework 3, Inclusive Economy Strategy 4. Environment Strategy. However, whilst we have agreed this strategic approach, there are still challenges of delivery to be navigated. Operational pressures are significant, alongside significant financial challenges across the partnership. This means that our ability to deliver on these in the short term is challenged. Due to capacity constraints realising the full benefits of the Economic Inactivity Accelerator and related programmes will be challenging, but progress is being made. Uncertainty around ongoing ICB organisational change and what this will mean for local partnership working in Kirklees and the ICBs ongoing role in this as we potentially move to a CKW footprint. Risk score to remain the same.
OPEN	**Likelihood**	**2**	**8**	**Likelihood**	**3**	**12**	
	Impact	**4**		**Impact**	**4**		

Key controls *(What helps us mitigate the risk?)*	
1	4 top tier strategies for Kirklees that go beyond just health and care and cover wider societal issues.
2	Ownership of these 4 strategies assigned to partnership boards or forums.
3	Partnership Executive in place which includes business, education in addition to health, care and LA.

Sources of assurance *(Where is the evidence that the controls work?)*	
1	Reporting to the relevant board/partnership forum on progress against each of the 4 strategies.
2	Use of other partnership forums to support this e.g. Partnership Forum, ICB committee.

Mitigating actions *(What more are we/should we be doing at place?)*

1. Commitment to the 4 top tier strategies reiterated at the Kirklees partnership executive. There is a programme of work agreed for 2025/26 overseeing by the partnership executive.

Link to place risk register:

None

Leeds — **Place lead:** Tim Ryley — **Nominated lead for this risk:** Tim Ryley (26.06.2025)

ICB risk appetite	Place risk scores	Target (Leeds)		Current (Leeds)		
OPEN	Likelihood	2	8	Likelihood	3	12
	Impact	4		Impact	4	

Rationale for current place score

Wider societal issues contribute significantly to health, wellbeing and inequalities. Working with partners to address these is a key part of our health and care strategy. We have dedicated capacity supporting this work which we will protect through the business planning process. The key is ensuring sufficient leadership focus.

Key controls *(What helps us mitigate the risk?)*	
1	Health & Wellbeing Board Strategy
2	Active participation and alignment to Marmot City agenda
3	Shared goals across Leeds Health & Care Partnership reflecting 10 big ambitions and requiring addressing
4	Continuing monitoring of metrics by ethnicity and deprivation as routine

Sources of assurance *(Where is the evidence that the controls work?)*	
1	Progress against 10 big ambitions in Leeds
2	Reporting on key Healthy Leeds Plan metrics by deprivation
3	Health & Wellbeing Board monitoring of HWB strategy
4	Director of public health annual reports

Mitigating actions *(What more are we/should we be doing at place?)*

1. Creation of a joint neighbourhood model between NHS and Local Authority (2025/26)
2. Monitor and report on anchor institution work to test impact for the city (ongoing piece of work)
3. Continue to drive digital and medical technology innovation through the Integrated digital service, Leeds Academic Health Partnership and the Leeds Health & Care Hub.
4. Implement action plan arising from Marmot city programme led through public health (2025 - 2027)
5. Leeds Health and Care Partnership have signed off four priority programmes all with a strong health inequality focus including links to wider social determinants (2025/26)

Link to Place Risk Register

None

Wakefield — **Place lead:** Mel Brown — **Nominated lead for this risk:** Ruth Unwin, Becky Barwick (02.07.2025)

ICB risk appetite	Place risk scores	Target (Wakefield)		Current (Wakefield)		
OPEN	Likelihood	2	8	Likelihood	2	8
	Impact	4		Impact	4	

Rationale for current place score

Impact score is high as there is strong evidence that failure to address social determinants leads to poor population health and increased demand on care services. Risk score remains the same this cycle.

Key controls *(What helps us mitigate the risk?)*	
1	Wakefield District Health and Wellbeing strategy provides a framework for tackling wider determinants of health
2	Wakefield Forward Plan includes work to deliver Health and Wellbeing Board priorities
3	Core20plus5 funding directed to addressing social determinants, to be confirmed via the investment panel for 2025/26.

