Leeds Health & Care Partnership

NHS West Yorkshire Integrated Care Board

WORKING WITH THE THIRD SECTOR

Annual Position Statement 2024

NHS WEST YORKSHIRE ICB IN LEEDS

A Strong and Purposeful Partnership

Version 1.2

September 2024

Leeds Health & Care Partnership

NHS West Yorkshire Integrated Care Board

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

Kim Shutler MBE, VCSE Sector Lead, West Yorkshire ICB

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Foreword

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

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

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

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

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

Pip Goff
Director, Volition/Forum Central

Jo Volpe
CEO, Leeds Older People's Forum/Forum Central

1. Purpose and Contextual Overview

1.1 Purpose

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

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

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

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

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

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

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

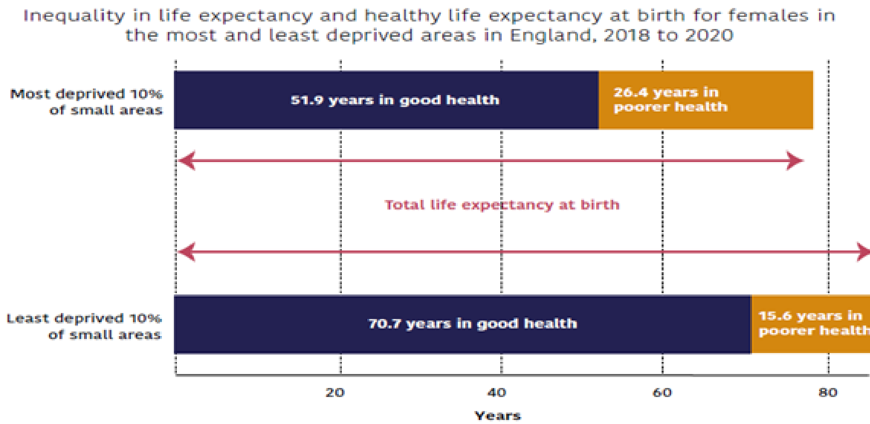
This document describes the contribution the ICB will make to this broader vision in partnership with the VCSE sector. It builds on our strong partnership recognition of the value of our Third Sector as a city asset. It is intended to inform not only the Third Sector, but also other colleagues in the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

1.2 The Challenge Facing Healthcare in the UK

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

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

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



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

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

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

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

1.3 The role of the NHS in Health

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

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

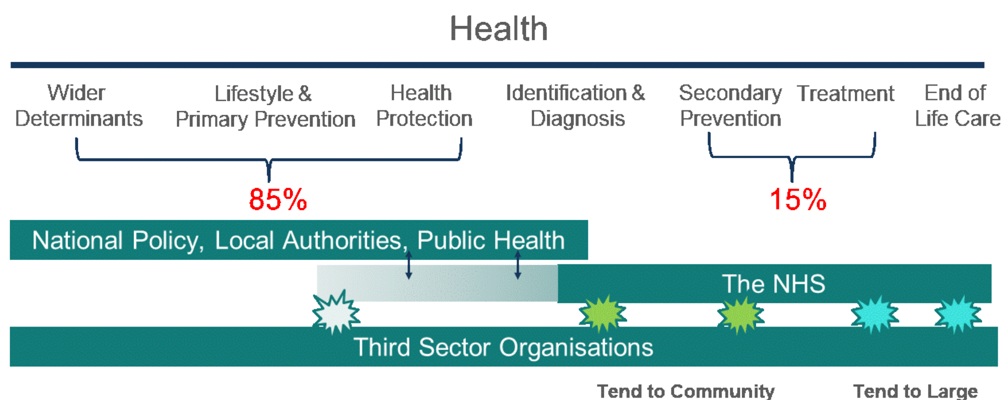
The NHS is funded to provide high quality and safe services and ongoing treatment to people when they are ill, whether that is with an acute or chronic illness. It is also

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

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

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

The Role of the NHS



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

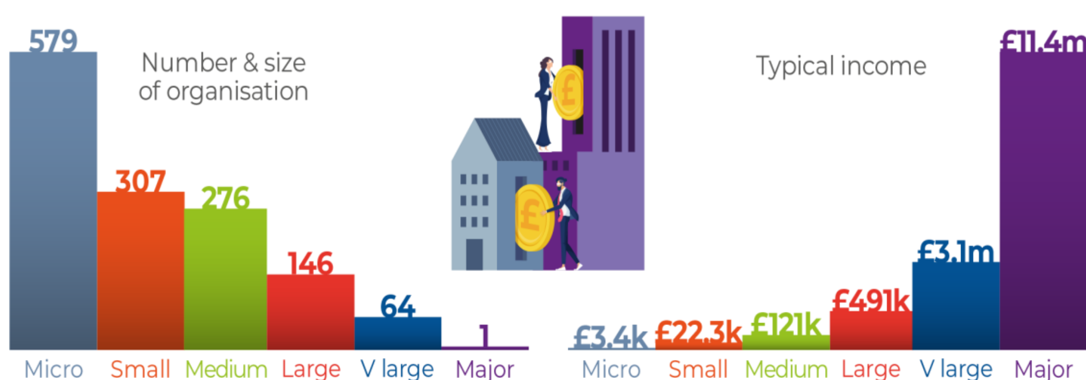
- Continuing to invest in service provision alongside statutory and independent providers with equal standing (See note on Social Value 5.2).
- Greater opportunity for support with the early identification of risk factors and access to appropriate preventative interventions particularly in addressing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

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

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

1.4 The Third Sector in Leeds

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



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

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

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

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

1.5 Limits and Constraints

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

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

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

1.6 Next Steps

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

2. The Current and Future Distribution of Funding

2.1 Looking Forward

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

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

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

2.2 Current Picture – Overview

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

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

2.3 Current Picture – ICB Direct Detail

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

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

3. The Priorities 2025-2028

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

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

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

3.1 Inequality and Neighbourhood

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3.2 City Wide Priorities

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

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

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

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

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

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

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

3.3 Wider Determinants Data

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

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

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

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

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

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

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

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

5. Procurement and Contractual Approach

5.1 Partnership

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

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

5.2 The Provider Section Regime

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

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

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

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

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

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

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

5.3 Joint Commissioning and Commissioning Consortia Approaches

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

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

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

5.4 Procurement and Contractual Principles

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

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

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

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

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

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

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

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

6. Opportunities for a Broader Contribution

6.1 The ICB in Leeds as an Anchor Organisation

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

6.2 Strategic Influence

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

6.3 Additional Features of Its Approach

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

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

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

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

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

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

6.4 Further Areas to Explore

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

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

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

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

7. Summary of Commitments and Opportunities

7.1 Commitments

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

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

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

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

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

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

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

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

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

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

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

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

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

7.2 Partnership

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

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

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

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

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

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

Appendices

A. West Yorkshire Commissioning Principles

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

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

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

Appendix B: Provider Selection Regime

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

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

The PSR has been designed to:

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

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

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

Decision-Making Circumstances (Healthcare Services Only)

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

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

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

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

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