Sources of assurance *(Where is the evidence that the controls work?)*	
1	Regular reports to Health and Wellbeing Board & Wakefield District Health and Care Partnership Committee on work to address priorities
2	Outcomes framework has been developed for both the Health and Wellbeing Board and Wakefield District Health and Care Partnership Committee and being reported through both committees
3	Impact of investment in Core20plus5 programmes was reported to Wakefield District Health and Care Partnership Committee November 2023

Mitigating actions *(What more are we/should we be doing at place?)*

1. A district plan is being developed under the joint leadership Wakefield Together (statutory, voluntary and commercial sectors), which includes plans to improve population health by addressing wider determinants. Plan will be in place by Autumn 2025.
2. The bid to the local vestment panel supported protection for the previous Core 20 plus 5 funding but not protecting all of the uncommitted resource.

Link to Place Risk Register

None.

WYICB - Board Assurance Framework - ICB and places							Version: 11	22 April 2025
Mission 4	Failure to manage the strategic risk could result in a failure to **SECURE BENEFITS OF INVESTING IN HEALTH AND CARE**						**Lead director(s) / board lead**	Ian Holmes
Strategic risk 4.2	There is a risk that we are unable to achieve our ambitions on equality diversity and inclusion due to ingrained attitudes that persist in society and across our health and care organisations.						**Lead committee / board**	Quality Committee
ICB risk appetite	**ICB risk scores**						**Rationale for current ICB score**	
	Target (ICB)			**Current (ICB)**			Our health and care partnership has done significant work on the race equality agenda, but we know that systemic problems still exist in all organisations in our system. We will continue to work with focus and energy on this agenda and broaden our focus to include other protected characteristics.	
BOLD	**Likelihood**	**2**	**8**	**Likelihood**	**3**	**12**		
	Impact	**4**		**Impact**	**4**			

	Key controls *(What helps us mitigate the risk?)*	**Mitigating actions** *(What more are we/should we be doing at ICB level?)*
1	Five Year Integrated Care Strategy - Ambition 8	(1) Equity and Fairness Strategy was approved Partnership Board in January 2025. This will be overseen by the Partnership Board including a number of objectives for delivery by the Partnership Board. Transformation Committee will oversee ICB actions in relation to the strategy. (2) The Race Equality Review undertaken in 2020 will be reviewed by Donna Kinnair during 2025/26. The findings reported to the Partnership Board in January 2025 and actions identified were included in the Equity and Fairness Strategy.
2	Race Equality Review Action Plan overseen by the Partnership Board	
3	EDI Oversight Group maintains oversight of statutory requirements and objectives	
4	ICB People Plan, with a strong focus on inclusivity	
5	EQIA process embedded to inform decision-making	

	Sources of assurance *(Where is the evidence that the controls work?)*	**Links to ICB risk register** *(Reference numbers/brief description)*
1	Internal Audit Review 2023/24	None identified
2	People Plan had ICB Board sign off in September 2024	
3	Staff survey data	
4	WRES data	
5	EMT discussion and oversight of priorities and responses to audit actions	
6	Agenda and minutes of EDI Oversight Group	
7	Examples of reports and minutes showing consideration of EQIAs during decision-making	**See the separate Positive Assurance Log**
8	Transformation Committee discussion and oversight of strategy action plan.	

Bradford District and Craven (BD&C)	**Place lead:**	**Therese Patten**	**Nominated lead for this risk:**	**Kez Hayat (30.06.2025)**

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

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

	Sources of assurance *(Where is the evidence that the controls work?)*
1	Minutes of the systems EDI group
2	BDC People Board
3	Assurance provided via Executive Leadership Executive, minutes.
4	BDC Extended Leadership Team meeting, minutes.
5	NHSE website for WRES and WDES data. WYICB PSED report on website

Calderdale	**Place lead:**	**Robin Tuddenham**	**Nominated lead for this risk:**	**Neil Smurthwaite (17.07.2025)**

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

	Key controls *(What helps us mitigate the risk?)*	**Mitigating actions** *(What more are we/should we be doing at place?)*
1	Race equality standard compliance is monitored at place level.	1. Suporting the EDI strategy in West Yorkshire (2025/26) **Link to place risk register:** None

	Sources of assurance *(Where is the evidence that the controls work?)*
1	Outcomes of staff survey is discussed at Calderdale senior leadership team meetings

Kirklees	**Place lead:**	**Vicky Dutchburn**	**Nominated lead for this risk:**	**Steve Brennan (25.06.2025)**

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

	Key controls *(What helps us mitigate the risk?)*	**Mitigating actions** *(What more are we/should we be doing at place?)*
1	Inclusive Communities Framework adopted by Place Committee	1. EDI Strategy is being developed for approval at ICB Board in January 2025 (assurance). This will be overseen by the Partnership Board including a number of objectives which have been developed for delivery by the WY Partnership Board. The Kirklees objectives of the EDI strategy have been developed and agreed and work is progressing (2025/26) **Link to place risk register:** None
2	EQIAs embedded as part of PMO functions	
3	Community champions / Community voices	

	Sources of assurance *(Where is the evidence that the controls work?)*
1	ICB (Kirklees) self-assessment against the ICF during 2025/26 (last completed 2023)
2	Examples of EQIAs and subsquent action / mitgation
3	Examples of voice and influence from diverse population in planning and transformation

Leeds	**Place lead:**	**Tim Ryley**	**Nominated lead for this risk:**	**Nick Earl 27.06.2025** **Cycle 3 review will be undertaken by Sharon Moore**

ICB risk appetite	**Place risk scores**		**Rationale for current place score**
	Target (Leeds)	**Current (Leeds)**	ICB in Leeds works proactively in relation to EDI in respect of our workforce,

BOLD	Likelihood	2	6	Likelihood	3	9	organisational development and commissioning responsibilities. The controls currently in place should limit any breaches in statutory duty. Although the risk appetite is set at BOLD, the target risk score was reviewed and the impact increased from 2 to 3, even though we can influence the likelihood, the impact will remain moderate, target risk is therefore 6 rather than 4. .
	Impact	3		Impact	3		

Key controls *(What helps us mitigate the risk?)*		**Mitigating actions** *(What more are we/should we be doing at place?)*
1	Compliance with the requirements of the Equality Act 2010 Public Sector Duties in relation to our workforce and commissioning responsibilities.	1. Suporting the EDI strategy in West Yorkshire (2025/26) and leading on the development of Leeds EDI priorities 2. Increased focus on personal wellbeing within objective setting which will include EDI components (2025/26) 3. On going improvement and development in relation to the integration of Equality Impact Assessments within the business process cycle and all decision making processes
2	NHS Equality Delivery System 2 (EDS) and transition to EDS 2022; Workforce Race Equality Standard (WRES); Workforce Disability Equality Standard (WDES); Gender Pay Gap (GPG) report and subsequent action plans.	
3	Integration of our Equality Impact Assessment and Quality and Equality Impact Assessment within all decision making processes	
4	Ongoing interaction/partnership working in relation to our insights, communication and involvement team and equality, diversity, and inclusion.	
Sources of assurance *(Where is the evidence that the controls work?)*		**Link to place risk register:**
1	Development of ICB in Leeds equality, diversity, and inclusion (EDI) priorities; annual contribution to WYICB Public Sector Equality Duty Report; equality impact assessments completed for commissioning programmes/projects and in relation to decisions.	None.
2	Ongoing partnership working across Leeds Health and Care partnership and the wider WYICB partnership in relation to the EDS transition and development of key priorities. WYICB WRES; WDES; GPG actions plans.	
3	Continuation of ICB in Leeds REN; continued implementation of the REN recruitment and selection procedure/ guidelines.	

Wakefield	**Place lead:**	**Mel Brown**	**Nominated lead for this risk:**	**Ruth Unwin, Dasa Farmer (07.07.25)**

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

Key controls *(What helps us mitigate the risk?)*		**Mitigating actions** *(What more are we/should we be doing at place?)*
1	Equality, Diversity and Inclusion network established for place	1. A proactive approach to monitoring population health and uptake of services by groups with protected characteristics. Linked data model implementation for children and young people and other cohorts continuing (2025/26) 2. Supporting delivery of WY wide equality and fairness strategy through localised objectives. The delivery will be monitored via the People Panel. 3. Workforce alliance has a dedicated pillar of work in addressing equality, diversity and inclusion in all aspects of workforce, recruitment, development and training (2025/26)
2	Local equality objectives in place	
3	Work programme to ensure compliance with Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), Public Sector Equality Duty (PSED)	
4	Local, multi-agency health inequalities alliance developed.	
5	The workforce alliance has a specific workstream for belonging to ensure equality of opportunity in recruitment and career progression	
6	Communication, Involvement and EDI at place	
Sources of assurance *(Where is the evidence that the controls work?)*		**Link to place risk register:**
1	People panel (partnership committee) receives and scrutinises delivery of equality agenda	None.
2	Formal reports - WRES,DES, PSED, Equality Delivery System to People Panel	
3	Equality and fairness strategy has been presented to the People Panel, to place management team and Healthcare Inequalities Steering Group	

WYICB - Board Assurance Framework - ICB (no requirement for places to complete)							Version: 11	Date: 3 April 2025
Mission 4	Failure to manage the strategic risk could result in a failure to **SECURE BENEFITS OF INVESTING IN HEALTH AND CARE**						**Lead director(s) / board lead**	Shaukat Ali Khan/ Lou Auger
Strategic risk 4.3	There is a risk that threats to our people and physical and digital infrastructure, e.g. from cyber-attacks, terrorism and other major incidents, prevents us from delivering our key functions and responsibilities.						**Lead committee / board**	ICB Board/Transformation Committee
ICB risk appetite	**ICB risk scores**						**Rationale for current ICB score**	
	Target (ICB)			**Current (ICB)**			This risk relates to the ability of the ICB to work with partners to mitigate the impact of a significant incident on the delivery of healthcare services. Our current score has been assessed against the operation of the controls during recent EPRR events and incidents . We have evidenced significant system ability to respond to an emergency, however there are limited controls the ICB can put in place for the largest scale event such as a future pandemic.	
AVERSE	**Likelihood**	**3**	**9**	**Likelihood**	**3**	**12**		
	Impact	**3**		**Impact**	**4**			

	Key controls *(What helps us mitigate the risk?)*	**Mitigating actions** *(What more are we/should we be doing at ICB level?)*
1	Engagement with all partners and direct alignment to WY Resilience Forum	1. Directorates and Places to complete Business Impact Assessments by June 2025 to support further development of business continuity plans. 2. Scheduled cyber security summit in June 2025 - a workshop to build awareness on cyber security. The second half of the day will feature a role play exercise to stress test our approach to real life scenarios. (2025) 3. Data Security Protection Toolkit is in progress and audit has commenced in April 2025. There remains substantial work to be done to complete the evidence and associated statements (2025/26) 4. Cyber Security Discovery exercise: we have undertaken a cyber security discovery to identify risks and mitigation to improve cyber security resilience. An action plan will be developed to begin implementation by June 2025.
2	Training at senior level - Principles of Health Command Training - Strategic Health Commander	
3	WY CIO Forum inc Place CIOs	
4	System Winter Plan with mitigating actions for surge and escalation inc Strategic Coordination Centre	
5	EPRR Compliance and Action Plans for each NHS organisation	
6	WY ICB has established arrangements for 1st and 2nd on-call.	
7	Business continuity plans are in place in the event of a prolonged IT system issue.	
8	WY ICB attends or facilitates a range of WY EPRR exercises during the course of each financial year.	
9	EPRR Team have completed testing and exercising of business continuity plans in March 2025	

	Sources of assurance *(Where is the evidence that the controls work?)*	**Links to ICB risk register** *(Reference numbers/brief description)*
1	Reporting of EPRR Compliance to Board	**2194** - industrial action **2036 -** Airedale Hospital structural RAAC **2166** - Risk of a successful cyber attack, hack and data breach on ICB. **2234** - Risk of cyber attack on commissioned services **2295** - Business continuity arrangements
2	Minutes of Audit Committee and Internal Audit Meetings	
3	WY EPRR exercises - outputs, from papers and Mins.	
4	Significant learning from incidents	
5	Regular reporting on progress with DSPT annual self-assessment to WY ICB Audit Committee and internal audit assurance of DSPT submission	
6	There is a newly established directorate called Digital, Data and Technology (DDaT) - output from papers.	**Positive Assurance -** see separate log

WYICB - Board Assurance Framework - ICB (no requirement for places to complete)							Version: 11	22 April 2025
Mission 4	Failure to manage the strategic risk could result in a failure to **SECURE BENEFITS OF INVESTING IN HEALTH AND CARE**						**Lead director(s) / board lead**	Ian Holmes
Strategic risk 4.4	Due to climate change, there is a risk of increased demand for health and care services and disruption to the provision of services. This will result in health and care services that cannot effectively meet population needs.						**Lead committee / board**	Transformation Committee
ICB risk appetite	**ICB risk scores**						**Rationale for current ICB score**	
	Target (ICB)			**Current (ICB)**			Climate change is already affecting us in West Yorkshire. International, national, regional and local strategies and actions are insufficient at present to avert the worst effects. In West Yorkshire, we are most likely to be directly affected by flooding, heatwaves, wind and wildfire, but specialist (medical) and general (food, office supplies) supply chains will be disrupted. There is a real risk of disruption to power, internet and gas grids at a regional level. We need to reduce our environmental impact (mitigation) and change what we do to make us ready for the new normal (adaptation).	
OPEN	**Likelihood**	**4**	**12**	**Likelihood**	**4**	**16**		
	Impact	**3**		**Impact**	**4**			

Key controls *(What helps us mitigate the risk?)*		**Mitigating actions** *(What more are we/should we be doing at ICB level?)*
1	Climate Change strategy approved by Partnership Board December 2023	No specific actions at this point, however consideration is being given to developing actions focused on adaptation.
2	Regular meetings and data submission to national Greener NHS team	
3	Transformation Committee will take oversight of ICB organisational response.	
4	Board Level Net Zero Leads network and the Operational Leads Network.	
5	Regional Greener NHS steering group.	
Sources of assurance *(Where is the evidence that the controls work?)*		**Links to ICB risk register** *(Reference numbers/brief description)*
1	Minutes of Partnership Board focus on Big Ambition number 9 (climate change)	None identified.
2	Dashboard received by ICB Board on 10 big ambitions	
3	Quarterly data submission to the National Greener NHS team	
4	Minutes of the Transformation Committee	**Positive Assurance** - see separate log

Leeds Health & Care Partnership

NHS West Yorkshire Integrated Care Board

Appendix 4

Leeds Health and Care Partners - Top Risks – July 2025						
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 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.	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 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	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 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.

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

				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.		
Leeds Community Healthcare Trust	⇔	**Waiting Times in Excess of 52 Weeks** There is a risk to a number of services with waiting times of over 52 weeks due to demand for services surpassing the capacity resulting in unmet need of patients and long waiting lists which will cause impact to patient outcomes.	⇔	**Imbalance of Capacity and Demand** Increasing demand for services (specific risks on the risk register relate to Neighbourhood Teams, CAMHS, Speech and Language Therapy, ICAN) coupled/reflected with increased complexity of the services required, resulting in reduced quality of patient care, delay in treatment, deterioration in health and wellbeing of patients, and additional pressure on staff, exacerbated by vacancies to some hard to recruit to roles.	⇔	**Financial Position 2025/26** Risk of not being able to deliver a balanced revenue financial plan for 2025/26 given underlying deficit and range of cost pressures. This is exacerbated by the reported planning positions of partner NHS organisations in Leeds, Leeds City Council and across the West Yorkshire Integrated Care System. There is expected to be little or no real terms growth in 2025/26, and a significant national efficiency ask to which will be added a requirement for LCH to address its own underlying deficit and play a major part in a Leeds place response to the Leeds financial planning gap. Whilst work across Leeds and the ICS has commenced to identify savings from transformation, improved system working and

						efficiencies, difficult decisions to be made about services the Trust is able to offer patients may be required and is being managed through the Quality and Value Programme. It is likely that require service changes will impact on stakeholders.
Leeds and York Partnership Foundation Trust	⇔	**System flow and Out of Area Placements** There is a risk to the quality of care of our service users as a result of ineffective patient flow within the system with an increasing use of Out of Area Placements, compounded by a lack of recurrent funding and a resulting financial cost to the system.	⇔	**Financial Position** There is a risk that the Trust does not meet its planned efficiency targets in 24/25 which could impact on delivering the overall financial plan. Non recurrent mitigations are not sustainable and there is a likely impact on quality of care over time. This is due to the underlying deficit and service pressures which compound the in-year position.	⇔	**Investment in Mental Health and Learning Disability Services** There is insufficient capacity to meet the level of demand of mental health needs within Leeds; this is manifested through the availability of core 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	⇔	**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	⇔	**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

		infrastructure with limited ability to deliver purpose.		there is a risk that mitigations will not work and we will return to a risk of deficit.		tenders.
Forum Central - Voluntary, Community and Social Enterprise	⇔	**Strategic:** Reduced capacity to provide a strategic voice for health & care third sector and manage rep & eng across the ICB/LHCP systems, compounded by changing structures and roles means increased 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	⇔	**Financial:** Where reduction in VCSE service capacity means these service users have no alternative but to present directly to NHS services such as A&E or crisis centres (increasing service demand) or are unable to return home after a stay in hospital (reducing service efficiency). VCSE is effectively being stopped from supporting HLP priority goals. If resources could be shifted it would relieve 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	⇔	**Operational:** Increased demand and level of complexity of need of people accessing VCSE services, alongside reduced capacity due to reduced contract values and contracts ending / short term funding. As VCSE sector is increasingly unable to support existing as well as rising demand amongst the most vulnerable groups 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.

		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. commissioned bereavement support.		of service due to balance of time spent budgeting / recruitment rather than delivery.		
Leeds City Council	⇔	**Workforce** Workforce resource not in place to deliver the service to the required standard. Worsening workforce pressures (including health, safety and wellbeing) and market sustainability position. Problems in both Adults and 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	⇔	**Major cyber incident** Cyber-attack / major IT outage has an adverse impact on our ability to keep delivering critical services (including those for Health and Social Care). <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.	⇔	**Sustained financial pressures** Financial and budgetary pressures within the organisation - in particular for Adults & Health and Children & Families directorates - is still very real/relevant and is high risk. <u>Sources</u> including market pressures relating to capacity and to increased cost of placements and packages of care.

		Contributions. Risk that the workforce capacity gap could worsen. <u>Sources:</u> Increased demand and complexity and experience of working in increasingly complex community contexts, including at times, heightened community tension. High vacancy factors that are proving difficult to fill. Market sustainability and competition in the labour market (internal and external to the sector). Underinvestment in the labour market. Staff leaving the sector(s) for better paid and less stressful jobs in other industries. Long term problems from the pandemic and Brexit.				
Note from Leeds City Council - *Underpinning these risks are the demands of responding to/implementing the national reforms alongside all the other competing pressures like finance, volume of demand, complexity of need, changes in ICB function.*						

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 and Introductions	X	X	X	X	Chair
Apologies and 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 and 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		Reporting paused			Various
GOVERNANCE AND 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	X		HL
Joint Working Agreements					LM
STRATEGY AND ASSURANCE					
Marmot City Update		X		X	VE
Health Inequalities / Core 20 Reporting		X		X	NE/NN
National Guidance Updates (Planning / Neighbourhood Working / Growth Accelerator Programme)	X	X		X	HL
Implications of changes to ICB and 10-year plan		X			
Director of Public Health Annual Report		X			VE